

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

PRINTED: 03/25/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/16/2016
NAME OF PROVIDER OR SUPPLIER  FRANKLIN HILLS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6021 NORTH LIDGERWOOD SPOKANE, WA 99207		
(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 Abbreviated Survey conducted at Franklin Hills Health &amp; Rehab Center on 03/10/16, 03/15/16 and 03/16/16. A sample of 8 residents was selected from a census of 86. The sample included 6 current residents, and 2 discharged residents.</p> <p>The following were complaints investigated as part of this survey: #3199410                      #3194884 #3194885</p> <p>The survey was conducted by: Hannah Adams, RN, MN</p> <p>The survey team is from: Department of Social &amp; Health Services Aging &amp; Long-Term Support Administration Residential Care Services, Region 1 - North 316 West Boone Avenue, Suite 170 Spokane, Washington 99201</p> <p>Telephone: (509) 323-7302 Fax: (509) 329-3993</p> <p><i>Cindy CoVille</i> 3/25/15 Residential Care Services                      Date</p>	F 000	<p>" This plan of correction constitutes this facility's written allegation of compliance For the deficiencies cited. This submission Of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."</p> <p style="text-align: center;"><b>RECEIVED</b> APR 01 2016 DSHS ADSA RCS SPOKANE WA</p>	4/3/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Michael Littman*

TITLE

*E.D.*

(X6) DATE

3/31/2016

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 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>How the nursing home will correct the Deficiency as it relates to the resident:</p> <p>Residents #1 &amp; #2 were not affected by the deficient practice. Staff will be educated on the Two-Tier Transmission Based Precautions: Contact Precautions Policy and Procedures which include Resident Placement, Gloves and Handwashing, Mask, gown and Resident Care Equipment, as indicated by care needs. Staff B is no longer contracted to work in facility. Staff A was educated immediately.</p> <p>How the nursing home will act to protect residents in similar situations:</p> <p>Residents residing at the facility have the Potential to be affected by this deficient practice.</p> <p>Staff to be educated on cleaning equipment And providing transmission base precautions Precautions per the Two-Tier protocols.</p> <p>Measures the nursing home will take or the Systems it will alter to ensure that the Problem does not recur:</p> <p>Enhance the General Orientation process to include hands on return demonstration training to validate proficiency &amp; aptitude of performing the aspects of the Two-Tier Transmission Based Precautions: Contact Precautions for current and new employees.</p>	

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F 441	<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 ensure staff consistently implemented practices to control the spread of illness, when providing care for 2 of 3 residents with a contagious illness (#1, 2), reviewed for infection control practices. Failure to wear gloves and wash hands when indicated, and to clean equipment with an effective disinfectant, placed other residents at risk for illness. Findings include:</p> <p>Per record review, Resident #1 and Resident #2 had [REDACTED] (infection), which required contact isolation precautions - including the use of gloves, gowns, handwashing, and proper disinfection of any equipment. Both residents had a sign on their door, directing individuals to check with the nurse before entering their rooms.</p> <p>In an observation on 03/15/16 at 11:34 a.m., Staff B, nursing assistant, entered Resident #1's room, and was touching items in the room, including the resident's overbed table and bed, without first applying gloves. At 11:36 a.m., Staff B did not wash her hands before she exited the room, and proceeded to another resident's room. In an interview on 03/15/16 at 1:15 p.m., Staff B stated she would normally wear gloves, when touching the overbed table or bed of a resident with contact isolation precautions.</p> <p>Further observation on 03/15/16 at 3:05 p.m. revealed Staff C, nursing assistant, emerged from Resident #2's room wearing gloves, and holding vital signs equipment. He set the equipment on the floor next to the room, and wiped it down with</p>	F 441	<p>How the nursing home plans to monitor its Performance to make sure that solutions are substantiated.</p> <p>Random audits with observations will be Performed five times weekly for next ninety days. Ongoing results reported to QAPI monthly for next 3 months for assessment and correction if necessary.</p> <p>Responsible party who will ensure Compliance.</p> <p>Executive Director or designee.</p>	

