

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

PRINTED: 05/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2014
NAME OF PROVIDER OR SUPPLIER PARK MANOR REHABILITATION CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 1710 PLAZA WAY WALLA WALLA, WA 99362	
(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	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Park Manor Rehabilitation Center on 05/05/14, 05/06/14, 05/07/14, 05/08/14, 05/09/14, 05/12/14, 05/13/14 and 05/14/14. A sample of 34 residents was selected from a census of 81. The sample included 29 current residents and the records of 5 former and/or discharged residents.</p> <p>The survey was conducted by: Lisa Herke, RD Liisa Johnson, RN Lucy Fromherz, RN Brenda Webster, RN</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Long-Term Support Administration Residential Care Services, District 1, Unit C 3611 River Road, Suite 200 Yakima, WA 98902</p> <p>Telephone: (509) 225-2800 Fax: (509) 574-5597</p> <p><i>[Signature]</i> 5/19/14 Residential Care Services Date</p>	F 000	<p>This Plan of Correction (POC) is prepared and submitted as required by law. By submitting this POC, Park Manor Rehabilitation Center (Park Manor) does not admit that the deficiencies listed on the CMS form 2567 exist, nor does Park Manor admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. Park Manor reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p style="text-align: right;">Received Yakima RCS JUN 11 2014</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE Administrator (X6) DATE 6/5/14

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.

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

PRINTED: 05/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PARK MANOR REHABILITATION CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 PLAZA WAY WALLA WALLA, WA 99362
---	--

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

F 241

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 observation and interview, the facility failed to promote care for residents in a manner and in an environment that maintained each resident's dignity for 1 of 2 dining rooms. Further, 1 of 1 resident (#86) was randomly observed being transported a long distance to the bathing area in an undignified manner. This placed residents at risk for minimized quality of life. Findings include:

DINING ROOM:

During the evening meal observation on 05/05/14, Resident #86 had a large amount of continuous sinus drainage. Staff Member F, a nursing assistant (NAC), was observed several times wiping his nose with his clothing protector. She commented to her co-worker, in front of all the residents at the table, how "messy" residents were and how they would have to wash everybody extra. She spoke of assisting one random male resident at the table to place food on his fork and how he dropped the food on his clothing protector.

During an observation of the noon meal on 05/07/14 at 11:45 a.m., Resident #86 was seated at a table with three other male residents. He was coughing. Staff Member N, a licensed nurse,

One on one in-service given to Nursing Assistant on 5/6/14 by the Director of Nursing Services (DNS) on transporting resident #86 in the hallway to shower room in a dignified manner which includes resident being fully dressed to and from shower room.

Staff member F had one on one in-service by the DNS on 5/13/14, related to resident #86 observation in dining room on 5/5/14, Staff F was given direction how to respect resident dignity in the dining room and while giving general care.

Concerning resident #86 - one on one in-service was conducted with licensed nurse N on 5/8/14 by the DNS to remove resident from dining room when a persistent cough occurs, without disrupting others and assessing for signs & symptoms of aspiration.

Resident #88 will be transported in the hallway to shower room in a dignified manner which includes resident being fully dressed to and from shower room per resident's preference.

Staff Q was in-serviced on utilizing the communication device appropriately while speaking to co-workers to promote care for residents in a manner and in an environment that maintained each resident's dignity and respect.

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

PRINTED: 05/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PARK MANOR REHABILITATION CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 PLAZA WAY WALLA WALLA, WA 99362
---	--

(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 241 Continued From page 2

was observed numerous times shielding his deep loose cough from the others with his clothing protector.

On 05/07/14 at 11:50 a.m., entering the door by the sink, Staff Member Q, a NAC, spoke into her communication device to other staff, "There is room for [a resident] in here and more feeders." Six residents were nearby at tables but her comment could be heard at other end of room also.

