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	06/26/2024

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

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review the facility failed to accurately transcribe provider orders, consistently administer medications as ordered by the provider, and ensure freedom from significant medication errors for 2 of 5 sampled residents (Resident 1 and 2), reviewed for medication administration. This failure placed residents at risk of medical complications, adverse side effects, and diminished quality of life. Findings included . Review of the facility's undated policy titled, Medication Administration, showed medications would be administered safely and timely as prescribed. The policy instructed staff administering medications to check the medication label to verify the right resident, right medication, right dosage, right time, and right method or route prior to administration of medications. If a drug was withheld, refused, or given at an unscheduled time, the policy instructed staff to document the reasoning in a progress note. The policy further showed staff who administered medications were to document in the record date and time a medication was administered, the dosage administered, any complaints or symptoms for which the drug was given, any results achieved and when those results were observed. Review of the facility's undated policy titled, Medication Error Report, showed medications were to be administered per doctor's order to ensure resident safety, resident right to safe and accurate delivery of medication and to establish parameters for monitoring and/or reporting of errors and guidelines for education. The policy included a medication error decision tree which started by asking if the error was a transcription error, the decision tree listed potential contributing factors for both transcription errors and non-transcription errors, and different severity levels for medication errors. The policy further showed when an error was made, the medication error form would be filled out, administration would review the error to determine the severity of the error, then the Director of Nursing (DNS) or administrator would decide on the course of action to follow based on the error and level of severity. The website nih.gov -which NIH refers to National Institute of Health showed, nurses have traditionally followed the '5 rights' of medication administration: right patient, right drug, right route, right time, right dose, to help prevent errors, and more recently, '7 rights' which includes right reason and right documentation. <Resident 1> (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission assessment, dated 05/07/2024, showed Resident 1 admitted to the facility on [DATE] with diagnoses that included debilitating cardiorespiratory conditions (diseases that affect the heart and lungs), hypertension (HTN- high blood pressure), acute respiratory failure (a serious condition that occurs when the lungs have difficulty getting oxygen into the blood) with hypoxia (low oxygen levels in the body's tissues), pulmonary hypertension (blood pressure in the lungs is higher than normal causing the heart to work harder than normal) dependent on supplemental oxygen. The assessment further showed Resident 1 had shortness of breath (SOB) with exertion, but none identified when sitting at rest or when lying flat. Resident 1 took a diuretic (medication that helps rid the body of excess water), used continuous oxygen therapy, was cognitively intact and able to verbalize their needs. Review of the hospital history and physical, dated 04/29/2024, showed Resident 1 was hospitalized for worsening hypoxemia (low blood oxygen) and difficulty breathing. The notes showed Resident 1 had pulmonary hypertension, heart failure (HF- long term condition that occurs when the heart cannot pump enough blood to meet the body's needs that can lead to inadequate blood flow and fluid buildup), and interstitial lung disease (group of chronic lung disorders that cause inflammation, irritation, or scarring of the lungs that makes it difficult to breathe and get enough oxygen into the bloodstream). The notes additionally showed Resident 1 had acute (severe and sudden onset) on worsening chronic heart failure from possible underdiuresis (not enough fluid removed from the body) and identified Resident 1's home dose of Torsemide (a diuretic) as 30 milligrams (mg) daily. The notes further showed Resident 1 admitted to the hospital with a weight of 158.5 pounds (lbs) and was 150.3 lbs upon hospital discharge after increased diuretics were given during the course of their hospital stay. The summary showed Resident 1 was able to converse in full sentences without increased SOB, and their oxygen level dropped to 87% after they walked 125 feet, but Resident 1's oxygen level returned to 90% within 30 seconds. Review of the hospital transfer orders, dated 