

1201

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 04/22/2013
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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 INITIAL COMMENTS

This report is the result of an unannounced Quality Indicator Survey conducted at Touchmark On South Hill on 4/16/13, 4/17/13, 4/18/13, 4/19/13, and 4/22/13. A sample of 33 residents was selected from a census of 31. The sample included 23 current residents and the records of 8 former and/or discharged residents.

The survey was conducted by:

██████████, R.N., B.S.N.
██████████, R.N., B.S.N.
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F 000

Plan of Correction begins on page 2

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MAY 1 2013

DSHS ADMIN RUC
SPOKANE WA


Residential Care Services Date

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jeffrey Wolpert</i>	TITLE Administrator	(X6) DATE 5-16-2013
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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 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP 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 interview, observation and record review, it was determined the facility failed to have a comprehensive care plan for 2 of 4 residents (#32, #41) in a sample of 33 related to oral health and accidents. Lack of a comprehensive care plan placed the resident at risk for unmet services and possible further decline in functional abilities.</p> <p>Findings include:</p> <p>1. Resident # 32, was admitted [REDACTED]/13, was</p>	F 279	<p>F279</p> <p>Resident # 32 now has a care plan in place to address her oral health. In addition this resident had a dental appointment scheduled on May 17th to evaluate the fit of the residents' new dentures.</p> <p>Resident # 41 care plan was updated to include keeping a wheel chair and walker within reach of the resident when resident is in the recliner chair. The resident has consistently demonstrated that resident does not utilize a call light, even when in reach. This residents care plan now includes fall prevention interventions of a pressurized bed and chair alarm. This alarm alerts staff to when resident initiates a self-transfer. As part of the care plan, the residents room location, near the nurses station is in an area of high observation to maximize response time to the alarm.</p> <p>To protect residents in similar situations, all residents care plans have been reviewed to ensure they are current.</p> <p>Too ensure that the problem does not reoccur, Touchmark will make two changes to the care planning process.</p> <p>First, a new medical records program has been implemented. The staff responsible for</p>		

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F 279	Continued From page 2 assessed to have no natural teeth, inflamed with bleeding gums and chewing problems. Per record review of local hospital admission records the resident had dental surgery 03/18/13 to remove all teeth and was fitted with dentures. Per record review of nurse progress notes dated 03/24/13, the resident took out her dentures and picked at her gums until they bled. The staff had resident rinse with water and used gauze to stop bleeding. Per dietary assessment dated 04/3/13, the resident had all her teeth removed recently and was adjusting to her new dentures. Per record review, there was no care plan to address her oral health needs including monitoring for comfort, fit, and adjustment to new dentures. Per interview on 04/19/13 at 10:25 a.m., Staff B confirmed there was no care plan in place for the resident regarding her oral health. 2. Resident # 41 was admitted [REDACTED]/13 with diagnoses including [REDACTED] and [REDACTED] and [REDACTED]. Per record review, the end of life care plan dated 02/10/13 noted the resident's mobility diminished due to disease progression with a goal of maintaining a safe environment. Interventions were to understand and prepare for resident safety. The resident was discharged from end of life care on 03/20/13. Per record review the most recent facility assessment dated 04/03/13 assessed the resident to have decreased balance, increased weakness, and was a fall risk. No care plan was developed after resident was discharged from end of life services. No individualized interventions were in place to direct staff in	F 279	care planning are being trained in the utilization of the care planning function in the medical records program which triggers care planning needs from the MDS and other assessment information. This new system prompts the user to review a list of care plans that are due based on their last comprehensive or significant change assessment. Second, staff resources have been reallocated to more thoroughly address care planning needs. The new medical records program has a function to allow for quick access to information regarding care plan goals due, incomplete care plans and care plan reviews due. The Director of Nurses will utilize this function to audit, monitor and supervise staff assigned to insure that the care plans are current and accurate. Completion Date, June 6, 2013 Director of Nursing is responsible.	

