

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 08/27/2024
NAME OF PROVIDER OR SUPPLIER Regency at Northpointe		STREET ADDRESS, CITY, STATE, ZIP CODE 1224 East Westview Court Spokane, WA 99218	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to implement their Abuse and Neglect Prohibition Policies and Procedures to include, not reporting to the State Agency (SA) within the required timeframe and completing a thorough investigation for 1 (Resident 397) of 2 residents reviewed for abuse. This failure placed the resident and other residents at risk for potential abuse or neglect and a diminished quality of life. Findings included . Review of a revised October 2022 facility policy titled Abuse/Neglect/Misappropriation/Exploitation showed, the facility protected the residents from abuse and neglect by implementing procedures designed to prevent, identify, report, and investigate allegations of abuse and neglect. The policy instructed the staff to report immediately to the Abuse Hotline (a SA), but no later than 2 hours after an allegation involving abuse or neglect was made, if the events that caused the allegation resulted in serious bodily injury and no later than 24 hours if the events that caused the allegation did not involve abuse or result in serious bodily injury. The policy showed that all alleged incidents of abuse or neglect were thoroughly investigated to determine what occurred and make necessary changes to the provision of care and services to prevent recurrence. The policy showed a thorough investigation included but was not limited to, an interview with the alleged resident victim, the assigned caregiver and caregivers in the immediate area, and a physical examination of the resident. This policy defined neglect as the facility's failure to provide goods or services to a resident that were necessary to avoid physical harm, mental anguish, or emotional distress. Review of an 08/16/2024 admission assessment showed Resident 397 admitted to the facility on [DATE] with medically complex conditions. This assessment showed the staff identified Resident 397 as cognitively intact and required assistance from the staff for completing Activities of Daily Living, like dressing, toileting, transfers, and bed mobility. Review of a 08/13/2024 progress note in Resident 397's medical record showed, Pt. [Patient] noted to have become upset when staff was doing 0200 [2:00 AM] rounds. Pt. stated that [they] had been waiting for 3 hrs [hours] and no one came to help [them]. This LN [Licensed Nurse] witnessed to [sic] NAC [Nursing Assistant-Certified] performing care on [the resident] around 0015 [12:15 AM]. Staff encouraged pt. to use call light when [they] needs [sic] assistance. (continued on next page)		

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.

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

TITLE

(X6) DATE

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/26/24 at 11:04 AM, Resident 397 re-told their account of the allegation identified by the facility on 08/13/2024. Resident 397 stated, I had to wait for them [the staff] to come and clean me up. I had a BM [bowel movement] in my bed and when I told the guy who came in, he just put two fingers up and I didn't see him until after 2 o'clock or after three [in the morning]. I called around midnight and he never did come back until 3 o'clock. I told him the first time what he needed to do, then he lifted his two fingers and left. Resident 397 stated that, I complained but nobody came to talk to me about it. I didn't talk to the nurse that night. I complained to the two aides but that's as far as it went. Review of the August 2024 Incident Log showed no documentation the facility reported the 08/13/2024 incident to the SA or that the facility thoroughly investigated Resident 397's complaint of having to wait three hours for staff to provide hygiene for fecal incontinence. On 08/26/24 at around 12:15 PM, Staff B, Director of Nursing, provided an incident report dated 08/14/2024, completed a day after the Resident 397's complaint was identified by the facility. The report showed, the Patient stated that no one came into his room for 3 hours to assist [them] on the night of August 13th 2024. The report showed the Immediate Action Taken by the facility was a chart review, call light response times reviewed, investigation initiated. The report showed no indication the facility completed a re-interview of Resident 397. The report stated, 6 patients were randomly selected for interview and included their initials but no documentation to show who the residents were, who interviewed the residents, or when they were interviewed. Similarly, the report showed the facility interviewed 2 NACs [Nursing Assistant Certified] and 2 LN [Licensed Nurse] that worked on the night shift, but showed no documentation who were the four staff interviewed, their own dated and signed witness statements, who interviewed the staff, and the content of the interviews. The document showed the facility reviewed the results of the investigation with the resident's daughter and the resident and that, all parties satisfied with resolution. The above information was shared with Staff A, Administrator, on 08/26/24 at 1:46 PM. Staff A stated that the 08/14/2024 incident report was interchangeable for an investigation. Staff A stated that when a resident tells the staff that they waited for three hours for someone to help them, My expectation is to report it to the Abuse Coordinator, make sure the resident is safe, and then report it to the nurse on shift. I tell the staff to call me directly and let me know right away so we can initiate protocols to rule out abuse or neglect. Staff A identified himself as the Abuse Coordinator. Staff A replied, I do not see it on here, when asked if the facility logged the incident in the Incident Reporting Log. Staff A stated that the complaint did and did not meet the definition of an allegation of neglect, It's double-sided. Since it was witnessed by the staff, we can rule it out right away. It's a case-by-case basis. Then alternately, Completely my mistake. It should have been logged. Even though the facility policy instructed the staff to report all alleged violations of abuse or neglect to the Abuse Hotline within a required timeframe, Staff A stated that they did not report it to the Abuse Hotline because, It was witnessed by the nurse, that's why it wasn't reported. It was witnessed by the staff that it didn't happen and I wouldn't consider it a reportable event so I wouldn't report it. Staff A acknowledged the 08/14/2024 investigation did not include supporting documentation the facility re-interviewed Resident 397, or the four staff and six residents mentioned in the incident report. Staff A stated on 08/26/24 at 1:50 PM, I personally interviewed the staff and residents. It was one nurse, the '2 LN' is a typo [sic], and two NACs, it was over the phone. So, I didn't get their statements. No additional information was provided by Staff A. (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97-0640(2)		

