

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

PRINTED: 06/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505369	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2015
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NAME OF PROVIDER OR SUPPLIER REGENCY AT NORTHPOINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EAST WESTVIEW COURT SPOKANE, WA 99218
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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 Regency Northpointe on 06/07/15, 06/08/15, 06/09/15, 06/10/15, 06/11/15, and 06/12/15. The survey included data collection on 06/07/15 from 7:00 p.m. to 9:20 p.m. A sample of 40 residents was selected from a census of 98. The sample included 23 current residents, and the records of 17 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>Hai Nguyen, RN Lisa Harting, RN Heather Moore, RN Kathleen Robl, RN Tamara Smith, MSW</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging and Long-Term Support Administration (AL TSA) Division of Residential Care Services Region 1 North 316 West Boone Avenue, Suite 170 Spokane, Washington 99201-2351</p> <p>Telephone: (509) 323-7300 Fax: (509) 329-3993</p> <p><i>Cindy Colville</i> 6/22/15 Residential Care Services Date</p>	F 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">JUL 02 2015</p> <p style="text-align: center;">DSHS ADSA RCS SPOKANE WA</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>TJ</i>	TITLE Administrator	(X8) DATE 7/1/15
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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 272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>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.</p>	F 272	<p>F 272</p> <p>SS = D</p> <p>MDS Dental assessment for Resident #59 has been updated and care plan corrected. Resident #192 has been discharged having gained wt and met therapeutic goals.</p> <p>All MDS dental assessments have been reviewed for accuracy and corrected as necessary.</p> <p>Nursing managers /MDS nurse have been educated on doing dental assessments with any noted dental issues, these will be completed as needed and reviewed on a quarterly bases, they will be utilized for care and by the MDS nurse for accuracy.</p> <p>MDS and Care Managers will conduct random quarterly audits of resident dental Assessments to ensure accuracy and compliance. Any noted issues will be corrected immediately and any trends will be brought to the facility QA process as deemed appropriate.</p> <p>7/10/15</p>	7/10/15	

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F 272	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to accurately assess 2 of 3 residents (#59, 192), reviewed for dental issues, in a sample of 40. This failed practice placed the residents at risk for unmet needs related to dental services. Findings included:</p> <p>1. Resident #59, admitted on [REDACTED] 14, had a history of poorly fitting dentures, secondary to no ridge on the lower jaw, and weight loss.</p> <p>Review of the Minimum Data Set (MDS), an assessment tool, dated 02/18/15 and 05/12/15, documented Resident #59 had her own teeth, and did not have loosely fitting dentures.</p> <p>A Social Service progress note dated 02/25/15, showed the dentist made a visit 02/25/15, and "realigned the upper dentures but was unable to do anything with the lower dentures due to no ridge".</p> <p>The care plan of 05/13/15 showed Resident #59 had upper dentures, but no lower dentures.</p> <p>On 06/08/15 at 1:22 p.m., Resident #59 had upper dentures in her mouth, and lower dentures in a cup at the sink. The upper dentures were loose, and did not fit properly.</p> <p>In a family interview on 06/09/15 at 10:59 a.m., Resident #59's daughter stated the resident had chewing problems, due to poorly fitting dentures.</p> <p>On 06/11/15 at 10:00 a.m., Staff Member A, MDS nurse, confirmed the MDS dental assessments</p>	F 272		

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F 272	<p>Continued From page 3</p> <p>for Resident #59, on 02/18/15 and 05/12/15, were incorrect.</p> <p>2. Resident #192 was admitted on [REDACTED] 15, from another long-term care facility, with diagnoses that included [REDACTED]</p> <p>Per review of a clinical note from the previous facility, dated 03/13/15, the resident had difficulty chewing, because his dentures were too big, which caused mouth sores.</p> <p>The Minimum Data Set (MDS) assessments, dated 04/08/15 and 05/26/15, documented the resident had his own teeth, and did not have loosely fitting dentures, or chewing difficulty.</p> <p>Per interview on 06/12/15 at 8:25 a.m., Resident #192 stated he had loose dentures, because he had lost so much weight. He stated he had seen a dentist in the past, and was told the dentures could not be adjusted. He stated he used Fixadent (a denture adhesive) which helped, but sometimes when he bit down on something hard, his teeth would flip up. When that happened, it caused him to bite the side of his cheek, and then he would get a canker sore. "I have told them a 100 times here I don't want toast, because I am tempted to eat it, and it just doesn't work with my teeth."</p> <p>Per interview on 06/12/15 at 9:05 a.m., Staff A, MDS nurse, confirmed the resident did not have his own teeth. She stated he had denture issues in the past, but she felt they were resolved when he was admitted. She was unaware the resident still had loose dentures, and complaints of mouth</p>	F 272			

