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

PRINTED: 01/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505291	A. BUILDING _____ B. WING _____	C 12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW LUTHERAN CARE CENTER	1841 EAST UPRIVER DRIVE SPOKANE, WA 99207

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F 000	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Survey conducted at Riverview Lutheran Care Center on 12/2/14, 12/11/14, 12/16/14, and 12/17/14. A sample of 5 residents was selected from a census of 74. The sample included 4 current residents, and the records of 1 former and/or discharged resident. The following were complaints investigated as part of this survey: #3054400 #3053970 #3056445 #3063630 #3054498 The survey was conducted by: Linda Loffredo, R.N., B.S.N. The survey team is from: Department of Social & Health Services Aging & Long-Term Support Administration Division of Residential Care Services, Region 1, Unit A 316 West Boone Avenue Spokane, Washington 99201 Telephone: (509) 323-7302 Fax: (509) 329-3993 Cindy Coville 1/2/15 Residential Care Services	F 000		1/30/15

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SPOKANE WA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Charles [signature]	ADMINISTRATOR	1/8/2015

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 000	Continued From page 1	F 000		
F 157 SS=D	Date 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by:	F 157	Riverview Lutheran Care Center takes great pride in providing a quality environment for residents and their families. We take each and every comment seriously and respond quickly and appropriately to these concerns. The completion of this plan of correction is done to comply with requirements of Medicare/Medicaid certification. The completion of this form in no way implies agreement with or implies admission to any and all liability to the allegations found within this document.	1/30/15

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F 157	Continued From page 2 Based on interview and record review, the facility failed to immediately consult with the resident's physician related to physical injures for 1 of 5 sample residents (#1). Failure to immediately consult with the resident's physician, when the resident exhibited symptoms of possible injury, placed the resident at risk for worsening injury and pain. Findings include: Resident #1 had diagnoses including a history of falls with [redacted] Per record review, the resident had short-term memory problems, and could verbally make her needs known. She transferred with 1-2 staff, using a front-wheeled walker, and required extensive assistance of 2 staff for most activities of daily living. The resident experienced episodes of mild to moderate generalized pain, and was prescribed 2 Tylenol tablets as needed, which provided effective pain relief. The resident's last fall at the facility was 9/24/14. In a progress note dated 11/12/14 at 10:45 a.m., Staff #E documented the resident had been complaining of increased pain to the left left side for the last 48 hours, intermittently. The resident stated the pain was sometimes on the left side and sometimes the left leg, but never consistently one location. The record documented that Tylenol was minimally helpful, and transfers were increasingly difficult. Staff #E notified the physician by fax, and placed the resident on alert charting (meaning nursing staff were to continue to evaluate the resident every shift). Staff #E did not attempt to consult with the physician at that time, to determine if additional evaluation, including obtaining X-rays and having the resident stay in bed until results were known, should be considered. Review of the facility investigation dated	F 157	F157 The facility will correct the deficiency as it relates to the resident by counselling and educating the staff involved. The facility acted quickly to evaluate and contact physician when change was noted on 11/13/14. To protect other residents in similar situations the facility will in-service all direct care staff on reporting changes to floor nurse or charge nurse in order to start the assessment and investigation process promptly to ensure the highest level of care is offered. To monitor that this correction is effective the facility will do weekly skin checks by licensed nurses and continue to educate staff on the facility's standard of practice through the orientation and yearly education. This Corrective action will be completed by 1/30/15. The Director of Nursing will be responsible to ensure the correction.	1/30/15

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F 157	Continued From page 3 11/20/14 revealed the following: On 11/12/14 in the evening, Staff #D observed a bruise on the resident's left inner thigh (a family member of Resident #1 was present). Staff #D said the family member told her the licensed nurse was aware of the bruise, so she did not report the bruise to the licensed nurse that shift. On [redacted]14 at 8:00 a.m., the family member informed Staff #B (a licensed nurse) that the resident had a dark purple bruise on the left inner thigh. Staff #B notified the physician, and the resident had an X-ray which identified a left hip fracture. The resident was transferred to the local hospital for surgical repair of the fracture, and was hospitalized for 6 days. On 12/16/14 at 3:20 p.m., Staff #C (the investigative licensed nurse) confirmed Staff #D should have reported the bruising to a licensed nurse on 11/12/14 so the licensed nurse could consult with the physician regarding evaluation for injury.	F 157	Riverview Lutheran Care Center takes great pride in providing a quality environment for residents and their families. We take each and every comment seriously and respond quickly and appropriately to these concerns. The completion of this plan of correction is done to comply with requirements of Medicare/Medicaid certification. The completion of this form in no way implies agreement with or implies admission to any and all liability to the allegations found within this document	1/30/15
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure adequate supervision was provided to	F 323		

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F 323	Continued From page 4 prevent falls with injury for 1 of 3 residents reviewed for falls (#2), in a sample of 5. Findings include: Resident #2 had diagnoses including [redacted] Per record review, the resident had short-term memory problems, could verbally make his needs known, and required one person assist with most activities of daily living. Review of the resident's clinical record revealed the resident had difficulty remembering to use his call light, and tried to self transfer, placing him at risk for falls with injury. On 10/2/14, the facility moved the resident to a room in the [redacted] hall for increased staff supervision. On 10/10/14, the resident had 2 falls due to getting out of bed without assistance. During the second fall, the resident sustained a deep laceration to the left eyebrow, requiring treatment in the local hospital emergency room. The resident's plan of care regarding safety directed staff to ensure the following: a sign was posted in the resident's room reminding him to use the call light, the resident was encouraged to wear non-skid socks when not wearing shoes, alarms were in place on the bed/wheelchair/toilet seat, and fall mats were on each side of the bed. Per record review, the resident had falls on 11/18, 11/19, and 11/20/14. During each fall, the resident attempted to transfer, without calling for assistance. On 11/19 and 11/20/14, the alarms were not in place to alert staff that the resident was getting up unassisted, as directed in the plan of care. The fall on 11/19/14 resulted in fractured [redacted] On 11/21/14, the facility moved the resident to a room in the [redacted] hall for increased staff supervision. During observation and interview on 12/2/14 at	F 323	F323 The nursing home will correct the deficiency as it relates to this resident by immediately making the environment free from hazards. Staff involved with this resident were counseled and educated. To protect other residents in similar situations and ensure the problem does not recur, the facility will in-service all staff on environmental hazards. To monitor our performance and maintain that the solutions are sustained the facility will conduct random room audits on each hall bi-weekly for four weeks. The corrective action will be completed on 1/30/15. The Director of Nursing will be responsible to ensure the correction.	1/30/15

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F 323	Continued From page 5 4:05 p.m., the resident was in a recliner chair in his room. The call light was out of reach, and lying on the bed. The fall mat was leaning against the stand across from the recliner chair. The resident had a sling on his left arm, pushed up on his shoulder, and he was freely moving it. When interviewed, the resident was asked how he would call for assistance. The resident picked up the TV remote and pushed the buttons. When asked, the resident accurately read the sign posted on the wall reminding him to call for assistance. The resident again pushed the buttons on the TV remote to activate the call light - which did not work. When asked about the left arm sling, the resident stated he fell and hurt his back. On 12/2/14 at 4:10 p.m., Staff #A, the licensed nurse, confirmed the resident could trip on the fall mat, and that he should have his call light in place. Staff #A said the resident could recognize his call light, and activate it, if it was placed in front of him. The facility's failure to consistently implement planned interventions for injury prevention placed the resident at risk for additional falls and injuries.	F 323		1/30/15