

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/29/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PROVIDENCE ST JOSEPH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 17 EAST 8TH AVENUE SPOKANE, WA 99202
--	--

(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 Providence St. Joseph Care Center on 10/21/14, 10/22/14, 10/23/14, 10/24/14 and 10/27/14. A sample of 39 residents was selected from a census of 104. The sample included 29 current residents and the records of 10 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>Kathleen Robl, R.N., B.S.N. Lisa Harting, R.N., B.S.N. Colleen Daniels, R.N., B.S.N. Jessica Dingwall, M.S.W. Jessica Wolfrum, R.N., B.S.N. Brenda Webster, R.N., B.S.N. Tamara Smith, M.S.W.</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging and Long-Term Support Administration Residential Care Services, District 1, Unit A 316 West Boone Avenue, Suite 170 Spokane, Washington 99201-2351</p> <p>Telephone: (509)323-7300 Fax: (509)329-3993</p> <p><i>Cindy Coyle</i> 11/5/14 Residential Care Services Date</p>	F 000	<p>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.</p> <p style="text-align: center;">RECEIVED NOV 21 2014 DSHS ADSA RCS SPOKANE WA</p>	11/25/14
-------	---	-------	--	----------

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X8) DATE 11/21/14
---	----------------------------	---------------------------

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: 11/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/29/2014
NAME OF PROVIDER OR SUPPLIER PROVIDENCE ST JOSEPH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 17 EAST 8TH AVENUE SPOKANE, WA 99202		
(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 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to accurately assess 1 of 2 residents (#86) reviewed for range of motion in a sample of 39. Failure to accurately assess for contractures placed the resident at risk for unmet care needs. Findings</p>	F 278	<p>F278</p> <p>SPECIFIC RESIDENTS Resident #86's MDS currently reflects her contractures to her feet.</p> <p>OTHER RESIDENTS Other residents have been assessed per the MDS schedule for contractures and coded as indicated.</p> <p>SYSTEMIC CHANGES Education provided to MDS nurses on accurately coding contractures on the mds.</p> <p>MONITOR Audits of MDS's will be performed randomly for accuracy of coding contractures.</p> <p>The individuals responsible for ensuring compliance are Logan Stroud, Administrator and Tena Flores, Director of Nursing Services.</p> <p>The date of compliance will be</p> <p>November 25th, 2014.</p>	

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

PRINTED: 11/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/29/2014
NAME OF PROVIDER OR SUPPLIER PROVIDENCE ST JOSEPH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 17 EAST 8TH AVENUE SPOKANE, WA 99202	
(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 278	Continued From page 2 include: Resident #86 was admitted on [REDACTED] 10 with diagnoses including [REDACTED] Per record review, a physician's note dated March 2011 indicated Resident #86 had [REDACTED] A physical therapy evaluation dated 6/4/11 documented the resident as having [REDACTED] of her [REDACTED] The Minimum Data Set (MDS) - an assessment tool - dated 8/12/14, coded Resident #86 as not having impairment of her lower extremities, despite both a physician and physical therapist previously documenting the resident had [REDACTED] her feet. Other MDS documents were reviewed, from the time of admission, through the 8/12/14 MDS - at no time were lower extremity contractures identified. On 10/24/14 at 1:32 p.m., with Staff # D's assistance, Resident #86's feet were observed while she was sitting in her wheelchair. Both feet [REDACTED] [REDACTED] Staff #D was able to move both feet at the ankles very slightly. The toes on the right foot were immovable, and the toes on the left foot were only able to be slightly flexed. In an interview on 10/27/14 at 8:49 a.m. Staff #E said Resident #86's ankles were "pretty tight and you couldn't really move them". She confirmed the resident was not coded as having impairment of her lower extremities on her 8/12/14 MDS, or on previous MDS documents.	F 278		
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		

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

PRINTED: 11/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/29/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PROVIDENCE ST JOSEPH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 17 EAST 8TH AVENUE SPOKANE, WA 99202
--	--