05/01/2024, showed Resident 1's Torsemide order was increased to 50mg daily and the hospital recommended daily weights. The discharge instructions showed changes to Resident 1's Torsemide were made to attempt to keep them from retaining water and having SOB. Review of the facility provider orders showed a 05/01/2024 Torsemide order for Resident 1 to be administered 10mg daily for HTN, not 50mg daily as ordered by the hospital. Review of a 05/02/2024 provider progress note showed Resident 1 was recently hospitalized for respiratory failure, hospital chest x-ray was concerning for HF, and Resident 1 was diuresed at the hospital with symptom improvement. Resident 1 currently had clear lung sounds, oxygen level was 93%, and the provider's plan was to continue the diuretics as ordered by the hospital. Review of the May 2024 Medication Administration Record (MAR) showed Resident 1 was administered 10mg of Torsemide for five days on 05/02/2024, 05/03/2024, 05/04/2024, 05/05/2024, and 05/06/2024. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of May 2024 nursing progress notes showed upon admission on 05/02/2024 Resident 1 had clear lung sounds, and SOB was noted during a transfer but maintained 93% oxygen level. On 05/03/2024 Resident 1 began to report breathing difficulty, lung pain, and rhonchi (abnormal breath sounds that sound loud and coarse like snoring and usually a sign of secretions in the airway) were observed. Resident 1's oxygen level was 86%, their supplemental oxygen rate was increased, and Resident 1's oxygen level increased to 91-92%. On 05/05/2024 Resident 1 oxygen level ran between 81-89% while on increased supplemental oxygen, Resident 1 was switched to an oxygen mask and their oxygen level increased to 92-93%. On 05/07/2024 Resident 1s therapy was limited by their severe respiratory condition, oxygen levels would drop to 84% with minimal activity, their supplemental oxygen rate was increased again and took several minutes for Resident 1's oxygen level to recover to 91%, once recovered Resident 1 was able to maintain 90-92% oxygen levels at their normal supplemental oxygen rate. On 05/08/2024 Resident 1 had frequent complaints of not being able to breathe, quick oxygen desaturations (blood oxygen levels drop below normal) with increased recovery time taking up to seven minutes to reach oxygen levels 90% or above. Resident 1's child spoke to nursing staff about medication related concerns. On 05/13/2024 Resident 1 frequently stated I can't breathe!, had congested lung sounds, their supplemental oxygen rate was readjusted, and started on a medication for congestion. Review of May 2024 physical therapy daily treatment progress notes showed on 05/02/2024 Resident 1 was able to walk up to 70 feet prior to their oxygen level dropping to 80%. On 05/03/2024 Resident 1 was able to walk up to 50 feet prior to their oxygen levels dropping to 85%. On 05/06/2024 Resident 1 required frequent rest breaks due to SOB but was able to walk up to 50 feet before their oxygen levels dropped to 84%. On 05/07/2024 Resident 1 completed seated exercises and was able to maintain their oxygen levels between 88%-92%. On 05/08/2024 Resident 1 completed chair to wheelchair transfers prior to their oxygen level dropping to 86%, without improvement after supplemental oxygen was increased. On 05/09/2024 Resident 1 reported feeling fatigued and congested but was agreeable to seated exercises. On 05/10/2024 Resident 1 had an oxygen mask in place while they moaned and fidgeted. Resident 1 reported deep chest pain and lungs wringing. Review of the 05/08/2024 facility medication error incident report showed Resident 1 admitted to the facility on [DATE] and a transcription error had been made on the Torsemide dose. The Torsemide order was entered into the electronic medical record as 10mg daily but should have been entered as 50mg daily. Staff spoke to Resident 1's child about the error, and they were concerned. The report showed the order was corrected, daily weights implemented, and staff was educated on double checking orders, no staff education documentation was included. Review of Resident 1's weights showed the following: 05/03/2024: 149.4 lbs 05/06/2024: 152.8 lbs 05/07/2024: 155 lbs 05/08/2024: 157.2 lbs Resident 1 gained 6.9 lbs during their first week at the facility. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident 1's provider orders showed a 05/08/2024 order for staff to obtain daily weights and notify the provider if the resident's weight increased by two lbs in one day or by five lbs in a wk. Review of a 05/09/2024 provider note showed Resident 1 was seen for severe heart failure, interstitial lung disease, and to discuss a possible referral for hospice (care and services for persons with serious illness who were approaching end of life). The note showed Resident 1's weight was steadily creeping up again, conversations about hospice were started with the family that day, and Ativan (medication used to treat anxiety) to help manage the symptom of air hunger (the feeling of being unable to breathe deeply enough, running out of air, or gasping for air) was ordered. Further review of the May 2024 MAR showed Resident 1 received Ativan routinely three times daily starting on 05/10/2024 for acute respiratory failure with additional as needed doses administered on 05/10/2024, 05/12/2024 and 05/13/2024. Review of the outside hospice provider contract showed Resident 1 began to receive hospice services on 05/26/2024. Review of 05/28/2024 hospice progress notes showed Resident 1 had interstitial lung disease, had SOB with conversation, and had swelling to their legs. In an interview on 06/25/2024 at 12:50 PM, Resident 1's child stated Resident 1 had interstitial lung disease and was supposed to take Torsemide to help remove fluid from the lungs. Resident 1 repeatedly informed them they were not getting their medication as ordered so they went to nursing with the concerns. Resident 1's child acknowledged Resident 1 went four or five days without getting the correct dose of their Torsemide, they had fluid buildup, and were now on hospice. In an interview on 06/26/2024 at 10:47 AM, Staff D, Licensed Practical Nurse (LPN), stated the facility received orders for new admits prior to their arrival at the building, the orders would be entered into a cue in the electronic medical record by a resident care manager (RCM) or the Director of Nursing (DNS), cued orders were verified for accuracy by a second nurse, orders activated once correct, then orders faxed to the pharmacy to be filled. Staff D stated Resident 1 admitted to the facility related to respiratory failure, HF, and was now on hospice. Staff D reviewed Resident 1's medical record. Staff D acknowledged a transcription error was made on the Torsemide when Resident 1 admitted , Torsemide was entered as 10mg daily but should have been 50mg daily, and Resident 1 received 10mg of Torsemide for five days. Staff D further stated Torsemide was an important medication, especially for someone like Resident 1 who had HF, not receiving the appropriate dose could very easily put someone back into fluid overload (when the body has too much fluid) and/or require a trip to the hospital. In an interview on 06/26/2024 at 12:12 PM, Staff E, RCM, stated orders for new admits should be entered into the electronic medical record according to the hospital orders but they automatically became active once entered. Staff E further stated the current facility practice was for one nurse to read the hospital orders from the paper and a second nurse would read the orders entered into the electronic medical record to verify for accuracy. Staff E reviewed Resident 1's medical record. Staff E acknowledged Resident 1's Torsemide was entered into the electronic medical record as 10mg daily and Resident 1 received that dose for five days, but the Torsemide should have been 50mg daily. Staff E further stated Resident 1 was on Torsemide because they had HF and interstitial lung disease. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/26/2024 at 1:16 PM, Staff B, DNS, stated orders entered into the electronic medical record were reviewed for accuracy by two nurses but orders entered automatically became active. Staff B reviewed Resident 1's medical record. Staff B acknowledged upon admission Resident 1's Torsemide was not entered into the electronic medical record correctly, it was entered as 10mg daily, Resident 1 received 10mg for five days, Torsemide 50mg was not started until 05/07/2024 but according to the hospital orders the Torsemide should have been 50mg all along. Staff B further stated Torsemide was an important medication for Resident 1 because of all their medical conditions. In an interview on 06/26/2024 at 1:57 PM, Staff A, Administrator, acknowledged Resident 1's Torsemide order was entered incorrectly upon their admission and there was an incident report about it. <Resident 2> Review of the admission assessment, dated 04/12/2024, showed Resident 2 admitted to the facility on [DATE] with diagnoses including HF, chronic lung disease (disorders that affect the lungs and respiratory system, usually develop slowly, and worsen over time), and respiratory failure. Resident 2 was cognitively intact and able to verbalize their needs. Review of the hospital history and physical, dated 04/03/2024, showed Resident 2 felt dizzy and fell which resulted in a left ankle fracture. Review of the 04/05/2024 hospital transfer orders showed Resident 2's admitting diagnoses included dizziness and HTN. A summary showed Resident 2 felt dizzy and fell but they had never fallen before, and upon arrival at the emergency room Resident 1's blood pressure (BP) was 91/63. Resident 2 was to be administered Carvedilol (medication that slows down one's heart rate and makes it easier for the heart to pump blood around