STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505498	A. Building B. Wing	04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Touchmark on South Hill Nursing	2929 South Waterford Drive Spokane, WA 99203

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45433 Based on interviews and record review, the facility failed to provide assistance with activities of daily living relative to toileting, transfers, personal hygiene and dressing for 1 of 3 residents (Resident 1) dependent on staff for that care. This failed practice placed residents at risk for embarrassment, poor hygiene, unmet care needs, diminished quality of life. Findings included . Review of Resident 1's medical record showed they were admitted to the facility on [DATE] with diagnosis including a repaired left hip fracture and unsteadiness on their feet. Review of the 03/12/2024 plan of care showed Resident 1 required assistance from staff to use the toilet, to complete transfers, to perform personal hygiene and to dress. In an interview on 04/08/2024 at 1:33 PM, Resident 1 stated they had had been left in the bathroom, naked for a long time after a nursing assistant had taken them into the bathroom after breakfast, assisted them to remove their wet, soiled clothing and then left them naked and cold sitting on the toilet and had not returned. They stated that this had happened several weeks prior, and they were bothered by it and worried they might be left naked and cold in the bathroom again. In an interview on 04/08/2024 at 2:08 PM, Staff C, Social Services Director, stated that they had become aware of the incident with Resident 1 on the morning of 03/25/2024 and had gone to talk to the resident to find out what had happened. They further stated they collected a statement from the resident and that they were concerned about what had happened to the resident because Resident 1 had been distressed about being left in the bathroom unclothed for an extended period of time. They further stated the resident reported feeling humiliated by the situation. Record review of the facility investigation into the incident involving Resident 1, dated 03/25/2024, indicated the incident involving Resident1 had occurred on 03/24/2024 around breakfast time. An untimed interview was conducted by Staff C, with Resident 1, on 03/25/2024. The statement given by Resident 1 was as follows: Being left in the restroom was the worst, I sat there for a long time before someone came back to help me. I was taken to the restroom after breakfast when the aide removed my clothing because they were wet. The aide did not tell me they were leaving the room just that my clothing was wet. A different aid came in and helped me get dressed and off the toilet . (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/08/2024 at 1:54 PM, Staff B, Director of Nursing, stated that they had been notified of the incident involving Resident 1 on 03/24/2025 when the Registered Nurse, Staff D, had reported to them that a Nursing Assistant, Staff E, had left Resident 1 in the bathroom, on the toilet, naked. Staff B, stated that they were concerned by the incident and that it was terrible. In an interview on 04/08/2024 at 2:26 PM, Staff A, Administrator, stated that Staff E, Nursing Assistant, had been terminated after some discussions with [them] about their CNA (certified nursing assistant) capabilities. They further stated that part of the reason for Staff E's termination was based upon Resident 1 reporting they were cold and bothered by it. Reference (WAC) 388-97-1060(2)(c)

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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 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** 45433 Based on interview and record review the facility failed to provide necessary supervision to 1 of 3 residents (Resident 2) reviewed for accidents. This failure placed residents at risk for potentially avoidable accidents, injuries, and diminished quality of life. Findings included . Review of 02/20/2024 pre-admission hospital notes showed Resident 2 fell at home striking their head and fracturing their left hip. Imaging of Resident 1's head on 02/20/2024 did not indicate any acute damage to the resident's brain or skull. Review of Resident 2's facility medical record showed Resident 2 admitted to the facility on [DATE] with diagnosis of left hip fracture, history of falling and heart failure (failure of the heart to pump blood throughout the body in an effective manner). A baseline care plan completed on 03/01/2024 at 12:42 PM indicated that Resident 1 was a high fall risk and was confused. A skin assessment dated [DATE] noted the resident to have no bruising on their head or face. Another skin check completed on 03/02/2024 also indicated no bruising on Resident 1's face or head. Review of Resident 2's progress notes showed they attempted to self-transfer, were confused, agitated and unable to be re-directed. - 03/02/2024 at 3:16 AM, resident was very confused, agitated and trying to get out of bed without assistance. Due to high fall risk the resident was helped into wheelchair after which the resident sat at the nurses' station and was given crushed pain medication in applesauce. - 03/02/2024 at 8:57 AM, resident is very confused with dementia, agitated and refusing all care. Resident unable to be redirected and is trying to stand up out of wheelchair and bed, call light in place. - 03/02/2024 at 11:55 AM, noted unsafe behaviors when left alone. -03/03/2024 at 10:38 AM, resident awake most of night, calling out and climbing out of bed, was brought to nurses' station in wee hours of morning and given a snack with a [narcotic] pain medication and then was taken back to bed. When checked on at shift exchange the resident was found laying at the end of their bed on their right side with their legs on the side of the bed resting on the floor. Was given more [narcotic] pain medication and taken in their wheelchair to the nurse station where they fell asleep. The resident's family member then pointed out a bruise to the right side of their face and stated that it was not their yesterday. -03/03/2024 at 10:54 AM, bruising observed to right side of head, bed in low position and fall mats on both sides of bed as it was reported that patient attempts to crawl out of bed, self-transfers and attempts to walk on [their] own. Received report that patient was seated at the nurses' station in [their] wheelchair for most of NOC (night) shift as [they were] anxious/restless and needed closer monitoring through the night. Was back in bed at 0300 (3:00 AM). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-03/03/2024 at 1:11 PM, bruising also observed to upper left forehead. -03/03/2024 at 1:47 PM, Resident with severe lethargy, neuro check is abnormal (indicating a problem with the brain and/or nervous system). Unknown cause of bruising to right temporal area (right side of head near eye) and left side of forehead. Sent to emergency room for evaluation. In an interview on 03/20/2024 at 11:50 AM, Staff D, Registered Nurse, stated that they were working with Resident 2 when the family member found the bruising on their face. They stated it was red and raised and near their right eye. They further stated that when they saw the resident at shift exchange, they were laying on their right side near the end of their bed with their feet on the floor. They woke the resident and helped the nursing assistant change their clothes and took them to the nurses' station in their wheelchair after which they did a pain assessment, gave the resident another narcotic pain pill and they then fell asleep again in their wheelchair. They stated that they did not know how the resident got the bruise on their face but thought they might have laid on their call light in bed or may have hit their face at the nurse station during the night. They stated that is was later in the shift that a physical therapist was helping the resident to wash their face and discovered the bruising on the resident's left forehead and told Staff D. Record review of hospital notes from Resident 2's admission starting 03/03/2024 stated that Resident 2 was given narcotic pain medication at 1:30 AM on 03/03/2024 and again at 7:14 AM. Resident 2's head was then imaged, and a small acute (new) intracranial (inside the skull) hemorrhage (bleed) was found over the right frontal lobe (right front of face/head) indicative of a fall. In an interview on 04/08/2024 at 1:54 PM, Staff B, Director of Nursing, stated that something had to have happened while Resident 2 was at the facility, that they had to have hit [their] head, it did not appear out of nowhere. Reference WAC: 388-97-1060 (3)(g)