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to identify what information was conveyed to the hospital at the time of transfer for 2 of 2 sampled residents (67, 94) reviewed for hospitalization s. This failure placed the residents at risk for a disruptive and ineffective transition from the facility to the hospital setting. Findings included . <Resident 94> Review of the progress notes showed Resident 94 admitted to the facility on [DATE]. The 07/25/2024 progress notes showed Resident 94 experienced a change in condition, the staff notified the provider, the staff transferred the resident to the hospital, and notified the resident representative. In an interview on 08/27/24 at 9:03 AM, Staff U, Licensed Practical Nurse (LPN), stated that when a resident is transferred to the hospital, she notifies the Unit Manager, the Director of Nursing (DON), the family, and the doctor. Staff U stated that at the time of a resident's transfer to the hospital, they send with the resident and ambulance personnel printed copies of the current medications and their administration record, progress notes, and recent vital signs. Staff U stated that they also call in report to the emergency room personnel. Staff U stated that they documented the type of information or documents conveyed to the hospital by making an entry in the progress notes. Staff U showed a Transfer to Hospital checklist the staff use as a reference of what information is to be sent to the hospital. This list included a physician order, an eInteract Transfer Form, an ambulance medical necessity certification statement, a copy of the medical record, and nurses notes. In an interview on 08/27/24 at 9:12 AM, Staff N (LPN) stated that when a change in condition required a hospital transfer, they notified the provider and resident representative. Staff N stated that the documents they send to the hospital include the most recent laboratory results, progress notes, a demographics sheet, a POLST form [Physician Orders for Life Sustaining Treatment], a bed hold notification form, and a Transfer to Hospital Evaluation form. Staff N stated that the information conveyed to the hospital is sent with the resident and ambulance personnel at the time of the transfer and documented in the progress notes. Review of Resident 94's medical record showed no documentation the facility communicated to the hospital adequate and required communication at the time of the Resident 94's transfer on 07/25/2024, including: The basis for the transfer, the specific resident need(s) that could not be met, facility attempts to meet the resident needs, or the information provided to the receiving facility to include contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, Advance Directive information, all special instructions or precautions for ongoing care as appropriate, comprehensive care plan goals, and all other necessary information, including a copy of the resident's discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care. (continued on next page)		

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The above information was shared with Staff B, Director of Nursing, on 08/27/24 at 9:39 AM. Staff B confirmed via record review that documentation to show the staff conveyed all necessary clinical information to the hospital at the time of a facility to hospital transfer was not present in Resident 94's medical record. <Resident 67> A review of the record showed Resident 67 had history of a broken vertebra in their back and stroke. A review of progress notes documented on 07/13/2024, the licensed nurse was notified by the nursing assistant that Resident 67 had difficulty breathing and their oxygen levels were extremely low. After supplemental oxygen was applied, the physician and the resident's representative were notified. A decision was made to send the resident to the hospital. The licensed nurse documented they called the emergency room and gave them report. Further review of the record was unable to locate documentation of what information of Resident 67's was provided to the local hospital to allow for continuity of care when the resident was transferred as required. On 08/27/2024 at 8:28 AM, Resident 67's record was reviewed with Staff B, and Staff H, Medical Records Supervisor. When asked, Staff H stated nursing staff printed documents from resident records at the time of transfer. Staff B stated nurses had a reference list they referred to when a resident was being transferred. The documents on the list were printed, placed in an envelope, and these accompanied a resident to the hospital. Staff B stated the nurses then documented in progress notes that they called report or who they spoke to, then completed the hospital transfer document in the Assessments section of the electronic medical record. When Resident 67's Assessment section was further reviewed, there was no hospital transfer documentation completed. Staff B stated they would have to ask staff why the resident did not have the documentation completed. Reference WAC 388-97-0120. 46033		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37544 Based on observation, interview and record review, the facility failure to ensure care plan revisions were made for 2 of 17 sampled residents (64, 397) whose care plans were reviewed. Failure to revised Resident 64's care plan to include additional interventions to prevent a further decrease in the ability to flex the fingers, and failure to revised Resident 397's care plan to include their preferences for bathing placed the residents at risk for diminished quality of life and unmet care needs. Findings included . <Resident 64> The 05/31/2024 quarterly assessment documented Resident 64 was severely cognitively impaired, non-verbal, had diagnoses which included stroke, and was dependent on nursing staff for activities of daily living (ADLS) such as dressing. In addition, the assessment documented the resident had impaired range of motion (ROM: the ability to move or flex a joint) to both upper and lower extremities and had received restorative services (a program in which staff work with residents to maintain and/or improve their functionality or independence). On 08/21/2024 at 10:21 AM, Resident 64 was observed being wheeled down the hall to the shower room by Staff L, Bath Aide. Resident 64 was sitting up right in the shower chair, with their forearms lying on their chest and both their hands clenched in a fist. The resident was not wearing hand splints, nor were any palm protector devices such as a rolled-up washcloth, placed in their hands to keep their fingers from staying in a fist position. On 08/22/2024 at 9:44 AM and 2:46 PM, Resident 64 was observed lying in bed with their eyes closed, their arms were lying at their sides and both hands were clenched in a fist. No hand splints or palm protector devices were being used. At 2:46 PM, the resident was again observed lying in bed with their eyes closed, both hands in a clenched fist position Similar observations of the resident's hands being clenched into fists with no hand splints or palm protector devices in place were made on 08/23/2024 at 10:22 AM, 11:17 AM, and 2:10 PM. A 07/13/2022 progress note documented Resident 64 received restorative services that included passive range of motion exercises to each extremity (exercises done with the assistance of nursing assistants to keep joint flexible). Review of the Contracture Screening Assessments, (an assessment to determine whether a resident was at risk of developing or had developed a contracture, a shortening of a muscle, which caused the muscle to be resistant to stretching) documented on 10/06/2022, the resident's joints were stiffer, and it was more difficult to do the passive range of motion exercises. The 11/29/2023 assessment documented Resident 64's fingers of both hands were difficult to extend fully. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 04/08/2022 skin integrity care plan documented the resident had potential for an alteration in their skin integrity and interventions were implemented and revisions were made as changes in the resident's skin occurred, but no interventions were found or added to include measures to prevent skin breakdown related to the resident keeping their hands clenched in a fist position. Review of the 04/21/2022 ADL and Restorative care plans documented Resident 64 was identified for being at risk for contractures and interventions were implemented to include passive range of motion to both upper and lower extremities, but no interventions were found or added to include measures to prevent contractures related to the resident keeping their hands clenched in a fist position. In an interview on 08/23/2024 at 2:25 PM, Staff L stated the resident could not open their hands. When asked how the nursing assistants knew what the resident's care needs were, Staff L stated the care plan informed them. In an interview on 08/23/2024 at 2:32 PM, Staff M, Restorative Aide, stated Resident 64 received range of motion exercises to their hands and could extend their fingers, but always held their hands tightly in a fist position. Staff M further stated hand splints were not used, but rolled washcloths were always placed in the resident's hands. In an interview on 08/26/2024 at 10:09 AM, Staff N, Licensed Practical Nurse, stated Resident 64 was able to extend their fingers, but liked to keep them clenched in fists, so rolled wash cloths were placed in the hands as a preventative measure. In an interview on 08/27/2024 at 9:48 AM, when informed of the observations of Resident 64's hands being clenched into fists and no palm protection devices/rolled wash cloths in place, Staff O, Resident Care Manager (RCM), stated Resident 64's care plan should have been revised. 40297 <Resident 397> Review of an 08/16/2024 admission assessment showed Resident 397 admitted to the facility on [DATE]. This assessment showed Resident 397 answered that it was Very important to choose between a tub bath, shower, bed bath, or sponge bath. In an interview on 08/21/24 at 10:50 AM, Resident 397 stated that the staff, come and get me once a week or whatever it is and that they prefer to take a shower one every day if I could. Resident 397 said, No one has asked [how often I want to get showers]. All [staff] said is I'm scheduled for showers. Review of an 08/15/2024 Bathing/Showering care plan showed the resident required assistance of one person for bathing. The care plan showed Bathing/Shower per resident preference (SPECIFY) but did not show the resident's preference, to include mode and frequency. In an interview on 08/23/24 at 11:06 AM, Staff G (RCM) acknowledged the resident's bathing preferences did not show in the care plan and should have. Reference (WAC): 388-97-1020 (2)(c)(d).		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 46033 Based on observation, interview and record review, the facility failed to ensure a resident received assistance setting up their meals for 1 of 4 sampled residents (67) reviewed for activities of daily living (ADLs). This failure placed the resident at risk of decreased dietary intake, potential weight loss and decreased quality of life. Findings included . <Resident 67> Review of the 07/26/2024 re-admission assessment documented Resident 67 had diagnoses including paralysis of the right side of the body following a stroke, difficulty speaking and swallowing, and severe calorie malnutrition. Resident 67 was severely cognitively impaired, coughed or choked during meals, held food in their mouth after meals, and required partial to moderate assistance for eating. The 07/06/2024 care plan documented Resident 67 had a deficit related to their ability to eat because of their stroke and a contracture (shortening of muscles and tendons that prevented normal movement) of their right hand. They required assistance of one staff to set up their meals. A 07/12/2024 weight change progress note documented Resident 67 had a major weight loss when compared to a previous stay at the facility. Resident 67 had poor oral intake since their current admission and their diet was changed to N.E.M. (nutritionally enhanced meals, adding gravies or butter to foods for example) for increased calories. On 07/31/2024, a provider order was given to provide Resident 67 a N.E.M., dysphagia (difficult swallowing) mechanical soft diet (foods that required little chewing such as ground, mashed or finely chopped items.) with thin consistency fluids. During a telephone interview on 08/21/2024 at 11:15 AM, Resident 67's representative stated they were unsure if the resident was eating well. They stated the resident had experienced a gradual weight loss over several months, but they were unsure of the cause. On 08/21/2024 at 12:12 PM, Resident 67 was observed seated in their wheelchair with their overbed table in front of them. The resident appeared thin and their trunk leaned slightly to the right. The resident's right arm and hand rested across their stomach and the hand was contracted. The resident's lunch was on the overbed table and included cooked carrots cut in cubes, a fruit cobbler in a separate dish, and a serving of lasagna that was covered in brown gravy. The lasagna was served in a square and was not cut up. Resident 67 was able to get small portions of cobbler on a spoon to eat. They were unable to use their right arm. When asked questions, Resident 67 answered each time saying, Good, good. An unidentified staff member entered the room and asked Resident 67 if they wanted help. The resident answered no and the staff member exited the room. The lasagna was again observed and was not cut up for the resident. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/23/2024 at 8:01 AM, breakfast trays were distributed to the residents. At 8:19 AM, Resident 67 was observed sitting upright in bed. There was a Velcro-type brace on the resident's right hand, and their right arm and hand rested across their stomach. Resident 67 attempted to eat a substance that looked like pudding. On the resident's plate was half of an English muffin. A hollandaise sauce with small pieces of ham circled the English muffin. The resident has scraped any of the sauce and ham off the top of the muffin and eaten it but left the English muffin. The English muffin had been served without being cut up for the resident. On 08/23/2024 at 12:03 PM, Resident 67's lunch was delivered. Resident 67 was seated in their wheelchair and said Oh! Oh! in pain and moaned. The lunch was observed to include a whole burrito, chopped lettuce and diced tomato, rice, and a piece of cake. The burrito was left whole, and the nursing assistant (NAC) left the room to notify the nurse of the resident's pain. At 12:35 PM, Resident 67 was observed no longer groaning. They were taking bites of their cake. The resident had a different meal before them that included a ground meat with gravy, mashed potatoes and gravy, and Capri style vegetables. When interviewed at 12:41 PM, Staff C, NAC, stated the staff had recognized that Resident 67 had received the wrong foods. They had arranged for a new meal so the resident had the correct food textures. On 08/26/2024 at 8:16 AM, Resident 67 was eating their breakfast seated upright in bed. The resident was taking bites of scrambled eggs. There were also two half slices of toast on the plate. A bowl of cereal was set off to the side of the plate with the cover still on it, and a whole banana still in the peel was beside the plate. When interviewed on 08/27/2024 at 9:06 AM, Staff D, NAC, stated Resident 67 ate bananas but they needed to be peeled. Staff D stated the resident's son visited often, and the son often cut up or opened foods for the resident. When interviewed on 08/27/24 at 11:35 AM, Staff E, NAC, stated Resident 67's right hand was contracted and the resident was not able to use it to help cut up food, or open a banana. Staff E stated Resident 67 needed to have that done for them. Staff E further stated it was important to help a resident open their food and cut it up because if not, the resident might get tired or distracted or lose interest and then not eat. They wanted the residents to eat so they did not lose weight. When interviewed on 08/27/24 at 1:09 PM, Resident G, Resident Care Manager, stated Resident 67's ability to eat varied from independent to minimal assistance. The resident was at risk for weight loss, and needed assistance removing lids, opening containers or cutting up foods. Staff G stated it was important for residents to get assistance they needed when eating. If not, they risked not getting the nutrition they needed. Reference: WAC 388-97-1060(2)(c)		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on observation, interview and record review, the facility failed to ensure 1 of 1 resident (91) reviewed for hearing, received the necessary treatment and services to maintain their hearing abilities. Failure to assess the etiology of and pursue services for Resident 91's identified hearing impairment, placed the resident at risk for a decline in communication, social isolation, changes in mood and behavior, and unmet needs. Findings included . Review of an 08/02/2024 admission assessment showed Resident 91 admitted to the facility on [DATE] with medically complex conditions. This assessment showed the staff identified Resident 91's hearing was highly impaired, used hearing aids, was able to make themselves understood, and usually understood others. Staff assessed the resident to have moderate cognitive impairment. The staff assessed Resident 91 required assistance from the staff with most Activities of Daily Living (ADL), like oral hygiene, toileting, bathing, bed mobility, transfers, and dressing. An observation on 08/21/24 at 9:21 AM showed Resident 91 sitting up and in front of their over-the-bed table and wearing hearing aids bilaterally. Resident 91 could not hear the Surveyor and used a notebook to communicate. Resident 91 stated that they did not know how to turn on the hearing aids and that is when they used the notebook to communicate with the staff. On 08/23/24 at 8:22 AM, Resident 91 was observed eating their breakfast, did not hear the Surveyor, and hearing aids were not in use. Resident 91 stated that the hearing aids were inside the case on the bedside table being charged. An observation on 08/23/24 at 1:41 PM showed Resident 91 sitting on their walker's seat and, although the hearing aids were in both ears, could not hear the Surveyor. In an interview on 08/23/24 at 8:26 AM, Staff D, Nursing Assistant, stated that they found information on the level of assistance and types of devices the residents required to complete their ADL successfully, in the Kardex [a set of care instructions for the nursing assistants derived from the care plan]. Staff D stated that Resident 91 used and took care of their hearing aids and that staff's responsibility was, just give [the resident] the case to charge them. Staff D stated that they communicated with Resident 91 verbally or wrote in the resident's notebook if the hearing aids were not in use. Staff D was unaware of concerns with hearing aid malfunction. Review of Resident 91's care plan showed, The resident has a communication problem r/t HOH [hard of hearing], and it instructed the staff to, Ensure hearing aid(s) (left and right) are in place, Identify & treat underlying cause(s) of communication impairment as appropriate, and Refer to Audiology [hearing, balance, and related disorders] for hearing consult as ordered. The care plan showed no information that a notebook was used between the resident and the staff for communication purposes when the hearing aids were not in use. Additionally, the care plan showed no instructions for the care of the hearing aids, to include who was responsible for its care and maintenance, or the type of assistance the resident required to ensure the hearing aids were charged and turned on when in use. (continued on next page)		

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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	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/26/24 at 10:11 AM, Resident 91 was observed sitting on their bed. Resident 91 communicated without the use of the notebook. Hearing aids were observed in use bilaterally. Resident 91 stated that on Friday (8/23/2024), a Collateral Contact of theirs took the hearing aids for overnight service at Costco. When asked how it felt to be able to hear, Resident 91 stated, It makes a big difference. Resident 91 stated that they use the notebook to communicate with staff when the hearing aids do not work, or they cannot hear well. On 08/27/24 at 12:11 PM, Resident 91 was observed sitting up with lunch in front of them. The hearing aids were observed next to the lunch tray on the over-the bed table. Resident 91 stated that the hearing aids were out of their ears because the staff, just put drops in [their ears]. Review of physician orders showed an order with a start date of 08/26/2024 that instructed the staff to instill drops in both ears for ear wax build-up for four days, and then flush the ears with warm water on day five. An 8/27/2024 progress note showed, Continues on ear gtt's [drops] for increase cerumen [ear wax] to bilateral ears. On 08/27/24 at 1:50 PM, Staff V, Licensed Practical Nurse, stated that they were familiar with Resident 91 and their care. Staff V stated that on Sunday afternoon, 08/25/2024, they overheard Resident 91's Collateral Contact tell Resident 91, The hearing aids worked. Maybe [the Resident's] ears are occluded [clogged up]. Staff V stated that when they overheard this conversation, they went to get the otoscope [a tool that uses a light and magnifying lens to examine the ear canal and eardrum] and checked [the resident's] ears. Staff V