the body) twice daily upon hospital discharge. The website heart.org - with regard to blood pressure showed systolic [SBP- upper number]/diastolic [DBP- lower number] a normal blood pressure is less than 120/80 . a low blood pressure is less than 90/60 . consistently low blood pressure can be dangerous if it causes signs and symptoms such as: confusion, dizziness, nausea, fainting, fatigue, neck or back pain, headache, blurred vision, Review of Resident 2's provider orders showed a 04/12/2024 order for Carvedilol twice daily (AM and PM) for HTN with parameters to hold if SBP was less than 100 or heart rate (HR) was less than 60. Review of Resident 2's April 2024 through June 2024 BP readings showed: 04/23/2024- 98/67 05/31/2024- 93/51 06/7/2024- 85/60 06/8/2024- 98/65 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No BP documentation was found for 04/12/2024, 04/13/2024, 04/14/2024, 04/15/2024, 04/16/2024 PM, 04/17/2024, 04/19/2024, 04/20/2024, 04/21/2024, 04/22/2024, 04/24/2024, 04/25/2024 PM, 04/26/2024, 04/29/2024, 04/30/2024 AM, 05/03/2024 PM, 05/04/2024, 05/10/2024 PM, 05/12/2024 PM, 05/17/2024 PM, 05/18/2024, 05/19/2024 AM, 05/24/2024 PM, 06/02/2024 PM, 06/08/2024 PM, 06/09/2024 PM, 06/15/2024 PM, 06/21/2024 PM. Review of Resident 2's April 2024 through June 2024 HR readings showed: 05/13/2024- 59 06/05/2024- 59 No HR documentation was found for 04/12/2024, 04/13/2024, 04/14/2024, 04/15/2024, 04/16/2024 PM, 04/17/2024, 04/19/2024, 04/20/2024, 04/21/2024, 04/22/2024, 04/24/2024, 04/25/2024 PM, 04/26/2024, 04/28/2024 PM, 05/01/2024-05/12/2024, 05/13/202 PM, 05/14/2024, 05/15/2024 PM, 05/16/2024-05/20/2024 AM, 05/21/2024 AM, 05/22/2024 AM, 05/23/2024 PM, 05/25/2024 PM, 05/26/2024 PM, 05/28/2024 AM-06/03/2024 AM, 06/04/2024, 06/05/2024 AM- 06/10/2024 AM, 06/11/2024, 06/12/2024, 06/13/2024 PM-06/18/2024 AM, 06/19/2024, 06/21/2024 AM, and 06/23/2024 PM. Review of Resident 2's April 2024 through June 2024 MAR related to Carvedilol administration showed: April- Resident 2 was administered 23 doses of Carvedilol without BP and/or HR documentation found from 04/12/2024 through 04/25/2024. Resident 2 was administered Carvedilol doses without BP and/or HR documentation on 04/12/2024 PM, 04/13/2024 AM/PM, 04/14/2024 AM/PM, 04/15/2024 AM/PM, 04/16/2024 AM/PM, 04/17/2024 AM/PM, 04/19/2024 AM/PM, 04/20/2024 AM/PM, 04/21/2024 AM/PM, 04/22/2024 AM/PM, 04/24/2024 AM/PM, and 04/25/2024 AM/PM. May- A code 5 which stood for hold see progress note was documented for the following doses 05/04/2024 AM/PM, 05/12/2024 PM, 05/24/2024 AM, 05/25/2024 PM, 05/26/2024 PM. A code 9 which stood for other see progress note was documented for the following doses 05/17/2024 PM, 05/18/2024 AM/PM, 05/19/2024 AM. On 05/31/2024 PM Carvedilol was documented as administered with a BP documented as 93/51, the medication dose should have been held according to the parameters. June- code 5 documented for the following doses 06/02/2024 PM, 06/08/2024 PM, 06/09/2024 PM, and 06/21/2024 PM. On 06/07/2024 PM dose Carvedilol was documented as administered with a BP documented as 85/60, the medication dose should have been held according to the parameters. On 06/08/2024 AM dose, Carvedilol was documented as administered with a BP documented as 98/65, the medication dose should have been held according to the parameters. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 2's May 2024 and June 2024 nursing progress notes showed on 05/04/2024 AM BP was documented as 108/70 and HR 60, and the PM BP documented as 106/63 and HR 62, both AM/PM Carvedilol doses were held but should have been administered according to the medication parameters. On 05/12/2024 PM BP was documented as 120/65 and HR 60, Carvedilol was held but should have been administered according to the medication parameters. Progress notes for the 05/17/2024 PM Carvedilol dose had bp low documented and the 05/18/2024 AM dose had low bp documented, but no BP reading was documented for those days. On 05/25/2024 PM BP was documented as 109/71 and HR 63, Carvedilol was held but should have been administered according to the medication parameters. On 05/26/2024 PM BP was documented as 102/60 and HR 62, Carvedilol was held but should have been administered according to the medication parameters. On 06/02/2024 PM BP was documented as 103/56 and HR 68, Carvedilol was held but should have been administered according to the medication parameters. No progress notes were found for the Carvedilol doses held on 05/18/2024 PM, 05/19/2024 AM, 05/24/2024 AM, 06/08/2024 or 06/21/2024 PM. In an interview on 06/26/2024 at 10:47 AM, Staff D, LPN, stated if a medication had parameters for administration, such as BP and/or HR parameters for a cardiac medication, staff should obtain the required vital signs and administer the medication according to the parameters for that particular medication. Staff D further stated if a BP medication was administered without