BATHING

Resident #86 was observed being wheeled down the hall to the shower from his room on 05/06/14 at approximately 10:00 a.m. He was wrapped in a bath blanket but his bare legs and feet were visible. He was taken down the hall an excessive distance past the nurse's station and many offices and resident rooms. Resident #86 was unable to be interviewed due to his dementia.

On 05/08/14 at 10:00 a.m., Resident #88 was observed sitting on the side of her bed with wet hair. She was wearing day clothing. She said she had just come from the shower several doors down the hallway from her room. She was taken there in a wheelchair with her clothing on, but came back to her room to dress covered with a bath blanket. When asked about her preference for being in the hallway covered only with a blanket, she stated "well, you have to give up a lot of modesty when you come here." Her preference would have been to undress and dress in the shower room before going out in the hallway where she could be seen by residents, visitors, and/or staff.

F 241

Weekly audits of bathing procedures including but not limited to transporting residents to and from shower in a dignified manner will be conducted times 4 weeks by the Staff Development Coordinator (SDC) and or designee and given to the DNS for follow up as needed.

Weekly audits will be conducted by SDC and or designee to include but not limited to promoting an environment that maintains resident dignity in the dining room times 4 weeks to include each meal service time. Findings will be given to the DNS for follow up as needed.

SDC and or designee will In-service nursing staff regarding how residents will be transported to shower rooms fully clothed and then undressed and dressed in the privacy of the shower room.

SDC will In-service staff on A) appropriate cleaning of resident's faces while dining, to offer tissue to residents and/or staff to assist resident to clean with tissue using gloves, and then washing hands appropriately. B) Using appropriate language in the presence of residents and while giving care. C) Use the appropriate tone and volume of voice. D) Not to use language that could be considered disrespectful or derogative when talking about and or with residents.

SDC and or designee will In-service licensed nursing staff to remove residents from dining room when a persistent cough occurs, without disrupting others and assessing for signs & symptoms of aspiration. Resume feeding resident in their room to protect resident's dignity.

DNS will take audit results to the Quality Assessment and Assurance (QA&A) Committee at the 4 week completion to be reviewed.

The QA&A Committee will review findings and make recommendations as needed.

Director of Nursing Services will ensure compliance.

7/6/14
Ceballos
JH

See enclosed documentation of verbal change of completion date.
R. Hunter
6/19/14

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

PRINTED: 05/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARK MANOR REHABILITATION CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 PLAZA WAY WALLA WALLA, WA 99362
--	--

(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 272	Continued From page 3	F 272		
F 272	483.20(b)(1) COMPREHENSIVE	F 272		
SS=D	ASSESSMENTS			

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:

- Identification and demographic information;
- Customary routine;
- Cognitive patterns;
- Communication;
- Vision;
- Mood and behavior patterns;
- Psychosocial well-being;
- Physical functioning and structural problems;
- Continence;
- Disease diagnosis and health conditions;
- Dental and nutritional status;
- Skin conditions;
- Activity pursuit;
- Medications;
- Special treatments and procedures;
- Discharge potential;
- Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and
- Documentation of participation in assessment.

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

PRINTED: 05/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PARK MANOR REHABILITATION CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 PLAZA WAY WALLA WALLA, WA 99362
---	--

(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 272 Continued From page 4

F 272

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to comprehensively and accurately assess 2 of 4 residents reviewed for oral care (#88, 100). This failed practice placed residents at risk for complications related to poor oral care. Findings include:

Resident #100. Per observation and verified in a resident interview on 05/06/14, his oral status was identified as no teeth in his upper jaw and missing teeth in the back of his mouth on his lower jaw.

Per the admission comprehensive nursing assessment completed on 09/05/13, Resident #100 was identified with some missing natural teeth.

Per the next two quarterly assessments completed on 12/05/13 and 03/07/14, he was identified with teeth in good condition.

These assessments did not accurately reflect the condition of his missing upper and lower teeth.