stated that they found the right ear had ear wax around the edges but I could see the ear drum, but left one was completely occluded. Staff V then started a provider's order for the ear drops to address the wax build-up. Review of an 08/05/2024 Social Services Note written by Staff W, Social Services Assistant, showed that, Resident scored moderately impaired on BIMS [a cognitive test]. Score seems to be reflective of resident being very hard of hearing even with hearing aids [sic] in and on. In an interview on 08/23/24 at 2:19 PM, Staff W shared that in a recent care conference, Resident 91's representative was present with the resident and the representative was reiterating things to Resident 91, repeating things louder into her ear. When asked if any care conference information was shared with the resident via written manner, Staff W stated, It seemed like [the resident] understood what we were talking about. Not from myself anyway. When asked if further enquiry or follow-up occurred as to why Resident 91 was, very hard of hearing even with hearing aids in and on, to include an audiology referral as mentioned in the care plan, Staff W stated, No. Not that I'm aware of. In an interview on 08/23/24 at 8:31 AM, Staff G, Resident Care Manager, stated that sometimes Resident 91 preferred verbal or written communication. Staff G stated that, while they were aware Resident 91 wrote in their notebook to communicate their needs to the staff even with hearing aids in use, Staff G did not enquire or determine why and stated, We allow [the resident] to use whatever [they] prefers. Staff G acknowledged the resident's care plan failed to but should have included Resident 91's preference for written communication even with the use of hearing aids, the type of assistance the resident required to ensure their hearing needs were met, and who was responsible for the care of the hearing aids. Staff G acknowledged on 08/27/24 at 1:35 PM that ear wax build-up can affect a resident's ability to hear adequately. No further information was provided. Reference WAC 388-97-1060(3)(a).		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on observation, interview and record review, the facility failed to put measures in place to ensure the staff delivered heat therapy with adequate and complete provider orders, to include monitoring for injury associated with the use of a heating pad, for 1 (Resident 397) of 1 resident reviewed for accidents. This failure placed the resident at risk for trauma associated with the use of a heating pad. Findings included . Review of an 08/16/2024 admission assessment showed Resident 397 admitted to the facility on [DATE] with medically complex conditions. This assessment showed the staff identified Resident 397 as cognitively intact and required assistance from the staff for completing Activities of Daily Living, like dressing, toileting, transfers, and bed mobility. Observations on 8/21/2024 at 10:32 AM, 8/22/2024 at 9:18 AM and 04:13 PM, and 8/23/2024 at 9:52 AM and 11:21 AM, showed a green pad wrapped around Resident 397's thigh while seated in their wheelchair. Resident 397 was fully dressed, to include pants. The green pad was connected to a device on the floor called a T/pump [a heating and cooling therapy system that uses pads to provide localized temperature control for pain relief and comfort]. Resident 397 stated that the nurse applied the green pad to his leg. The green pad was connected to the T/ pump via connecting tubing. Resident 397 stated that he used the green pad, all day and all night. Observation of the T/pump showed it had four temperature settings, 50 - 95 - 100 - 107 degrees Fahrenheit. The T/pump also provided 3 modes of treatment delivery - continuous, 20 minutes or 30 minutes. Resident 397's T/pump was set to 107 degrees, the highest setting, in continuous mode. In an interview on 08/23/24 at 11:21 AM, Resident 397 stated, I didn't realize that the T/pump had different settings and temperature ranges to address their comfort level. An observation on 08/26/24 at 10:22 AM showed both the green pad and the T/pump on the floor. Review of a Service Manual for the T/Pump showed the T/pump carried a risk of explosion and electric shock. The manual showed the device pumps temperature-controlled water through a pad. The manual instructed the staff to set the pad temperature only as directed by and under the guidance of the prescriber and to monitor the resident's temperature and skin condition every 20 minutes or as directed by a physician. The manual showed that failure to adhere to the warnings could result in resident injury. Review of Resident 397's medical record showed a physician order and a care plan (both dated 08/15/2024) that instructed the staff to apply a Kpad [heating pad] as needed to the left hip and thigh. The order showed no defined temperature setting, if it was continuous application or a time-specific treatment duration, nor the required monitoring of the skin condition. Additionally, review of the August 2024 Medication Administration Record showed no documentation the staff applied the Kpad even though resident observation and review of the progress notes between 08/16/2024 to 08/23/2024 showed its use. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/23/24 at 10:46 AM, Staff G, Resident Care Manager, stated that the use of a heating pad carried the risk for temperature-associated injury to the skin. Staff G stated that measures to prevent potential injury from the use of a heating pad included monitoring its use and scheduled preventive maintenance checks. Staff G stated that the provider order should carry the settings for the T/pump and acknowledged that the current order did not carry those treatment details. In an interview on 08/23/24 at 11:18 AM Staff X, Registered Nurse, stated that Resident 397 used the Kpad as needed for thigh pain and lower left hip pain. Staff X stated that they knew what temperature and mode the heat therapy would be delivered by looking at the machine. Staff X stated that either nursing or therapy sets up the T/pump setting. Staff X stated the settings for the T/pump should be in the initial orders and acknowledged they were not upon order review. The above information was shared with Staff B, Director of Nursing, on 08/26/2024 at 8:57 AM. Staff B stated that her expectation with the use of a T-pump and heating pad is for the orders to show, a specific time frame when placed, how long it's on, what the setting is if multiple, and if monitored then who is responsible for that. Pretty specific not just a generic order so that we know what we are doing. No further information was provided. Reference WAC 388-97-1060 (3)(g).		