following parameters it could cause a residents BP to drop even lower and potentially fall or cause harm. Staff D stated medications needed to be documented as administered in the MAR when administered, if a code 5 or code 9 was documented the medication was typically not administered and a progress note should be entered with details of why it was not administered. Staff D reviewed Resident 2's medical record. Staff D acknowledged Resident 1's Carvedilol had BP and HR parameters for administration, but it was not administered per parameters on several occasions. In an interview on 06/26/2024 at 12:12 PM, Staff E, RCM, stated if a medication had administration parameters, vital signs should be obtained, medication administered or held according to parameters, a progress note should be written if it was not administered, and provider notified each time because the provider may want to follow up and further assess if there was an acute change in condition. Staff E further stated medication parameters should be followed to optimize the health of the resident and not place them in an unsafe situation. Staff E reviewed Resident 2's medical record. Staff E acknowledged Resident 2's Carvedilol was not administered as ordered numerous times. In an interview on 06/26/2024 at 1:16 PM, Staff B, DNS, stated if a medication had parameters for administration they should be followed, if a medication was held related to parameters the provider should be notified, and a progress note written with details of why the medication was not administered. Staff B reviewed Resident 2's medical record. Staff B acknowledged Resident 2's Carvedilol was not administered according to parameters on 06/07/2024 and 06/08/2024. In an interview on 06/26/2024 at 1:57 PM, Staff A stated they expected staff to administer medications as ordered by the provider. Reference WAC 388-97-1060 (3)(k)(iii)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on observation, interview, and record review the facility failed to implement a system for recording infections identified with corrective actions taken, consistently implement transmission-based precautions to prevent or control the spread of infections, and post appropriate signage for 2 of 3 sampled residents (Resident 3 and 2), reviewed for infection control. These failures placed residents at risk for transmission of communicable diseases and/or healthcare associated diseases, and diminished quality of life. Findings included . Review of the undated facility policy titled, Infection Prevention and Control Program showed if a resident experienced signs and/or symptoms of a communicable disease it should be documented, the interdisciplinary team would identify immediate precautions to implement to protect the resident and prevent the spread of the identified infection to other residents, staff, and family. The policy further showed the medical provider would assess, test, diagnose, and provide a plan of care for the resident to include any laboratory testing, medications, or special precautions to implement. Review of the facility policy titled, Contact Precautions dated 2020, showed contact precautions would be used in addition to standard precautions for specified residents known or suspected to be infected with organisms that could be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. The policy gave examples which included nausea and diarrhea. The policy instructed persons entering the resident's room to wear gloves and a gown if it was anticipated a person's clothing could have contact with the resident, environmental surfaces, items in the resident's room, if the resident was incontinent or had diarrhea. The policy further showed resident transport from the room should be limited to essential purposes only. If a resident was transported out of the room, staff was to ensure precautions were maintained to minimize the risk of organism transmission to other resident and contamination of environmental surfaces or equipment. The website CDC.gov - in which CDC refers to Centers for Disease Control and Prevention- with regard to transmission-based precautions showed transmission-based precautions are the second tier of basic infection control and are to be used in addition to standard precautions for patients who may be infected or colonized with certain infections agents for which additional precautions are needed to prevent infection transmission. There are three categories of transmission-based precautions: contact precautions, droplet precautions, and airborne precautions use contact precautions for patients with known or suspected infections that represent an increased risk for contact transmission . wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The website CDC.gov - regarding Norovirus showed Norovirus is the leading cause of vomiting and diarrhea from acute gastroenteritis [inflammation of the lining of the stomach and intestines] norovirus