On 05/13/14 at 2:30 p.m., Staff Member H, Resident Care Manager, stated she had not looked at Resident #100's teeth prior to completing the admission or the quarterly assessments. After further review, Staff Member H verified the status of the resident's poor oral condition and the inaccuracy of the assessments.

Resident #88. On 05/07/14 at approximately 1:00 p.m., the resident stated her dentures were loose

Resident #88 was immediately scheduled a dental appointment and saw dentist on 5/29/14, a dietary consult was completed on 5/8/14.

Resident #100 was given a complete oral assessment by the Minimum Data Set (MDS) nurse on 5/13/14 and teeth and gums were cleaned.

Current resident's oral status will be evaluated and assessed by the Director of Nursing Services (DNS) and or designee to ensure documentation accuracy and needed dental services are provided to residents as required.

The MDS nurse will assess each resident's dental needs quarterly and annually.

Nursing staff will be in-serviced by the Staff Development Coordinator (SDC) and or designee on thorough nursing assessment on admission, quarterly, significant change of condition, and annual comprehensive assessment. If problems are found it is to be reported to charge nurse immediately. Charge nurse then to assure dental appointment scheduled if appropriate. Staff will monitor during meal times and denture care, then report to charge nurse if dentures do not fit appropriately and/or if resident complains of ill-fitting dentures.

Audits will be conducted weekly times 4 weeks on new admissions dental assessments, and random resident oral assessments by the DNS and or designee during oral care.

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

PRINTED: 05/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PARK MANOR REHABILITATION CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 PLAZA WAY WALLA WALLA, WA 99362
---	--

(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 272 Continued From page 5

causing her chewing problems. She stated she needed to see a dentist. Her family had taken her in the past but they had now moved out of the area. She said no one had asked her nor had she told any staff about her loose dentures.

On 05/08/14 at 10:00 a.m., the resident again stated that her dentures were loose and when she had gone to the dentist last, he had tried to glue them in for a better fit. She stated she had dental adhesive in her drawer, but it did not always hold. She reported she kept her dentures in her mouth at all times, and, the other night, one set had fallen out in her bed. She stated when she chewed, her dentures "flop around" in her mouth. She opened her mouth to show her dentures were loose.

The 01/14/14 admission comprehensive assessment identified the resident's dental status as no broken or loosely fitting full or partial dentures.

The 04/08/14 quarterly comprehensive assessment continued to identify the resident's dental status as no broken or loosely fitting full or partial denture.

When interviewed on 05/08/14 at 11:15 a.m., Staff Member H, the 'MDS' Coordinator, stated she was not aware of the resident's loose fitting dentures. She was not aware of any problems with her dentures at that time. She said there was a quarterly comprehensive assessment recently done, but she herself had not observed the resident's mouth or interviewed the resident for that assessment. She stated the licensed nurse would have documented in the resident's record if there were any issues. The record was

F 272

DNS will take audit results to the Quality Assessment and Assurance (QA&A) Committee after 4 week completion of audits.

The QA&A Committee will review findings and make recommendations as needed.

The Director of Nursing Services will ensure compliance.

Handwritten: 7/6/14
6/28/14
JH

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

PRINTED: 05/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PARK MANOR REHABILITATION CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 PLAZA WAY WALLA WALLA, WA 99362
---	--

(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 272 Continued From page 6
where she obtained her information for the comprehensive assessment.

F 272

On 05/08/14 at 11:45 a.m., Staff Member L, a licensed nurse, stated she did not assess a resident's dental status unless there was a specific problem the resident or a nursing assistant told her about. She had not been told the resident's dentures were loose and there had been no need to ask as her job position did not include a routine oral assessment.

The 'MDS' Coordinator was not assessing the resident's oral status visually and/or by resident interview. Thus, the quarterly comprehensive assessment was not accurate as related to the resident's oral status. Therefore, she was at risk for not receiving needed services.