(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 282 SS=D	<p>Continued From page 3 PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to implement a care plan for 1 of 4 residents (#106), to ensure they received adequate supervision and safety for swallowing precautions, in a sample of 39.</p> <p>Findings include: Resident #166 had diagnoses of [REDACTED] [REDACTED] The resident had some deficits with hearing, speech, and vision. She also had memory loss and severe cognitive impairment. The resident's plan of care identified problems with nutrition related to [REDACTED] [REDACTED]</p> <p>The care plan interventions related to the identified problems were: provide high protein foods, provide assistance with meals, to have liquids in cups, and to not use straws to drink. On 10/23/14 at 11:23 a.m., Resident #166 had a straw in her pitcher of water on her bedside table. On 10/23/14 at 1:28 p.m., Staff #A stated the resident was on swallowing precautions (because of her identified difficulty with swallowing), and</p>	F 282	<p>F282</p> <p>SPECIFIC RESIDENTS Resident #166 does not receive</p> <p>straws in her liquids. Resident has a sign above her bed indicating no straws to be used.</p> <p>OTHER RESIDENTS Other residents had the potential to be affected by this practice. No other residents were affected by this practice.</p> <p>SYSTEMIC CHANGES Education provided to all staff in regards to residents who should not be offered straws in their liquids.</p> <p>MONITOR Random audits for the use of Straws.</p> <p>The individuals responsible for ensuring compliance are Logan Stroud, Administrator and Tena Flores, Director of Nursing Services.</p> <p>DATE OF COMPLIANCE: November 25, 2014</p>	
---------------	--	-------	--	--

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

PRINTED: 11/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/29/2014
NAME OF PROVIDER OR SUPPLIER PROVIDENCE ST JOSEPH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 17 EAST 8TH AVENUE SPOKANE, WA 99202		
(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 282	<p>Continued From page 4</p> <p>said the resident was able to give herself fluids with monitoring.</p> <p>On 10/23/14 at 7:20 p.m., Resident #166 continued to have a straw in her water pitcher on her bedside table.</p> <p>On 10/24/14 at 12:47 p.m., a Speech Therapist (Staff #B) stated the resident [REDACTED] was not supposed to use a straw when drinking liquids. Staff #B said the risk of using a straw included possible aspiration (inhaling fluid into the lungs) and pneumonia.</p> <p>On 10/24/14 at 12:53 p.m., the resident's water pitcher continued to have a straw in it.</p> <p>Later in the afternoon of 10/24/14, Staff #C was interviewed. She said the resident was capable of reaching the water pitcher, and consuming liquids independently. Staff #C stated the resident routinely used a straw in her water pitcher to drink.</p> <p>The facility failed to ensure the care plan, which identified the resident as having difficulty swallowing, was followed related to the use of a straw when drinking fluids. This placed her at risk for medical complications.</p>	F 282		
F 318 SS=D	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 318		

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

PRINTED: 11/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PROVIDENCE ST JOSEPH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 17 EAST 8TH AVENUE SPOKANE, WA 99202
---	--

(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 318	<p>Continued From page 5</p> <p>Based on observation, interview, and record review, it was determined the facility failed to ensure 1 of 2 residents (#86) with [REDACTED] in a sample of 39, received appropriate treatment and services to prevent a further decrease in range of motion. This placed the resident at risk for worsening of her [REDACTED]. Findings include:</p> <p>Resident #86 was admitted with diagnoses including [REDACTED]. She required extensive assist with bed mobility, and was totally dependent on staff for her activities of daily living.</p> <p>A physician's note from March 2011 indicated Resident #86 had [REDACTED]. A physical therapy evaluation, dated 6/4/11, documented the resident had a [REDACTED] of her ankles/feet, and would benefit from a restorative program (a range of motion exercise program done by staff to prevent an increase in contractures). The facility was unable to provide any documentation to show that Resident #86 was started on a restorative program since her admission to the facility.</p> <p>In addition, there was no mention of the resident's [REDACTED] and no interventions addressing range of motion in the resident's care plan.</p> <p>On 10/24/14 at 1:32 p.m. with Staff #D's assistance, Resident #86's feet were observed while she was sitting in her wheelchair. Both feet [REDACTED]. Staff #D was able to move both feet at the ankles very slightly. The toes on</p>	F 318	<p>F318</p> <p>SPECIFIC RESIDENTS Resident #86 has a current ROM screen and is currently on caseload of restorative nursing.</p> <p>OTHER RESIDENTS Other residents had the potential to be affected by this practice. Other current residents have been screened for current function of ROM and treated as indicated.</p> <p>SYSTEMIC CHANGES Education provided to RNA aides, and Rehabilitation Manager on new process to screen residents on admit then quarterly thereafter.</p> <p>MONITOR Audits of residents on admit and then Quarterly for ROM screening with proper follow through of treatment if indicated.</p> <p>The individuals responsible for ensuring compliance are Logan Stroud, Administrator and Tena Flores, Director of Nursing Services.</p> <p>DATE OF COMPLIANCE: November 25, 2014</p>	
-------	--	-------	--	--