is a very contagious virus that causes vomiting and diarrhea . most people with norovirus illness get better within 1 to 3 days; but they can still spread the virus for a few days after a person usually develops symptoms 12 to 48 hours after being exposed . norovirus spreads very easily and quickly by having direct contact with someone with norovirus, like caring for them, sharing food or eating utensils with them, touching contaminated objects or surfaces . you are most contagious when you have symptoms of norovirus illness, especially vomiting and during the first few days after you feel better. Review of the facility acute gastroenteritis/Norovirus case report worksheet, dated 06/13/2024, showed five residents listed as affected. Resident 2 was listed as the first resident on the spreadsheet, but the symptoms, symptom onset date, and diagnostics section of the form were left blank. The worksheet further showed Resident 3 vomited once with the symptom onset date listed as 06/10/2024. <Resident 3> Review of the quarterly assessment, dated 04/17/2024, showed Resident 3 had diagnoses including stroke with hemiplegia or hemiparesis (weakness or paralysis on one side of the body after a stroke), dementia (disease that affects the brain and worsens over time causing a loss of cognitive function that interferes with daily life), and gastroesophageal reflux (GERD, also known as heartburn, a digestive disorder that occurs when stomach acid flows back into the esophagus). Resident 3 had severe cognitive impairment. Review of the 05/21/2024 provider progress notes showed Resident 3 had six putty like stools on 05/20/2024. The provider's plan was to avoid laxatives and continue to monitor bowels. Review of May 2024 through June 2024 provider orders showed Resident 3 was not on routine laxatives. Review of Resident 3's May 2024 through June 2024 nursing progress notes showed that on 05/20/2024 day shift Resident 3 went to the dining room for breakfast and lunch, no concerns were identified that shift and the day was uneventful. At 4:23 PM, Resident 3 attended a social event, visited the cafe, and took a stroll with their family. At 10 PM, it was identified Resident 3 had multiple bowel movements that day shift and two loose stools that evening. Resident 3 also attended the dining room for their dinner meal. On 06/05/2024 Resident 3 was placed on alert for loose stools but continued to eat their meals in the dining room daily and attend social activities. On 06/10/2024, Resident 3 vomited during the day shift but continued to eat their meals in the dining room daily and attend social activities. On 06/13/2024 at 7:44 PM Resident 3 was placed on enteric precautions for nausea and vomiting; the precautions were removed on 06/14/2024 at 11:29 AM, approximately 11.5 hours after precautions were implemented. Review of the 06/10/2024 provider progress notes showed Resident 3 vomited twice and was ordered a medication to prevent or reduce nausea and vomiting. (continued on next page)

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	06/26/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/26/2024 at 10:47 AM, Staff D, Licensed Practical Nurse (LPN), stated contact precautions required anyone who entered the room to put on a pair of gloves and a gown. Staff D further stated during the recent gastrointestinal (GI) outbreak residents who experienced three episodes of nausea, vomiting, or diarrhea were placed on contact precautions until they were symptom free for 24 hours, without the use of medications for symptom control. Staff D acknowledged all the residents who showed GI signs and/or symptoms during the outbreak had eaten in the dining room. Staff D stated residents on contact precautions should not attend group activities or communal dining and should stay in their rooms until they are 24 hours symptom free or else other residents were at risk of exposure and the infection could spread. Staff D reviewed Resident 3's medical record. Staff D acknowledged Resident 3 should not have participated in group activities or communal dining and should have stayed in their room until they were symptom free for 24 hours without the use of medication to manage symptoms. In an interview on 06/26/2024 at 12:12 PM, Staff E, Resident Care Manager (RCM), stated during the recent GI outbreak, residents were placed on enteric precautions because those precautions were GI based and required anyone who entered the room to put on a pair of gloves, gown, mask, and eye protection if there was a potential for splashing. Residents with precautions implemented should have stayed on precautions until they were symptom free for 24 hours without the use of medications to manage symptoms. Staff E further stated residents on enteric precautions should not participate in group activities or communal dining because GI infections were highly transmissible, they should have had 1:1 activities