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on observation, interview and record review, the facility failed to ensure 2 of 2 residents (396 and 397) reviewed for incontinence, received the care and services necessary to maintain and avoid loss of bowel and bladder functions. This failure placed the residents at risk for continued decline in bowel and bladder function, skin issues, and feelings of frustration and embarrassment. Findings included . <Resident 396> A resident observation and interview on 08/21/24 at 09:49 AM with their Collateral Contact present showed, Resident 396 in bed and in a hospital gown. The resident stated it was hard to go to the bathroom and that she go Number 2 [bowel elimination] in their incontinence brief. No commode was nearby. Resident 396 stated that staff did not offer them a bed pan and that its use would be, more comfortable, less painful. Resident 396 described that when they experienced loss of control of their bowels it made them feel, shame myself. In another interview on 08/22/24 at 4:09 PM, Resident # 396 stated that they used just diaper for bowel elimination and the staff used no bed pan. Review of an 08/19/2024 admission assessment showed Resident 396 admitted to the facility on [DATE] with a fracture and other medically complex conditions. This assessment showed staff assessed the resident to be cognitively intact and was dependent on staff assistance to complete various Activities of Daily Living (dressing, bathing, personal hygiene, bed mobility, and toileting). This assessment showed the staff identified Resident 396 was frequently incontinent of their bowels and on no toileting program. Review of an 08/28/2024 Care Area Assessment (CAA - an analysis tool) associated with the 08/19/2024 admission assessment showed, the staff identified Resident 396, has remained frequently INC [incontinent] of bowel. Disposable incontinence products used to manage moisture This assessment showed the resident was able to make their needs known and use their call light appropriately. Review of bowel movement flow sheets from 8/15/2024 to 8/22/2024 showed Resident 396 experienced bowel incontinence 4 out of the 8 days reviewed, or half of the time. Review of the medical record showed no documentation the facility evaluated and subsequently developed effective and resident-centered interventions to address Resident 396's episodes of bowel incontinence. Review of an 08/15/2024 TOILET USE care plan showed a goal of, The resident will participate in toileting in the highest practicable level for their current condition. Interventions included, Prefers a bed pan and required maximum assistance of one person. Another 08/15/2024 care plan showed Resident 396 was at risk for bowel incontinence, and the goal was to ensure optimal bowel continence and instructed the staff to offer a bedpan or bedside commode. The Care Plan showed no interventions to anticipate Resident 396's episodes of bowel incontinence, like a toileting program based on the resident's preference or when the incontinence episodes occurred. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview 08/23/24 at 11:12 AM, Staff G, Resident Care Manager, acknowledged Resident 396's continued frequency of bowel incontinence episodes. Staff G stated, It's facility wide policy to check on [the residents] every 2 hours. Staff G acknowledged there was no toileting program to address Resident 396's continued bowel incontinence. Review of the medical record showed Staff G completed a Bowel Incontinence Evaluation on 08/25/2024. This evaluation showed the staff assessed Resident 396 developed new onset of bowel incontinence, was alert, oriented, and aware of the urge to evacuate their bowels. This evaluation concluded a Bowel Training program was indicated to help manage Resident 396's bowel incontinence. <Resident 397> On 08/21/24 at 10:32 AM, an empty urinal was observed on Resident 397's bedside table. Resident 397 sat in his wheelchair and stated, I use [the bedpan] at night [but] it's too late by the time [staff] get here in the daytime. In the daytime, I wet myself. Resident 397 stated that he must call the staff to let them know he needs to be toileted. No bedside commode was visible in Resident 397's room. In another interview on 08/23/24 at 9:52 AM, Resident 397 stated, [The staff are] not here when I need them. I messed on myself all day yesterday. So, I had to change my clothes. Resident 397 stated that he experienced bowel incontinence. Resident 397 stated, No, no, no. God, no, it never happened [bowel incontinence] at home. It makes me really upset when that happens. It's just upsetting to me. Resident 397 stated that staff do not come to offer to take them to the bathroom, that the resident must use the call light to let the staff know of their toileting needs. Review of an 8/16/2024 admission assessment showed the resident admitted to the facility on [DATE] with medically complex conditions. This assessment showed the staff identified the resident as cognitively intact, used a walker and wheelchair, and was dependent on the staff for transfers and toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement). The assessment also showed Resident 397 was frequently incontinent of bowel and bladder but on no toileting program. Review of an 08/22/2024 CAA showed Resident 397, to be frequently incontinent of bowel and bladder, incontinent briefs and barrier cream in use for dignity and reducing risks of further skin breakdown. Resident needs staff assistance with toileting and hygiene needs post incontinence and can communicate [their] needs and use the call light system. The CAA also showed, Incontinence issues place [the resident] at increased risks for further skin breakdown, infections, falls, injury, pain and further health decline. Will proceed to care planning. Review of an 8/15/2024 Bladder Incontinence Determination and Evaluation showed the staff identified medical conditions that contributed to Resident 397's bladder incontinence and that the bladder incontinence would be managed with, Bladder Retraining: candidates are alert, aware of urge to void & require limited assist with toileting. A bladder retraining program is a behavior therapy that can help people with overactive or weak bladders regain control of their bladder by learning to hold more urine and decrease the frequency of urination]. Review of the resident's medical record showed no documentation the staff completed an evaluation to determine and address why Resident 397 experienced bowel incontinence. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 08/15/2024 care plan showed a goal that Resident 397 would have optimal bowel continence. The care plan also showed the staff identified the resident had three types of bladder incontinence. The interventions instructed the staff to provide assistance of one person, Assess pattern of incontinence, and initiate toileting schedule if indicated, Provide bedpan/bedside commode, Evaluate incontinence per protocol to ensure optimal care is being provided and appropriate program is in place, and a BLADDER RETRAINING PROGRAM. The care plan showed no mention of the use or role of the urinal in managing Resident 397's bladder incontinence, no actual directions to the staff on how the bladder retraining program would be implemented, and no well-defined instructions on how the staff would help Resident 397 achieve optimal bowel continence. In an interview on 08/23/24 at 11:42 AM Staff D, Nursing Assistant, stated that they find information on a resident's toileting needs in the Kardex (care instructions derived from the care plan). Staff D described that residents may have a timed toileting schedule, a 2-hour check schedule, or the staff go to