F 279 483.20(d), 483.20(k)(1) DEVELOP SS=D COMPREHENSIVE CARE PLANS
F 279

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided

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

PRINTED: 05/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PARK MANOR REHABILITATION CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 PLAZA WAY WALLA WALLA, WA 99362
---	--

(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 279 Continued From page 7
due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to use the results of the assessment to develop a comprehensive plan of care related to medication use for 1 of 5 residents (#62) reviewed for medication use. Failure to develop a plan of care for the use of anti-coagulant medication placed this resident at risk of adverse side effects of the medication. Findings include:

Resident #62. Admitted [redacted] 14 with diagnoses including aftercare following surgery for peripheral vascular disease (a condition in which the blood vessels in the lower extremities are narrowed, restricting blood flow) and congestive heart failure. Per his comprehensive assessment, Resident #62 received an anti-coagulant medication (Coumadin) daily (an anti-coagulant helps prevent blood clots from forming with a risk for uncontrolled bleeding).

Review of physician orders and medication administration records on 05/12/14 revealed Resident #62 was prescribed and received Coumadin from the time of his admission. However, review of his care plan revealed no plan to monitor for potential adverse effects of Coumadin.

Further, on 05/12/14 at 1:15 p.m. Staff Member E, a Licensed Nurse, stated Resident #62 received Coumadin as a way to prevent blood clots after surgery. After reviewing his record,

F 279
Resident #62 physician orders for continued use of Coumadin was received and the residents care plan was updated on 5/13/14 to reflect the use of anti-coagulant medication as ordered and to include monitoring for potential adverse effects.
One on one education done with LN that initiated care plan for resident #62 regarding policy and procedure for Anti-coagulant therapy and on the importance of Coumadin being on residents care plan. Coumadin was put on residents care plan on 5/13/14 by MDS nurse.

Resident Care Manager (RCM) and/or designee will conduct audits on current residents receiving anticoagulant therapy to ensure policy and procedure is followed to include monitoring for appropriate blood levels, monitoring for potential adverse side affects, and that it is appropriately care planned. Findings will be given to the Director of Nursing Services (DNS)

Director of Nursing Services and or designee will in-service licensed staff to ensure anticoagulant therapy policy and procedure is followed to include but not limited to monitoring blood levels for medication, care plan is in place, and monitoring for potential side affects.

DNS will take audit results will to Quality Assessment and Assurance (QA&A) Committee after 4 week completion of audits.

The QA&A Committee will review findings and make recommendations as needed.

The Director of Nursing Services will ensure compliance.

Att
6/28/14
7/6/14

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

PRINTED: 05/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PARK MANOR REHABILITATION CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 PLAZA WAY WALLA WALLA, WA 99362
---	--

(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 279 Continued From page 8
she stated she could not find any blood test monitoring to ensure the appropriate amount of Coumadin was being given, except once on 04/21/14.

On 05/12/14 at 3:30 p.m., the facility contracted Pharmacist, stated typically after surgery, if a person was prescribed Coumadin, a blood test should be done weekly to ensure the amount of Coumadin was appropriate for that person.

On 05/13/14 at 11:00 a.m. Staff Member B, Director of Nursing Services, stated a care plan should be in place when Coumadin was administered, and monitoring for adverse effects should be part of the plan.

The facility failed to develop and implement a care plan for the use of Coumadin after identifying it on the comprehensive assessment. As no plan was in place to monitor for appropriate blood levels or adverse side effects, the resident was placed at risk of adverse side effects caused by too much or too little anti-coagulant medication.

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO 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

F 279

F 280

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

PRINTED: 05/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PARK MANOR REHABILITATION CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 PLAZA WAY WALLA WALLA, WA 99362
---	--

(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 280 Continued From page 9

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, the facility failed to ensure the plan of care was reassessed and updated to meet the needs of 2 of 2 residents (#24, 86) in the sample reviewed with a significant change of condition. This failed practice placed residents at risk to receive less than optimal care. Findings include:

Resident #86. Admitted on [REDACTED] 10 with diagnoses which included dementia (memory loss) and dysphagia (difficulty swallowing).

