

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

PRINTED: 07/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505498	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/13/2012
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NAME OF PROVIDER OR SUPPLIER TOUCHMARK ON SOUTH HILL NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 2929 SOUTH WATERFORD DRIVE SPOKANE, WA 99203
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Off-Hours Quality Indicator Survey conducted at Touchmark on the South Hill Nursing & Rehab on 7/9/12, 7/10/12, 7/11/12, 7/12/12, and 7/13/12. The survey included data collection on 7/9/12 from 6:30 p.m. to 8:45 p.m. A sample of 31 residents was selected from a census of 44. The sample included 26 current residents and the records of 5 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>Linda Loffredo R.N., B.S.N. Mara Ryan, B.S.W. Lisa Harting, R.N., B.S.N. Colleen Daniels, R.N., B.S.N.</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, District 1, Unit A Rock Pointe Tower 316 West Boone Avenue, Suite 170 Spokane, Washington 99201-2351</p> <p>Telephone: (509) 323-7302 Fax: (509) 329-3993</p> <p> Residential Care Services Date</p>	F 000	<p>The plan of correction begins on page 2</p> <p style="text-align: center;">RECEIVED AUG 09 2012 DSHS ADISA RCS SPOKANE WA</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>J. Jeffrey Walcott</i>	TITLE Administrator	(X6) DATE 8-8-2012
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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, it was determined the facility failed to consult with the</p>	F 157	<p>F157</p> <p>#102 is no longer a resident</p> <p>All residents are at risk for this citation.</p> <p>A contributing factor to the delay in response by the resident's physician was found to be that the resident had chosen a specialist as primary care physician. Specialists are not as accustomed to frequent communication between the facility and physician and are less likely to have systems in place to triage and expedite a reply. The facility has concluded that the course of action to be taken when a resident is admitted with a specialist as primary care physician is to alert the facility medical director and have the medical director become familiar with the resident's case so as to be available to intervene should a similar situation arise.</p> <p>The facility has updated the policy regarding contacting physicians when a resident experiences a significant change of condition. The staff will attempt to contact the primary physician three times by fax and phone. If no response is received the staff will then contact the facility's medical director. The time frame for contacting the Medical Director will be dictated by nursing</p>	

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F 157	<p>Continued From page 2</p> <p>physician related to significant changes for 1 resident (#102) in a sample of 31. Findings include:</p> <p>Resident #102 had diagnoses including [REDACTED]</p> <p>[REDACTED] Per record review, the resident required extensive assistance with most activities of daily living, and was able to make daily decisions independently. The resident was physically weak, short of breath with activity, and required oxygen therapy to reduce the shortness of breath. The resident did not reside in the facility at the time of the survey.</p> <p>Per record review, the resident was admitted to the facility on [REDACTED] from the hospital for therapy. The resident was noted to be very involved in his own care and made his own health care decisions. The resident's pulmonologist was the resident's primary care physician.</p> <p>Nursing notes dated 5/23/12 revealed the resident had blood in his stool and was having diarrhea. A Fax was sent to the physician to inform him of the resident's condition. At that time, the resident decided he did not want any interventions, including not wanting to go to the hospital.</p> <p>Per nursing notes dated 5/24/12, the resident had a fall and complained of shortness of breath. The physician was notified via fax of the fall and the resident's complaints of shortness of breath. The nurse also indicated to the physician the resident could possibly be dehydrated. The physician was asked if he wanted to order labs, start fluids or test for a possible urinary tract infection.</p> <p>Per record review, there was no response from the physician on 5/25/12 and a phone call</p>	F 157	<p>judgment as to the urgency of the need for response. As per nursing judgment, in a sudden or worsening change of condition in which a self-directing resident exhibits decrease decision making capacity, 911 will be called.</p> <p>All current resident charts have been reviewed for delay in physician response. This review did not identify any situations that would qualify to contact the medical director.</p> <p>The interdisciplinary team holds a weekday meeting at which all residents with a change of condition are discussed. Delay in physician response will be reviewed by the Director of Nursing and the Resident Care Managers at this meeting. Emphasis will be given to unanswered physician notification as the weekend approaches to ensure a response or to notify the medical director. This daily discussion will ensure the problem does not recur, as well as to monitor continued performance.</p> <p>The facility has updated the policy regarding physician contact, involvement of medical director and review of unanswered physician notification when a resident has experienced a significant change of condition. All Licensed Nursing Staff will</p>		