the resident when the resident turns on the call light. Staff D stated that they become aware of Resident 397's toileting needs as the resident, will call if they need help. Staff D stated that Resident 397 uses a urinal or staff assist them to the bathroom with a one-person assist. Review of bladder episodes flow sheets between 8/12/2024 to 8/22/2024 showed, Resident 397 experienced urinary incontinence two to three times daily, and bowel incontinence on an almost daily basis. In an interview on 08/23/24 at 10:51 AM, Staff G acknowledged this information as correct. Staff G could not say why Resident 397 experienced incontinence. Staff G stated that the staff had not evaluated Resident 397's bowel incontinence presently. In an interview on 08/26/24 at 8:34 AM, Staff T, Therapy Director, stated that when staff identified a resident experienced incontinence, he expected a referral request from the Nursing Department and get an order for Therapy to work with the resident. Staff T explained that for bladder retraining, the program starts with the therapy department, then handed off to the nursing department. Staff T was unaware of any residents in the facility currently on a bladder retraining program and stated, We get an order through nursing. [The resident] would need something more than just every 2-hour schedule. Therapy takes it up a notch. Staff T was unaware Resident 397 experienced dual incontinence. In an interview on 08/23/24 at 10:51 AM, Staff G stated that staff should complete bladder and bowel evaluations and implement a plan based on what we are seeing. Staff G acknowledged the staff failed to comprehensively evaluate Resident 397's bowel incontinence. Staff G acknowledged the staff identified Resident 397 was assessed to require a bladder retraining program, but that the care plan showed no instructions on how to implement the program. Staff G acknowledged the care plan lacked effective and resident-centered interventions to address the resident's dual incontinence. Staff G stated that at the minimum they would want to see interventions to show a toileting program, or a check and change schedule. No further information was provided by the facility. Reference WAC 388-97-1060 (3)(c).		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on observation, interview, and record review, the facility failed to ensure the staff accurately monitored the fluid intake of 1 of 1 resident (91) reviewed for hydration. This failure placed Resident 91, who was on fluid restrictions, at risk for dehydration or fluid volume deficit. Findings included . Review of an 08/02/2024 admission assessment showed Resident 91 admitted to the facility on [DATE] with medically complex conditions, to include heart failure and an acute kidney infection. An observation on 08/21/24 at 9:18 AM showed signage above Resident 91's bed that stated the resident was on a fluid restriction. Two glasses of juice and water and a cup of coffee were observed on Resident 91's over-the-bed table. When asked why they were on a fluid restriction, Resident 91 stated, I don't know. They [staff] just told me I was on one. So, they limit the amount of fluids they have to give me. Review of an 08/05/2024 Nutrition Assessment showed Resident 91's fluid needs between 1,275 to 1,525 mL (milliliter - unit used to measure capacity). The assessment showed the resident, requires 1800 mL fluid restriction. Compliant w/ [with] fluid restriction and was on a diuretic [a drug that make the kidneys produce more urine] for heart failure. Review of the August 2024 Medication Administration Record (MAR) showed orders to restrict Resident 91's fluid intake to 1,800 mL every day. The orders showed the Kitchen Department provided 1,320 mL of the 1, 800 mL at mealtimes, leaving the Nursing Department to provide 480 mL in a 24-hour period. Review of the August 2024 MAR showed that the nurses documented the total amount of fluids Resident 91 consumed daily. Record review showed the staff documented the amounts of fluids Resident 91 consumed at mealtimes in the Fluid Monitor Task Section. Interviews on 08/26/24 09:12 AM with Staff Y, Nursing Assistant, and on 08/23/24 at 08:47 AM with Staff G, Resident Care Manager, confirmed that Health Shakes 120 mL at mealtimes were included in the total tally of fluids documented in the Fluid Monitor Task Section. A comparison between what the Licensed Nurses (LNs) and Nursing Assistants (NAs) documented in the medical record showed, the amount of fluids Resident 91 consumed did not match the total daily tally of fluids the LNs documented in the August 2024 MAR from 08/06/2024 to 08/22/2024. The August 2024 MAR showed the nurses documented Resident 91 consumed a total daily average of 1,781 mL in the MAR, but the actual amount of fluids the resident consumed between what the LNs and NAs documented in the medical record fluctuated between a low of 540 mL and a high of 1,400 mL. Additionally, on six of the 17 days reviewed, the resident's fluid consumption stayed below one liter of fluid. On none of the days Resident 91's fluid consumption reached 1,500 mL of fluid. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The above findings were shared with Staff G on 08/23/24 at 08:47 AM. Staff G stated that the fluid tally documentation, do not add up. Staff G acknowledged inaccurate fluid monitoring placed Resident 91 at risk for dehydration. Reference WAC 388-97-1060 (3)(i).		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46115 Based on observation, interview, and record review, the facility failed to ensure oxygen delivery equipment was maintained in a clean manner and oxygen orders were followed for 1 of 2 sampled residents (19) reviewed for respiratory care. These failures placed the residents at risk for respiratory complications and infection. Findings included . Per the 07/09/2024 quarterly assessment, Resident 19 had diagnoses which included morbid obesity, high blood pressure and had moderate cognitive impairments. Review of the 04/03/2024 physician order documented Resident 19 had been prescribed oxygen to maintain oxygen saturation greater than 91%, due to hypoxia (a condition in which the body is deprived of adequate oxygen). Per the August 2024 Medication Administration Record (MAR), the resident was not administered oxygen for levels of less than 92% on the following dates: -08/03/2024 oxygen level was 91% on day and night shift -08/09/2024 oxygen level was 90% on evening shift -08/10/2024 oxygen level was 90% on night shift -08/11/2024 oxygen level was 91% on day, evening and night shift -08/13/2024 oxygen level was 90% on evening shift -08/22/2024 oxygen level was 91% on day shift -08/24/2024 oxygen level was 90% on night shift -08/25/2024 oxygen level was 91% on night shift The 04/25/2022 physician order instructed nursing to change the oxygen tubing and filter weekly and as needed. According to the August 2024 MAR, the oxygen tubing had not been changed on 08/10/2024 and 08/17/2024 as ordered. On 08/22/2024 at 10:15 AM, Resident 19 was observed lying in bed and was not wearing oxygen. An inspection of the oxygen concentrator in the resident's room showed the concentrator was unclean with thick dust inside the vented area, and the