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F 285	<p>Continued From page 5</p> <p>condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>For purposes of this section:</p> <p>(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).</p> <p>(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Reviews (PASRR) were completed by a qualified individual, prior to admission, for 1 of 5 residents (#51), reviewed for PASRR, in a sample of 40. Failure to have a completed PASRR, prior to admission, created the potential for a delay in Resident #51 receiving mental health services. Findings included:</p> <p>Per record review Resident #51 was admitted to the facility on [REDACTED] 14, with diagnoses of [REDACTED]</p> <p>Resident #51's PASRR level I assessment was not completed until 10/20/14, which [REDACTED] days after she was admitted.</p> <p>On 06/16/15 at 10:20 a.m., Staff D confirmed the PASRR level I was not completed prior to</p>	F 285	<p>Admission and/or SS will review all referrals for completed PASSR's prior to admission. Any noted issues will be communicated to the team and corrected immediately. Any trends will be brought to the facility QA process for further follow up as deemed appropriate.</p> <p>Date: 7/10/2015</p>	7/10/15
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<p>F 285</p> <p>F 323 SS=D</p>	<p>Continued From page 6 admission, as required.</p> <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, the facility failed to implement planned interventions to prevent potential injuries for 1 of 3 residents (#171), reviewed for falls, in a sample of 40. This failure put the resident, who had a fall history, at risk for potential injury. Findings included:</p> <p>Resident #171 was admitted with diagnoses including [REDACTED]. The resident was unsteady, required assistance for transfers, and used a wheelchair.</p> <p>An admission fall assessment dated 05/10/15 determined the resident was at moderate risk for falls.</p> <p>Per review of an admission assessment dated 05/26/15, the resident had been experiencing increased confusion, was impulsive, had poor safety awareness and did not use his call light.</p> <p>A nursing progress note, dated 05/29/15 at 1:42</p>	<p>F 285</p> <p>F 323</p>	<p>F -323</p> <p>SS = D</p> <p>Care Plan was updated and mats placed at Bedside immediately upon identification of this issue. Resident 171 Discharged to lower level of care on 6/14/2015 without incident.</p> <p>Each Resident Care Manager will complete an audit of all care planned safety devices to ensure they are present and utilized. Results of audit will be given to DNS.</p> <p>All nurses have been in serviced regarding ensuring that all care planned interventions are present.</p> <p>All NAC's will be in-serviced on understanding care planned environments and ensuring safety devices are present.</p>	

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F 323	Continued From page 7 p.m., documented Resident #171 had an unwitnessed fall in a hallway bathroom. A note at 7:51 p.m., the same day, documented a second unwitnessed fall, approximately 10 minutes after the resident was assisted to bed by staff. The resident's care plan was updated after both falls, and included an intervention, dated 06/2/15, for bilateral fall mats to be in place when the resident was in bed. On 06/8/15 at 1:18 p.m., Resident #171 was lying on his back in bed, with his eyes closed. No fall mats were observed. At 3:08 p.m. the same day, the resident remained in bed with his eyes closed; no fall mats were in place. On 06/10/15 at 10:07 a.m., the resident was again observed to be lying in bed, eyes closed, with no fall mats in place. On 06/12/15 at 8:50 a.m., Staff B, Residential Care Manager, stated she thought the resident's fall mats had been discontinued, but the care plan had not been updated. In a follow-up interview at 8:57 a.m., Staff B confirmed the fall mats had not been discontinued, and should be in place.	F 323	Random audits will be completed by DNS or designee quarterly to ensure sustained compliance. Any trends will be brought to the facility QA process for further follow up as deemed appropriate. 7/10/2015	7/10/15	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371			