A significant change in status assessment was completed on 03/24/14 related to the resident's decrease in weight and compromised nutritional status. Per the record, a decision was made by the physician and family representative to effect a comfort care status.

The care plan was updated on 09/24/13 with nutritional concerns identified. The interventions included directives that resident was able to feed himself with set up and supervision. Additionally, he was to be assisted to eat in the dining room or

F 280

Resident #86 and his family were interviewed as to resident preference pertaining to dining preferences with care plan updated to preference.

Resident #24 interviewed as to his preference for re-positioning for comfort with cares. Care plan/care guide updated to preference.

Residents to be interviewed as to their preferences related to meal/dining and positioning in bed. Preferences will then be added to care plan/care guides. Interviews will be done by social services, MDS nurse or designee.

Staff Development Coordinator (SDC) will in-service nursing and therapy staff on how to read, understand and follow each individual care plan/care guide. If resident reports preference other than and/or in addition to what is on care plan/care guide then staff member is to report to charge nurse in order to adjust plan.

Resident Care Manager (RCM) and/or designee will conduct random audits of residents care plan/care guide weekly times 4 weeks to ensure they are appropriate and individualized. Audits will be given to the Director of Nursing Services (DNS).

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

PRINTED: 05/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PARK MANOR REHABILITATION CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 PLAZA WAY WALLA WALLA, WA 99362
---	--

(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 280 Continued From page 10
in his room at his preference.

On 05/07/14, an interview with the resident's family identified that the resident did not like to be pushed or perceive he was being forced to eat. She stated that he would then just quit eating. She stated the best way to get him to eat was to place the food in front of him and attempt to distract him with conversation. She said she brought food in for him and he ate some, but not always all, of it. She was concerned about his overall condition wanting him to eat as much as he could and be as comfortable as possible.

On 05/07/14 at 4:45 p.m., Staff Member G, an evening shift nursing assistant, stated his observation of the resident's dinner in his room. The resident usually refused most of the food from the kitchen, but ate what his family brought and he ate better when his family was in the facility.

On 05/13/14, Staff Member D, the Social Services Director, stated the resident ate better when his family was there and talking to him; he ate without thinking about it. Staff Member D reviewed and verified the lack of updated information regarding eating on the resident's care plan.

Although information was available from Resident #86's family and various staff members about other interventions that might improve his nutrition intake, the information failed to be considered as additional interventions for the plan of care to prevent additional weight loss.

Resident #24. Progress notes dated 03/13/14 documented a significant change in condition had

F 280
DNS will take audit results to the Quality Assessment and Assurance (QA&A) Committee after 4 week completion of audits.

The QA&A Committee will review findings and make recommendations as needed.

The Director of Nursing Services will ensure compliance.

7/9/14
6/25/14
ATT

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

PRINTED: 05/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PARK MANOR REHABILITATION CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 PLAZA WAY WALLA WALLA, WA 99362
---	--

(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 280	<p>Continued From page 11</p> <p>required a 02/27/14 comprehensive assessment. It revealed he had medical complications following multiple recent hospitalizations for heart disease and a hip fracture.</p> <p>The 02/26/14 weekly skin observation documented the resident had a non-repairable left hip fracture with moderate to severe pain when repositioned by staff. He also had been admitted with a pressure ulcer and was turned off of his back routinely to assist in the healing process.</p> <p>On 05/06/2014 at 3:34 p.m., he stated he had broken his left hip quite sometime ago, but the crack was still there and moving kept it from healing. He stated there was a lot of pain, especially when he turned.</p> <p>On 5/13/14 at 4:30 p.m., Staff Member L, a licensed nurse, stated the resident had been on bedrest since he returned to the facility with a healing hip fracture. Staff Member L stated the resident had pain in his hip but the amount depended on what had happened that day. The days he had therapy working with him, he was in more pain. She stated the nursing assistants used the 'log roll technique' to turn him.</p> <p>On 05/14/14 at 8:55 a.m., Staff Member M, a licensed nurse, stated the nursing assistants turned the resident using the drawsheet and hand placement so that there was the least pressure possible on his hip. This helped to lessen the pain he experienced.</p> <p>On 05/14/14 at approximately 9:00 a.m., Staff Member O, a nursing assistant, stated the resident was turned using a draw sheet. He</p>	F 280		
-------	--	-------	--	--