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

PRINTED: 11/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/29/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PROVIDENCE ST JOSEPH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 17 EAST 8TH AVENUE SPOKANE, WA 99202
--	--

(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 318	<p>Continued From page 6</p> <p>the [REDACTED] and the toes on the left foot were able to be slightly flexed.</p> <p>In an interview on 10/27/14 at 8:49 a.m., Staff #E said that Resident #86's [REDACTED] were present on admission to the facility. She stated that physical therapy would usually assess residents upon admission, and determine if they needed any range of motion services. She indicated that she would have to look at the records to determine if Resident #86 had ever received any treatment or services to address her [REDACTED]. No additional information related to treatment or services for the resident's [REDACTED] was provided.</p> <p>The facility failed to provide range of motion to a resident with [REDACTED]. This placed her at risk for the worsening of the [REDACTED].</p>	F 318		
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide adequate supervision for 1 of 4 residents (#166) with swallowing difficulty, to prevent potential accidents, in a sample of 39.</p> <p>Findings include:</p>	F 323		

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

PRINTED: 11/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 506414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/29/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PROVIDENCE ST JOSEPH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 17 EAST 8TH AVENUE SPOKANE, WA 99202
--	--

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 7</p> <p>Resident #166 had a diagnoses of [REDACTED]. The resident had hearing, speech, and vision impairments. She also had memory impairment and severe cognitive deficits.</p> <p>An order (signed by the Nurse Practitioner) on 8/27/14 directed a speech therapist to evaluate the resident, treat her for [REDACTED] and provide liquids in cups.</p> <p>The resident's plan of care identified interventions to include: receiving assistance with meals, to have liquids in a cup, and to not drink out of a straw. The resident was also in a specialized dining program, where she received direct observation and assistance from staff at meals.</p> <p>Per record review, the most current speech/language pathology assessment documented the resident needed to use safe swallowing strategies, which included very specific instructions for staff to use so that she would not choke or aspirate (inhale food/fluids into the lungs).</p> <p>On 10/23/14 at 11:23 a.m., Resident #166 had a straw in her pitcher of water on her bedside table.</p> <p>On 10/23/14 at 1:28 p.m., Staff #A stated the resident was on swallowing precautions (because of her known history of difficulty with swallowing) and said the resident was able to give herself fluids with monitoring.</p> <p>On 10/23/14 at 7:20 p.m., Resident #166 continued to have a straw in her water pitcher on her bedside table.</p> <p>On 10/24/14 at 12:47 p.m., Speech Therapist (Staff #B) stated the resident had [REDACTED] and was not supposed to</p>	F 323	<p>F323</p> <p>SPECIFIC RESIDENTS Resident #166 has been screened And should not use straws in her Liquids.</p> <p>OTHER RESIDENTS Other residents were at risk r\ this practice. Other resident have been assessed for the use of straws.</p> <p>SYSTEMIC CHANGES Education of staff to provide Adequate supervision and assistance to residents with a known history of swallowing difficulties.</p> <p>MONITOR Audits will be performed to ensure residents receive supervision and assistance with a known swallowing difficulty.</p> <p>The individuals responsible for ensuring compliance are Logan Stroud, Administrator and Tena Flores, Director of Nursing Services.</p> <p>DATE OF COMPLIANCE: November 25, 2014</p>	
-------	--	-------	--	--

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

PRINTED: 11/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/29/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PROVIDENCE ST JOSEPH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 17 EAST 8TH AVENUE SPOKANE, WA 99202
--	--

(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 323	<p>Continued From page 8</p> <p>use a straw when drinking liquids. She said the concern with the resident using a straw was related to the rate of the water entering the straw, which increased the speed liquid traveled down the throat. This was a potential problem for someone who had a slower swallow. Staff #B said the risk of using a straw included possible aspiration and pneumonia.</p> <p>On 10/24/14 at 12:53 p.m., the resident's water pitcher continued to have a straw in it.</p> <p>Later in the afternoon on 10/24/14, Staff #C said the resident was capable of reaching the water pitcher and consuming liquids independently. Staff #C said the resident routinely used a straw to drink from her water pitcher.</p> <p>The facility failed to provide adequate supervision and assistance to a resident with a known history of swallowing difficulties, requiring direct supervision and assistance at meals, and with very specific instructions to follow for safe consumption of food and fluids. This placed her at risk for medical complications, including aspiration and pneumonia.</p>	F 323		
-------	---	-------	--	--