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F 371	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain safe food temperatures prior to serving. This failure placed residents at risk for food-borne illness. Findings included:</p> <p>In an interview on 06/08/15 at 10:11 a.m., Resident #102 stated "sometimes food is cold at night."</p> <p>In an interview on 06/08/15 at 11:03 a.m., Resident #78 stated "sometimes the food is cold at dinner."</p> <p>In an interview on 06/08/15 at 1:22 p.m., Resident #87 stated "sometimes the food is too cold at night."</p> <p>In an interview on 06/09/15 at 10:33 a.m., Resident #49 stated "dinner is not always hot."</p> <p>On 06/11/15 at 5:10 p.m., the dinner meal tray line was observed. At 5:15 p.m., a test tray was requested. The Dietary Manager was present, and tested the temperature of the foods being served, using a facility thermometer. The temperature of the baked beans was 106 dF (degrees Fahrenheit).</p> <p>On 06/11/15, the Washington State Food Code was reviewed for safe cooking and holding temperatures. The following directions were given: "Hot foods should be at 135 dF or above when</p>	F 371	<p>F - 371</p> <p>SS = E</p> <p>All food leaving the kitchen will be served within the regulatory required temperatures.</p> <p>All Dietary chef's and cooks will be re-inserviced on temperatures required for serving, temperature taking techniques and procedures for ensuring food is at temperature.</p> <p>Dietary manager will ensure that temperatures are taken at point of delivery and no food will be served unless within required parameters.</p> <p>Dietitian will conduct monthly audits of temperatures of all meals to ensure compliance.</p> <p>ED will meet with residents monthly x 3 months to ensure resident satisfaction related to food temperature.</p> <p>Any noted trends will be brought to facility QA process as deemed appropriate for further follow up.</p> <p>7/10/2015</p>	7/10/15

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F 371	Continued From page 9 served."	F 371			
F 431 SS=E	<p>In an interview on 06/11/15 at 5:30 p.m., Staff E, Dietary Manager, stated the baked beans should have been at a temperature of "145 dF." In addition, Staff E stated the evening cook was new, and should have placed the beans in 2 shallow pans, to maintain temperature, instead of one deep pan.</p> <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> <p>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.</p> <p>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</p>	F 431	<p>F - 431</p> <p>SS = E</p> <p>Audits and visual inspection of medication rooms, central supply and all medication carts was completed by nursing management team. Any found expired medications were disposed of.</p> <p>All nurses will be in-serviced on policy on expiration dates of medications, labeling OTC when opened and discarding of expired medications.</p> <p>New Central supply coordinator hired and expectations reviewed with her regarding monitoring of all OTC medication stock for expiration.</p>		

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F 431	<p>Continued From page 10</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to discard expired medications in 1 of 2 medication rooms, the central supply room, and 2 of 5 medication carts. This failure placed residents at risk for receiving expired medications. Findings included:</p> <p>On 06/10/15 at 9:50 a.m., the East hall medication cart had one bottle of Novolog insulin, dated 05/10/15 - the date it was opened. Per review of the facility policy/recommendations regarding insulin storage, dated 03/31/15, it indicated Novolog insulin, once opened, expired after 28 days. Staff B, a licensed nurse, confirmed this information on 06/10/15 at 10:25 a.m.</p> <p>On 06/10/15 at 10:00 a.m., observation of the Northwest hall medication cart revealed 2 medications were outdated. The medications included a bottle of Iron supplement liquid, expired February 2015, and a bottle of chlorophyll tablets, expired May 2015. Staff G, a licensed nurse, confirmed the medications were expired.</p> <p>On 06/10/15 at 10:30 a.m., observation of the East hall medication room revealed 3 medications were outdated. The medications included throat relief spray dated, expired</p>	F 431	<p>Random audits will be completed by DNS or designee quarterly to ensure sustained compliance. Any trends will be brought to the facility QA process for further follow up as deemed appropriate.</p> <p>7/10/2015</p>	7/10/15

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F 431	Continued From page 11 October 2014, liquid multivitamins, and aspirin tablets, both expired March 2015. Staff B was present, and confirmed the medications were expired. On 6/10/15 at 11:00 a.m., observation of the central supply room revealed 3 bottles of aspirin tablets, which expired March 2015. Staff H was present, and confirmed the medications were expired.	F 431			