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F 279 Continued From page 3
preventing falls and maintaining resident safety.
Per observation on 04/19/13 at 2:00 p.m., the resident was seated in his recliner, his call light and walker were not in reach. At 2:25 p.m., Staff #D stated the resident had a seat alarm under him and his door was kept open so staff could hear the resident when he tried to get up. Staff #D also stated he usually kept the resident's walker and wheelchair within reach of resident when he was in the recliner. Staff #D confirmed the call light was not within reach of the resident.

F 318 SS=D 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION

Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined the facility failed to develop and implement in a timely manner a restorative ambulation program for 1 of 1 resident (#8) reviewed for range of motion. Findings include:

Resident #8 was admitted after surgery for a [redacted] and [redacted]. Per record review, the resident had [redacted] and [redacted], and required extensive assistance of 2 staff for activities of daily living.

F 279

F 318

F318
Resident #8 re-started physical therapy on 4/10/13. Therapy was discharged on 4/18/13 and restorative nursing was implemented timely. Restorative program includes seated core strength, posture, standing tolerance and transfer training five times per week. This program is reviewed monthly for any needed changes.

All current residents have been assessed to insure that initiation of needed restorative services were not missed. It is our policy that restorative services are promptly initiated for residents in need of a restorative program upon discharge from therapy services. Assessment of the current residents indicates that this is an isolated incident caused by a communication breakdown.

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F 318	Continued From page 4 Per record review, physical therapy services were initiated upon admission. The resident could not initially bear weight on the right leg. Review of the physical therapy note dated 3/18/13 revealed the resident had been cleared for weight bearing on the right leg, required maximum assist during therapy, and could not walk. Per record review, physical therapy discontinued services on 3/28/13 without referring the resident for restorative services for walking. Per record review, the physician re-ordered physical therapy on 4/10/13 for ambulation training. During interview on 4/22/13 at 10:00 a.m., Staff #F stated the referral for restorative services was missed when physical therapy services were discontinued in March 2013. She stated the services were ordered by the physician when he reviewed the resident's status during the visit on 4/10/13. The delay in initiating restorative services placed the resident at risk for further decline in walking.	F 318	To insure prompt implementation of post therapy restorative programs, all residents discharging from therapy will be reviewed at the weekly interdisciplinary team (IDT) meeting, a subcommittee of the quality assurance committee. The IDT will confirm that a restorative program has been written, initiated and the appropriate documentation is placed in the residents chart. The resident name will not be removed from the IDT therapy roster until this step has been completed. Completion Date May 15, 2013 Director Nursing is responsible		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329	F329 A new monitoring form is in place for resident #38 that encourages input from more team members regarding frequency and severity of this residents distressful behaviors. All residents with the need for a behavior monitor are now using the new behavior monitoring format. Residents with behavior monitors are now identified on an existing internal daily report used by floor staff.		

