

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

PRINTED: 08/26/2013
FORM APPROVED
OMB NO. 0938-0391

1432

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 C 08/06/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER REGENCY AT NORTHPOINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EAST WESTVIEW COURT SPOKANE, WA 99218
--	--

(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 Abbreviated Survey conducted at Regency at Northpointe on 7/31/13, 8/1/13, and 8/6/13. A sample of 6 residents was selected from a census of 98. The sample included 5 current residents and the records of 1 former and/or discharged residents.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#2844359. #2842349</p> <p>The survey was conducted by: [REDACTED] R.N., B.S.N.</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Long-term Support Administration Residential Care Services, District 1, Unit B 316 West Boone Avenue, Suite 170 Spokane, Washington 99201</p> <p>Telephone: (509) 323-7303 Fax: (509) 329-3993</p> <p><i>[Signature]</i> Residential Care Services Date 8/6/13</p>	F 000	<p style="text-align: center;">RECEIVED SEP 06 2013 DSHS ADMIN FOR SPOKANE WA</p>	
-------	---	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 9/4/13
---	------------------------	---------------------

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: 08/26/2013
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 C 08/06/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT NORTHPOINTE			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EAST WESTVIEW COURT SPOKANE, WA 99218	
(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 314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to take action and evaluate a pressure ulcer for 1 of 3 residents (#3) in a sample of 6, which resulted in harm for Resident #3. Findings include:</p> <p>Resident #3, per record review, admitted to the facility for rehabilitation following a [REDACTED] with no pressure ulcers on [REDACTED]/13. He was nutritionally at risk due to [REDACTED] and had a history of [REDACTED]. On admission to the facility staff assessed him as a mild risk for skin break down. He had memory problems and required extensive assistance with dressing/bathing. On 7/4/13, the facility put general interventions in place for the resident upon admission, which included weekly skin checks, pressure reduction for bed/wheel chair, and for staff to report any red areas to the licensed nurse.</p> <p>The resident discharged home on [REDACTED]/13 with orders for home health. Per the home health assessment dated 7/29/13, the resident had a pressure ulcer on the [REDACTED] that measured</p>	F 314	<p>Resident # 3 was discharged from facility on 7/25/13</p> <p>Weekly skin checks have been completed and documented in MAR to ensure skin integrity of all residents of the facility at the current time.</p> <p>Nursing and therapy department have been educated on the communication process regarding identification of new or worsening skin issues. This ensures that residents don't develop unavoidable pressure ulcers within the facility and that they receive timely treatment for identified skin issues to promote healing, prevent infection, and prevent new sores from developing.</p> <p>LN management will follow up on all communicated and identified skin issues of the facility via shift report and the facility communication process to ensure that resident are getting appropriate and timely treatment</p>	

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

PRINTED: 08/26/2013
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 C 08/06/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT NORTHPOINTE		STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EAST WESTVIEW COURT SPOKANE, WA 99218		
(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 314	<p>Continued From page 2</p> <p>1.0 centimeters (cm) x 1.0 cm and the [REDACTED] had a necrotic area that measured 5 cm x 5 cm and had a foul odor. The wound edges were red, warm, and inflamed. The home health nurse notified the doctor and he recommended that he be seen at the emergency room. He had an infection and required surgical debridement of the pressure ulcer.</p> <p>Per review of the discharge instructions completed by the facility dated 7/25/13, there was direction to monitor the resident's feet, but there was no mention of a pressure ulcer on the resident's right heel or top of the right foot.</p> <p>Per review of therapy notes on 7/9/13, a "black or dark blue blister" was discovered on the resident's right heel. Staff #B implemented a special boot to alleviate pressure, put the resident on the 24 hour report, and notified his nurse.</p> <p>Per review of the medication administration record (MAR) for July 2013, nursing staff initiated skin checks to his right lower extremity (RLE) with boot changes twice daily. The nurses signed off that they checked his right foot twice daily.</p> <p>Per review of therapy notes on 7/17/13, the blister on his right heel was open and weeping fluid.</p> <p>During an interview with Staff #B on 7/31/13 at 3:30 p.m., she reported the resident had blisters on top of his right foot and had a quarter sized "mushy" area on his right heel. She notified the nurse and implemented a special boot for his right foot. She reported on 7/17/13 during therapy, he did not have a sock on she noticed his right heel ulcer was open and draining fluid. She again notified the nurse that the pressure ulcer was now open and draining.</p> <p>On 7/31/13 at 5:10 p.m., Staff #C did not know that he had a pressure ulcer on his heel. She thought the twice daily check was just to make</p>	F 314	<p>for noted skin issues. Any identified issues will be corrected immediately and any trends will be brought to the facility QA process as deemed necessary for further evaluation. The DON will review all pressure ulcer skin reports weekly to</p> <p>ensure that skin issues are progressing per regulatory guidelines.</p> <p>DON is responsible and will ensure compliance.</p>	9/6/13

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

PRINTED: 08/26/2013
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 C 08/06/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT NORTHPOINTE		STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EAST WESTVIEW COURT SPOKANE, WA 99218		
(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 314	<p>Continued From page 3</p> <p>sure his boot was on and in place.</p> <p>On 8/1/13 at 10:10 a.m., Staff #G reported the facility practice was for the treatment nurse to monitor skin/pressure ulcers. She stated she never looked at his heel.</p> <p>On 8/1/13 at 10:30 a.m., Staff #F (wound nurse) reported she was never told about the pressure ulcer on the resident's right heel.</p> <p>Per record review, there was no measurement of the right heel pressure ulcer when the pressure ulcer was red or when it opened and was draining.</p> <p>On 8/6/13 at 3:25 p.m., Staff #A reported she investigated the resident's skin breakdown after notification of the status from the home health agency, and was told the resident's right heel was "mushy," but staff never reported the skin breakdown. She discussed that through her investigation she was able to determine the resident had some type of skin impairment at the time of discharge, but he was not seen by the home health agency until 4 days after he went home.</p> <p>The facility failed to take action or re-evaluate the pressure ulcer on his right heel after the specialty boot was placed or when the pressure ulcer got worse. This failure resulted in harm for Resident #3.</p>	F 314		