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F 441	<p>Continued From page 3</p> <p>an alcohol wipe. He removed his gloves without washing his hands, and then carried the equipment in a caddy, down to a cupboard on the other end of the hallway. He entered another resident's room before washing his hands.</p> <p>In an interview on 03/16/16 at 2:15 p.m., Staff A, Director of Nursing, confirmed staff should apply gloves before entering the room of a resident infected with C. diff., because there could be bacterial spores on items in the environment. She also indicated staff should wash their hands before exiting the resident's room. Staff A stated staff should use bleach to disinfect equipment after it has been used for residents with C. diff, and indicated the alcohol wipe would not be sufficient.</p>	F 441		



AGING AND DISABILITY SERVICES ADMINISTRATION  
**Nursing Home Survey Report**  
 STATE AND CORRESPONDING FEDERAL REQUIREMENTS

1. Page 1 of 1 Pages  
 2. DATES OF DATA COLLECTION  
**04/14/16**

3. NAME OF FACILITY  
**Franklin Hills Health & Rehab**

4. TYPE OF SURVEY  
 Full  Post  Complaint  Other: specify \_\_\_\_\_

5. TIME OF SURVEY  Day  Night  
 Weekend  Holiday

6. STREET ADDRESS  
**6021 N LIDGERWOOD**

CITY STATE ZIP CODE  
**Spokane WA 99207**

7. LICENSE NUMBER  
**1517**

**NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.**

8.	9. WASHINGTON ADMINISTRATIVE CODES 388-97	10. CODE OF FEDERAL REGULATION 42 CFR 483.	11. FEDERAL DATA TAG NUMBER	12. REPEAT DEFICIENCY FROM SURVEY DATED	13. NEW CITATION ON POST SURVEY	14. LICENSEE'S PLANNED DATE OF CORRECTION
<input type="checkbox"/> The requirements of the following WAC's and corresponding CFR's were not met. The text of the statements of deficiencies and the licensee's plan of correction may be read on CMS form 2567, dated: <u>03/16/16</u> .  **Licensee must complete column 14.  <input checked="" type="checkbox"/> The following deficiencies were determined to be corrected.	-1320(1)(a)(c), (5)(c)	483.65 (b)(1)(3)	441		<input type="checkbox"/>	
					<input type="checkbox"/>	
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					<input type="checkbox"/>	

**15. SURVEYOR'S SIGNATURE(S)**

SIGNATURE <i>Germa Weger</i>	DATE <b>03/17/16 4/14/16</b>	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

**16. LICENSEE OR AGENT**

SIGNATURE OF LICENSEE (OR AGENT)	TITLE	DATE
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**Nursing Home Survey Report**  
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1. Page <u>1</u> of <u>1</u> Pages
2. DATES OF DATA COLLECTION 03/10/16, 03/15/16, 03/16/16
5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Holiday
7. LICENSE NUMBER 1517

3. NAME OF FACILITY Franklin Hills Health & Rehab	4. TYPE OF SURVEY <input type="checkbox"/> Full <input type="checkbox"/> Post <input checked="" type="checkbox"/> Complaint <input type="checkbox"/> Other: specify _____
6. STREET ADDRESS 6021 N LIDGERWOOD	CITY STATE ZIP CODE Spokane WA 99207

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**RECEIVED**  
 APR 01 2016  
 DSHS AD SA RCS  
 SPOKANE WA

15. SURVEYOR'S SIGNATURE(S)

SIGNATURE <i>Hand Ales</i>	DATE 03/17/16	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

16. LICENSEE OR AGENT

SIGNATURE OF LICENSEE (OR AGENT) <i>Michael L...</i>	TITLE <i>SD</i>	DATE 3/31/2016
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