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

PRINTED: 05/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PARK MANOR REHABILITATION CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 PLAZA WAY WALLA WALLA, WA 99362
---	--

(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 280 Continued From page 12
described hand placement and how the draw sheet was used to avoid pain to the hip.

On 05/14/14 at 9:10 a.m., Staff Member P, a nursing assistant, stated the staff had been trained by the therapy department on how to appropriately turn the resident. She described positioning with use of the drawsheet, specific hand placement on the shoulder and below the hip - she stated the resident was always turned with 2 and sometimes 3 staff members. She stated he always had hip pain.

On 05/14/14 at 10:30 a.m., a physical therapist involved in the resident's care stated she had reviewed the therapy notes and found there were no written instructions for the nursing home staff on proper turning and positioning of the resident. She stated the resident would always have pain as his fractured left hip was displaced from the socket and he had other pain issues as well.

However, review of the care plan noted bed mobility interventions which directed that the resident required extensive assistance by one staff member to turn him side-to-side, rather than the two to three staff members it was actually requiring. Further, the plan was not updated with the specific turning and positioning techniques to meet the resident's specific care needs.

F 280

F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

F 441

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

PRINTED: 05/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PARK MANOR REHABILITATION CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 PLAZA WAY WALLA WALLA, WA 99362
---	--

(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 441 Continued From page 13

F 441

(a) Infection Control Program

The facility must establish an Infection Control Program under which it -

- (1) Investigates, controls, and prevents infections in the facility;
- (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
- (3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection

- (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
- (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
- (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens

Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure proper hand hygiene to prevent cross contamination of germs when assisting residents with meals in the North Dining Room. Findings include:

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

PRINTED: 05/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PARK MANOR REHABILITATION CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 PLAZA WAY WALLA WALLA, WA 99362
---	--

(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 441 Continued From page 14

During observation of the meal on 05/05/14 at approximately 5:00 p.m. in the North Dining Room, Staff Member F, a nursing assistant, was assisting residents with eating. She assisted multiple residents consecutively with no hand washing observed between residents. She was observed bare-handed wiping Resident #86's nose with a clothing protector which was dripping mucous. She was also observed to crawl between two wheelchairs which were close together, touch the tires, and then resume assisting with feeding another resident without first washing her hands.

The facility hand washing procedure was reviewed which directed all staff to cleanse hands to prevent transmission of possible infectious material and to provide clean, healthy environment for residents and staff.

Per interview on 05/13/14 at 12:00 p.m., Staff Member C, Infection Control Licensed Nurse, verified that Staff Member F's observed actions were not consistent with the facility's hand washing policy.

F 441

Resident #86 will have nose clean prior to entering dining room. Tissue and gloves will be made available in the dining room for use as needed.

One on one education conducted with staff F by Staff Development Coordinator (SDC) and/or designee on proper hand hygiene and to prevent cross contamination.

In-service for nursing will be conducted by the SDC and/or designee on infection control and appropriate hand washing to include but not limited to preventing cross contamination.

Resident Care Manager and/or designee will conduct weekly random audits to ensure proper infection control practices are in place including but not limited to hand hygiene and providing a clean healthy environment that prevents cross contamination. Audit results will be given to the Director of Nursing Services (DNS).

DNS will take audit results to the Quality Assessment and Assurance (QA&A) committee after 4 week completion of audits.

The QA&A committee will review findings and make recommendations as needed.

The Director of Nursing Services will ensure compliance.

7/8/14
6/28/14
JH