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F 329	<p>Continued From page 5</p> <p>resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to consistently monitor behavior for 1 of 11 residents reviewed for unnecessary medications (#38) in a sample of 33. Findings include:</p> <p>Resident #38 had diagnoses including [REDACTED]. Per record review, the resident had [REDACTED], no mood/behavior problems, and required extensive assistance of 2 staff staff for most activities of daily living.</p> <p>Per record review, the resident's [REDACTED] medication was decreased as a trial dosage reduction on 2/4/13.</p> <p>Review of social services, nursing and activity notes dated 2/7/13 noted the resident asked repetitive questions and showed signs of distress on 2/6/13 and 2/7/13.</p> <p>Per record review, there was no additional documentation that the resident was having distressful behavior until a nurse's noted dated</p>	F 329	<p>Analysis of the cause of the lack of consistent documentation revealed that the documentation system did not allow for entries from multiple team members per shift and the need for staff education on documentation. Recognized distressful behaviors went undocumented due to the limitation of the format.</p> <p>The behavior monitor flow sheet has been enhanced with expanded space for behavior tracking. This additional space allows for more then one entry during each shift so consistent and complete documentation can be collected to reflect the frequency and severity of the resident's distressful behaviors.</p> <p>An inservice will be held to provide training to staff to include Nurses, Nursing Assistants, Activities staff, Dietary managers and Therapy staff. Staff will receive training on the importance of documentation of observations, how to use the behavior monitor, where to find the form and how to quickly identify from our daily report, residents using behavior monitors.</p> <p>The monthly psychotropic and behavioral team meeting, a subcommittee of the quality</p>	
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F 329	<p>Continued From page 6</p> <p>2/25/13 noted the resident was asking lots of questions.</p> <p>Per record review, on 2/20/13, the medication review committee noted the resident had repetitive questions with no additional information regarding frequency or severity of the behavior. On 2/26/13, the facility requested an increase of the medication medication which was approved by the physician.</p> <p>On 4/18/13 at 1:15 p.m., the resident was sitting with other residents in the common area near the nurse's station. Staff offered individual activities throughout the afternoon and the resident attended a group activity at 3:30 p.m.</p> <p>In an interview on 4/22/13 at 9:50 a.m., Staff #B confirmed staff did not consistently monitor the frequency and severity of the resident's distressful behavior that was the basis for increasing the resident's medication medication.</p>	F 329	<p>assurance committee will monitor the effectiveness of the training and enhanced behavior tracking system for compliance with consistent documentation of identified residents.</p> <p>Completion Date: June 6, 2013 Director of Nursing is responsible</p>	
F 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p>	F 431	<p>F431</p> <p>The locking of the treatment cart was identified as predominately a mechanical problem with the cart. The treatment cart was found to have a two-step lock and latch mechanism that would appear to be latched when it was not. Our pharmacy replaced this cart with a treatment cart that easily, consistently locks with a single step.</p> <p>The locking of the medication cart was identified as a training issue with a new nurse and a student nurse. All nurses are at risk for this citation.</p> <p>It is our policy that medication and treatment carts are to be locked unless in full view of the licensed nurse. All nurses will be informed of this citation and reminded of the</p>	

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F 431	Continued From page 7 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the Station 1 medication cart and treatment cart were consistently locked when unattended by licensed nurses. Failure to consistently secure medications potentially allowed residents and visitors in Station 1 access to potentially harmful medications. Findings include: Station 1 included resident rooms 260 through 275. 1. On 4/16/13 at 10:30 a.m., the Station 1 medication cart was unlocked and not within sight of a licensed nurse.	F 431	potential negative outcome from leaving a cart unsecured. All floor nurses scheduled to work will be randomly audited for compliance with this policy at least three times between now and June 6, 2013. Any nurse identified to not be in compliance with this policy as of June 6 will continue to be subject to random audits, the frequency of which will be determined by the level of non-compliance discovered during the initial audit period. New nurses currently watch a medication pass video at orientation. A section on the importance of locking the cart and the potential negative outcome of leaving the cart unsecured will be added to the orientation video. Each new nurse will be randomly audited at least three times for compliance during the first two weeks of employment following the completion of floor orientation. To ensure continued compliance, management staff will frequently randomly audit carts when passing in the hall. Director of Nursing is responsible Completion Date: June 6, 2013	
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F 431	<p>Continued From page 8</p> <p>2. On 4/18/13 at 10:35 a.m., the treatment cart outside of room 274 was unlocked and not within sight of a licensed nurse. The cart contained multiple medicated creams/ointments and a sharps container. Staff members, residents and visitors walked by the cart. At 10:50 am Staff #C verified the cart should have been locked when left unattended.</p> <p>3. On 04/22/13 at 10:00 a.m., the Section 1 medication cart was left unlocked and unattended in the hallway. Staff #B was informed and the cart was locked.</p> <p>4. On 4/22/13 at 2:45 p.m., the treatment cart was in the Station 1 hall, unattended and unlocked. Staff #A verified the cart should be locked and commented the facility was going to purchase a new cart.</p> <p>Medication/treatment carts are to be locked and/or in full view of the licensed nurse in order to be considered secure from possible misuse or accidental ingestion by residents.</p>	F 431		