filter had thick dust and debris. The oxygen tubing had no date as to when it had last been changed. (continued on next page)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subsequent observations of the oxygen concentrator being unclean and the filter being dirty were made on 08/22/2024 at 3:57 PM and 08/23/2024 at 8:09 AM. During an observation on 08/23/2024 at 8:27 AM, Resident 19's undated nasal cannula and oxygen tubing was observed lying on the floor. On 08/23/2024 at 8:27 AM, Staff I, Respiratory Therapy Director, and the surveyor observed Resident 19's concentrator. The area inside the vent of the concentrator and the filter had thick dust. Staff I confirmed the filter was dusty and should have been changed. Staff I wound up Resident 19's oxygen tubing and nasal cannula that was on the floor and placed it in a bag on the concentrator and stated the tubing was stored in the bag until it needed to be used. Staff I added that the tubing was to be changed weekly. In an interview on 08/23/2024 at 9:30 AM, Staff J, Resource Nurse, stated nasal cannulas that touched the floor needed to be discarded because they were dirty and had germs. During an interview on 08/27/2024 at 11:04 AM, Staff B, Director of Nursing, stated oxygen filters needed to be kept clean and this was important to maintain functionality of the equipment. Staff B added that nasal cannulas found on the floor needed to be discarded immediately to ensure it was not used for the resident. During an interview on 08/27/2024 at 11:57 AM with Staff K, Resident Care Manager, stated Resident 19 according to the order should have worn oxygen when their saturation was less than 92% and it was important, so the resident had adequate oxygenation for their vital organs. Reference: WAC 388-97-1060 (3)(j)(vi)		

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 08/27/2024
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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 46115 Based on interview and record review, the facility failed to ensure blood pressure medications were consistently monitored for 1 of 5 sample resident (90) reviewed for unnecessary medications. This failure placed the residents at risk for potential adverse side effects and medical conditions. Findings included . Per the 08/03/2024 admission assessment, Resident 90 had diagnoses which included high blood pressure. Review of the Physician Order Report documented the physician prescribed a blood pressure medication (Metoprolol) on 07/30/2024 to be given twice daily. The order instructed nursing staff to hold the medication if the heart rate was less than 60 beats per minute or the systolic blood pressure (the pressure in your arteries when your heart is beating and sending blood into your arteries) was under 100. In addition, the nursing staff were to notify the physician if Resident 90's blood pressure was out of the parameters listed. Review of the July and August 2024 Medication Administration Record (MAR) documented no blood pressures were taken prior to administration of the blood pressure medication as instructed in the physician's order. Review of the Vitals Parameters report from 07/30/2024 through 08/23/2024 documented Resident 90's blood pressure had not been taken twice daily most days and times did not always correlate when blood pressure medication was administered. In an interview on 08/26/2024 at 11:15 AM, Staff B, Director of Nursing, stated the blood pressure should have been monitored every time it was given, and the order was typically placed on the MAR and was missed. Staff B added it was important to monitor the blood pressure, so nursing knew when to hold the medication and notify the physician. Reference (WAC): 388-97-1060 (3)(k)(i)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47728 Based on observation and interview, the facility failed to ensure hand hygiene and use of hair coverings was implemented properly during the preparation and serving of food during 2 of 2 kitchen observations. This failure caused exposure of all residents to potential food contamination and food borne illness. Findings included: According to the CDC, Clinical Safety: Hand Hygiene for Healthcare Workers, hands should be cleaned using soap and water or an alcohol-based hand sanitizer immediately before touching a patient, before performing a task such as placing an indwelling device or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or patient's surroundings, after contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal. When washing hands with soap and water the CDC recommends, wet hands with water, apply the soap to the hands, rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers, rinse hands with water and use disposable towels to dry. Use a towel to turn off the faucet. <Hair Restraints> During a observation in the kitchen on 08/21/2024 at 8:59 AM Staff Q, prep cook was observed working in the kitchen and wearing their hair up in a bun. The hairnet they were wearing was covering only the bun on the top of their head and loose hair was hanging down over the back of their neck. During an interview on 08/21/2024 at 9:31am when asked why the hairnet was only covering the bun on top of their head, Staff Q stated they had always done it that way. Staff Q stated it was important to have to the hairnet covering all their hair to keep hair out of the food. During an observation of the lunch meal service on 08/26/2024 at 11:23 AM, Staff R, cook was not wearing a hair restraint and was serving food for the residents onto plates. Staff Q, prep cook, was putting the plates of food onto the trays and was wearing a hairnet however strands of hair not covered by the hairnet were loose on the back of their neck. Both Staff P, dietary manager and Staff S, dietary aide were setting up separate meal trays with food and beverages. Staff P as well as Staff S had their bangs and hair on the side of their faces exposed, the hairnets they were wearing were only covered the top and back of their hair. In an interview on 08/26/2024 at 12:23 PM, Staff R stated they had forgotten to put on a hair restraint. During an interview on 08/26/2024 at 2:41 PM Staff P stated all hair was supposed to be covered by the hairnet and it was important to keep hair and germs out of the food. <Hand Hygiene> (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 08/26/2024 at 11:46 AM Staff P, dietary manager performed hand hygiene and scrubbed their hands with soap for only two seconds, then proceeded to put on gloves and cook eggs and toast for a resident. During an observation on 08/26/2024 12:11 PM During lunch service, Staff R, cook was serving food and removed gloves, opened and removed an item from a refrigerator, then without performing hand hygiene proceeded to put on new gloves and continue serving food. In an interview on 08/26/2024 at 12:17 PM Staff R stated hand hygiene should be performed before starting food prep, after using the restroom or emptying the trash, and when moving from a dirty surface to a clean surface. They stated they supposed hand hygiene should be performed between glove changes. Staff R stated this was important to prevent disease transfer. Reference: WAC 483.60(i)(1)(2)-1100, 2980		