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F 157	<p>Continued From page 3</p> <p>was placed to follow up with him.</p> <p>On 5/26/12, the resident had a change in condition. He needed more oxygen to keep his saturation levels up and the resident was more short of breath at rest.</p> <p>On 5/27/12 at 10:00 a.m., nursing staff noted the resident had a temperature and the resident did not participate in therapy.</p> <p>At 10:00 p.m., the resident continued to have a temperature and he continued having difficulty keeping his oxygen levels up.</p> <p>Per record review on 5/27/12, the facility had not heard from the physician in regard to the resident's fall, possible dehydration and increased shortness of breath. The facility did not follow up with a phone call to the physician to consult regarding the resident's changes in condition.</p> <p>On 5/28/12 at 2:45 a.m., nursing staff noted the resident was calling out for help from his room. The resident was very weak and his oxygen levels were between 40-50%. The nurse had to increase the resident's amount of oxygen to get his saturation levels up. The resident had the chills, was shivering and was noted to have a temperature but refused to go to the hospital.</p> <p>On 5/28/12, nursing noted the on-call nurse practitioner ordered an antibiotic however there was no information to show the facility addressed the other concerns with the nurse practitioner.</p> <p>On 5/29/12 staff notified physician about resident's symptoms and requested response, a delay of 4 days since the last phone call on 5/25/12.</p> <p>The facility did not continue to make efforts to consult with the physician when the resident continued to show a change in condition in respiratory status and possible infection.</p>	F 157	<p>attend an inservice regarding these updates between August 13th and 16th, 2012.</p> <p>This inservice will be videotaped and all newly hired nurses will view this inservice at orientation.</p> <p>Completion Date: August 17, 2012</p> <p>The Director of Nursing is responsible</p>		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279			

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F 279 SS=D	<p>Continued From page 4</p> <p>COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to develop a comprehensive plan of care for 3 of 3 residents (#4, 46, 95) related to pain management in a sample of 31. Findings include:</p> <p>1. Resident #4, per record review, had diagnoses that included [REDACTED]. The resident was alert and oriented and able to make her needs known. The resident's pain assessment dated 5/9/12</p>	F 279	<p>F 279</p> <p>Resident #4, #46 and #95 have had their comprehensive care plan updated to address pain.</p> <p>All residents are at risk for this citation. All current residents' charts have been reviewed and updated for pain care plans.</p> <p>It has been determined that due to the nature of the resident population, all residents should have comfort and pain addressed in the comprehensive plan of care. Therefore, the Resident Care Managers have been directed to include the section on "alteration in comfort: pain" in all resident comprehensive care plans to be updated quarterly, upon change of condition and whenever a change in pain management is necessary.</p> <p>Routine inclusion of this section will insure that the problem does not recur. To insure that the solution is sustained, the facility will conduct quarterly audits of comprehensive care plans and report results at the quarterly quality assurance meeting. The quality</p>		

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F 279	<p>Continued From page 5</p> <p>showed the resident's pain was almost constant. The resident's origin of pain was [REDACTED] and her [REDACTED]</p> <p>The Physician's Orders noted the resident received a routine narcotic medication two times each day. She also received a narcotic medication for pain if needed.</p> <p>Review of the resident's chart revealed no Care Plan for pain.</p> <p>In an interview on 7/12/12 at 3:30 p.m., Staff #B confirmed the resident did not have a care plan for pain.</p> <p>Lack of an individualized/comprehensive care plan for pain placed the resident at risk for not having adequate pain relief.</p> <p>2. Resident #46 had diagnoses including [REDACTED]. Per record review, the resident had cognitive and memory problems, and required total assistance for activities of daily living. The resident received ancillary services for end of life care that were coordinated with facility staff.</p> <p>Per record review, the resident had physician orders for routine and as needed pain medications. Licensed staff evaluated the resident's pain daily as moderate pain relieved with the medications.</p> <p>Per record review, the facility did not develop a comprehensive plan of care that addressed the resident's goals for pain control and effective non-pharmacological interventions to reduce the resident's pain level.</p> <p>In an interview on 7/13/12 at 11:30 a.m., Staff #C confirmed the resident should have a pain care plan.</p>	F 279	<p>assurance committee shall recommend further actions if necessary.</p> <p>Completion Date: August 16, 2012</p> <p>The Director of Nursing is responsible</p>		

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F 279	Continued From page 6 3. Resident #95, per record review, had respiratory problems and recently underwent surgery for cancer. The resident required extensive assistance with activities of daily living and was able to make decisions independently. The resident's most recent pain assessment showed the resident had intermittent pain, moderate in severity. The resident's origin of pain was identified [REDACTED] The physician's orders noted the resident received routine pain medication and she also received a narcotic pain medication if needed. Review of the resident's chart revealed no care plan for pain. In an interview on 7/13/12 at 10:30 a.m., Staff #B confirmed the resident did not have a plan for pain control in the comprehensive care plan. The facility did not include a plan of care for pain for the resident which placed the resident at risk for not receiving adequate and individualized pain relief.	F 279		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328	F 328 #102 is no longer a resident All residents are at risk for this citation. The facility has re written the policy and procedure for use of oxygen via nasal cannula, simple oxygen mask and non-rebreathing mask to include procedures for: <ul style="list-style-type: none"> • Indication for use of each delivery system • Non-rebreather mask will only be used in a medical emergency with Physician order and notification of Director of Nursing or Resident Care Manager • Notification of physician • Direction the Physician's order must include • Staff direction regarding respiratory monitoring 	