and eaten in their room. Staff E stated they 100% expected staff to follow any transmission-based precautions implemented because if they were not followed then the infection could spread. In an interview on 06/26/2024 at 1:16 PM, Staff B, Director of Nursing, stated enteric precautions were implemented during the recent GI outbreak, because those precautions required persons entering a room to place a pair of gloves, gown, and mask. Staff B further stated residents were to remain on precautions until they were 24 hours symptom free without the use of medications for symptom management. Staff B stated residents on enteric precautions were not to attend the dining room and should be encouraged to stay in their room. Staff B further stated they absolutely expected staff to follow transmission-based precautions because other residents and staff could become sick if they were not followed. Staff B acknowledged Resident 3 was the first resident to show signs and/or symptoms of GI illness on 06/10/2024. Staff B reviewed Resident 3's record. Staff B further acknowledged Resident 3 should have been encouraged to eat their meals in their room versus the dining room and not participate in group activities. <Resident 2> Review of the admission assessment, dated 04/12/2024, showed Resident 2 admitted to the facility on [DATE] with diagnoses including heart failure (long term condition that occurs when the heart cannot pump enough blood and oxygen to the body), chronic lung disease (disorders that affect the lungs and respiratory system, usually develop slowly and worsen over time), and respiratory failure (a serious condition that makes it difficult to breathe on one's own). The assessment further showed Resident 2 was frequently incontinent of bowel and bladder. Resident 2 was cognitively intact and able to verbalize their needs. (continued on next page)

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	06/26/2024

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of June 2024 nursing progress notes showed Resident 2 was placed on contact enteric precautions for GI upset on 06/13/2024 at 12:55 PM. A 2:16 PM note the same day, showed Resident 2 was placed on precautions for nausea and could come off precautions later that night at 11:05 PM (nine and a half hours after precautions were implemented). During observation on 06/26/2024 at 10:20 AM, an airborne contact precaution sign was posted outside of Resident 2's room door. The sign was not from the CDC and showed personal protective equipment (PPE) use recommendations for the hospital setting, not a skilled nursing environment. In an interview on 06/26/2024 at 10:38 AM, Staff C, Nursing Assistant, was unable to state what PPE was required for the different types of transmission-based precautions. Staff C stated they would typically read the transmission-based precaution signs that would be posted on a residents' room's door to obtain that information. Staff C acknowledged that if a resident was on specific transmission-based precaution then they should not participate in group activities or communal dining because it could expose other residents to the infection and spread to others. In an interview on 06/26/2024 at 10:47 AM, Staff D, LPN, reviewed Resident 2's medical record. Staff D acknowledged Resident 2's contact precaution removal on 06/13/2024 was not correct because they had not been symptom free for 24 hours. In an interview on 06/26/2024 at 12:12 PM, Staff E, RCM, reviewed Resident 2's medical record. Staff E acknowledged Resident 2 should not have been removed from precautions on 06/13/2024 because they had not met the 24 hours criteria. In an interview on 06/26/2024 at 1:16 PM, Staff B, DNS reviewed Resident 2's medical record. Staff B acknowledged the removal of Resident 2's contact precautions were not appropriate because Resident 2 should have been symptom free for 24 hours. In an interview on 06/26/2024 at 1:57 PM, Staff A, Administrator, stated during the recent GI illness, residents were placed on enteric precautions which required person's entering the room to place a pair of gloves and gown prior to entering a room then perform hand hygiene using soap and water instead of alcohol-based hand rub use. Staff A stated they absolutely expected staff to follow transmission-based precautions implemented because if they were not then the illness could continue to spread. Staff A further stated residents who were placed on enteric precautions should have been educated not to participate in group activities or communal dining until at least 24 hours after their symptoms had resolved. Staff A was unaware the facility's transmission-based precautions signage was for hospital use, not the skilled nursing setting. Staff A reviewed Resident 2 and 3's medical records. Staff A acknowledged there was more infection control staff education that needed to be done. Reference WAC: 388-97-1320 (2)(a), (2)(b), (2)(c)