

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

PRINTED: 06/04/2013
FORM APPROVED
OMB NO. 0938-0391

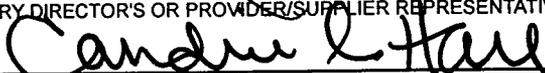
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505257	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/28/2013
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NAME OF PROVIDER OR SUPPLIER ALDERWOOD MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 EAST HARTSON AVENUE SPOKANE, WA 99202
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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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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Alderwood Manor on 5/23/13 and 5/28/13. A sample of 5 residents was selected from a census of 61. The sample included 2 current and the records of 3 former and/or discharged residents.</p> <p>The following complaints were investigated as part of his survey:</p> <p>#2796922 #2809084 #2792258</p> <p>The survey was conducted by: [REDACTED] R.N.</p> <p>The surveyor was from:</p> <p>Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services, District 1, Unit A Rock Pointe Tower 316 W. Boone Ave, Suite 170 Spokane, Washington 99201-2351</p> <p>Telephone: (509) 323-7302 Fax: (509) 329-3993</p> <p> Residential Care Services Date 6/1/13</p>	F 000	<p><i>This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and, such liability is hereby specifically denied. The submission of the plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.</i></p> <p>RECEIVED JUN 17 2013 DSHS ADISA RCS SPOKANE WA</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 6/13/13
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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 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify the designated decision maker of</p>	F 157	<p>F 157 - D</p> <p><i>How the nursing home will correct the deficiency as it relates to the resident</i> <i>Resident #3's family has been notified of the medication changes.</i></p> <p><i>How the nursing home will act to protect residents in similar situations</i> <i>The facility immediately in-serviced LN's regarding the importance of notifying the residents legal representative or an interested family member when there is a need to alter treatment significantly</i></p> <p><i>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur</i> <i>The facility in-serviced LN's regarding the importance of notifying the residents legal representative or an interested family member when there is a need to alter treatment significantly; including, Notifying the residents designated decision maker of medication changes</i></p> <p><i>How the nursing home plans to monitor it's performance to make sure that solutions are sustained</i> <i>DON\RCM will audit new medication orders and changes in medication orders to ensure the resident's designated decision maker has been notified; Audits will occur weekly x 4 weeks then monthly x 3. Results will be reviewed through the facility PI Committee with further plan of action if required</i></p>	<p>6/12/13</p> <p>6/12/13</p> <p>6/12/13</p> <p>6/12/13</p>	

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F 157	<p>Continued From page 2 medication changes for 1 of 5 sample residents, (#3). Findings include:</p> <p>Resident #1 had diagnoses that included [REDACTED] with [REDACTED] and [REDACTED]. Per record review, the resident had some cognitive impairment, had a [REDACTED]; and received an [REDACTED] medication.</p> <p>According to the record, on 3/20/13 the resident's [REDACTED] medication was discontinued as part of a trial drug reduction. There was no documentation to indicate the resident's designated decision maker was notified of the change in the resident's medication regime.</p> <p>When interviewed on 5/28/13 at 8:00 a.m., the resident's designated decision maker stated they were not told the medication had been discontinued until 5/13/13 when they met with facility staff to discuss the resident's increased behaviors.</p> <p>During an interview on 5/23/13 at 11:10 a.m., facility administration stated the family should have been informed of the change at the time it was implemented, but was unable to locate any documentation to verify this was done.</p> <p>The facility failed to notify the resident legal decision maker when treatment was altered significantly.</p>	F 157	<p><i>Date when the corrective action will be completed</i> 6/12/13</p> <p><i>The title of the person responsible to ensure correction</i> <i>The Executive Director is responsible to ensure corrective actions</i></p>	6/12/13 <i>ongoing</i>