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F 328	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure 1 of 1 residents reviewed for respiratory care (#102) in a sample of 31 received proper care and treatment related to oxygen therapy. Findings include:</p> <p>Refer to F157 for additional findings.</p> <p>A nasal cannula is used to deliver a low concentration of supplemental oxygen. A simple oxygen face mask is used to deliver moderate concentration of oxygen. A non-rebreather mask, often used in an emergency situation, is used to deliver a high flow rate of oxygen at 90-100% concentration.</p> <p>The facility procedure for oxygen therapy included the procedure for the delivery of supplemental oxygen using the nasal cannula. There were no procedures for use of oxygen face masks, including indications for use, notification of the physician, and directions to staff regarding consistent respiratory monitoring.</p> <p>Resident #102 had diagnoses including [REDACTED]</p> <p>[REDACTED] Per record review, the resident required extensive assistance with most activities of daily living, and was able to make daily decisions independently. The resident was weak, short of breath with any activity, and required oxygen therapy to reduce the shortness of breath. The resident did not reside in the facility at the time of the survey. The resident's physician orders directed staff</p>	F 328	<p>All Licensed Nursing Staff will attend training regarding the policy and procedure for oxygen use and Physician notification between August 13th and 16th, 2012.</p> <p>This inservice will be videotaped and all newly hired nurses will view this inservice at orientation.</p> <p>To ensure that the situation does not recur, the policy and procedure states that the Director of Nursing or the on call Resident Care Manager will be called when a non-rebreather mask is considered for use.</p> <p>New hires will receive training regarding the Oxygen policy.</p> <p>Non- rebreather masks will be used only in a medical emergency for short duration while decision regarding further care is determined.</p> <p>Completion Date: August 17, 2012 The Director of Nursing is responsible</p>	

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F 328	<p>Continued From page 8</p> <p>to titrate (adjust) the resident's oxygen flow meter to maintain oxygen saturation at 88% or above. The physician orders did not specify oxygen delivery via a nasal cannula and/or mask.</p> <p>Per record review, on admission, the resident required 2-4 liters (l) of supplemental oxygen per nasal cannula to maintain oxygen saturation above 88%.</p> <p>A nursing note dated 5/28/12 at 4:45 a.m. noted the resident's respiratory condition changed. The oxygen saturation fluctuated between 40-50% on 5 liters of supplemental oxygen per nasal cannula. The facility placed a "mask" and the oxygen saturation increased to 88% on 6 liters oxygen.</p> <p>A nursing note dated 5/28/12 at 1:20 p.m. noted the resident's oxygen saturation with the face mask decreased and a non-rebreather mask was applied. Additional record review revealed the facility notified a nurse practitioner, but there was no information to indicate the facility informed the nurse practitioner regarding the use of the non-rebreather mask and obtained additional orders for respiratory care.</p> <p>Per record review, the facility changed the resident back to a nasal cannula on 5/28/12 (time and resident tolerance not documented).</p> <p>Per record review, the resident's condition changed again on 5/29/12 at 4:05 a.m. The facility placed the non-rebreather mask and adjusted the oxygen flow rate to 7 l. Additional review of the nursing note revealed a nursing plan to monitor the resident's oxygen saturation every 2 hours.</p> <p>Per record review, the facility did not attempt to notify the physician when the resident's condition changed at 4:05 a.m. and did not document any respiratory monitoring after 4:05</p>	F 328			

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F 328	Continued From page 9 a.m. on 5/29/12. On 7/13/12 at 10:00 a.m., Staff #D, a licensed nurse was interviewed regarding the facility procedures for use of non-rebreather masks. He stated he had used a non-rebreather mask on occasion but not for quite some time. He stated he did not know if there was a facility procedure. He stated if he placed a non-rebreather mask on a resident, he would notify the physician for additional orders for respiratory care. In an interview on 7/13/12 at 10:30 a.m., Staff #C confirmed there was no facility procedure for use of a non-rebreather mask and did not have additional information to offer regarding whether the facility had the capability for safe use of a non-rebreather mask except in an emergency. The failure to obtain physician orders for respiratory care with the use of a non-rebreather mask, and the failure to consistently monitor the resident when using the mask placed the resident at risk for avoidable exacerbation of respiratory distress.	F 328			