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	08/22/2024

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review the facility failed to repeatedly ensure residents were free from misappropriation of property and/or exploitation for 3 of 3 sampled residents (Resident 1, 2, and 3), reviewed for missing property. This failure placed residents at risk of further misappropriation of personal possessions and diminished quality of life. Findings included . Reivew of the undated facility policy titled, Personal Property Policy showed residents were encouraged to bring personal belongings to provide familiarity and a homey atmosphere. The policy showed the facility would not ask a resident to waive their rights including the right to collect payment for lost or stolen articles. The policy showed a personal inventory sheet would be completed and updated whenever items were brought into or removed from a resident's possession. Reimbursement for missing items may depend upon verification of the presence of the item. The policy further showed it would not be reasonable or prudent for a resident to maintain cash in their possession; the resident is vulnerable to theft of cash and there was little to spend money on inside the community. For an item to be considered for replacement, missing items must be promptly reported, a search would be conducted, if the loss was deemed to be the responsibility of the community, the community would replace the item. Review of the undated facility policy titled, Grievance Policy showed a grievance was a formal or informal written or verbal complaint made by a resident, their representative, family member, or staff member about quality of care, treatment, or concerns related to the facility. The grievance officer was responsible for overseeing the grievance process, documenting and tracking grievances, conducting investigations, and maintaining confidentiality. The policy showed a praise, concern, suggestion form may be used if a concern was NOT an allegation of abuse or neglect, those concerns were to be reported to the director of nursing or administrator immediately. If a grievance involved potential abuse, neglect, or exploitation, the policy instructed staff to follow mandatory reporting procedures. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled, Abuse Policy dated 2023, showed abuse was prohibited and must be reported in a timely manner to allow for proper investigation and implementation of measures to prevent recurrence or retaliation. The policy defined an allegation as a statement, or a gesture made by someone (regardless of capacity or decision-making ability) that indicated abuse, neglect, exploitation, or misappropriation of resident property may have occurred and required a thorough investigation. Abuse included sexual abuse, mental abuse, physical abuse, and exploitation. The policy defined financial exploitation as illegal or improper use of the property, income, resources, or trust funds of the vulnerable adult by any person for any person's profit or advantage. The policy further showed all alleged violations of abuse, neglect, mistreatment, and/or exploitation must be reported to the administrator, director of nursing or their designee and reported to the State Survey Agency hotline. The policy showed staff were mandatory reporters, trained to identify and report allegations including disappearance or misappropriation of resident's personal property, and expected to understand individual responsibilities as mandatory reporters. <Resident 1> Review of the admission assessment, dated 07/22/2024, showed Resident 1 admitted to the facility on [DATE] with diagnoses including hypertension (high blood pressure) and polyneuropathy (group of conditions that cause multiple peripheral nerves throughout the body to malfunction at the same time). Resident 1 was cognitively intact and able to verbalize their needs. The assessment further showed it was very important for Resident 1 to take care of their personal belongings, have a place to lock items for safety, and have family or friends involved in their care, while in the facility. Review of the 07/16/2024 resident preference evaluation showed it was very important for Resident 1 to take care of their personal belongings, have a place to lock items for safety, and have family or friends involved in their care. Review of the 07/19/2024 personalized care care plan showed it was very important for Resident 1 to take care of their personal belongings, have a place to lock items for safety, and have family or friends involved in their care. The 07/22/2024 care plan showed Resident 1 preferred to have their power of attorney (POA-legal document that allows a person to designate someone else to act on one's behalf regarding finance and/or health care decisions) involved in their care. Review of the July 2024 through August 2024 facility reporting incident log showed entries for Resident 1 missing property on 07/31/2024, 15 days after their admission to the facility, and 08/01/2024, 16 days after their admission. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 07/31/2024 facility incident investigation report showed Resident 1 reported $526 was missing from their room which they had rubber banded together with all their credit cards in the top nightstand drawer with the lock, but the lock did not work. The incident investigation summary note showed staff had seen credit cards, medical cards, gift cards, a blank check, and a lot of cash lying around on 07/26/2024 and moved the items to the top nightstand drawer. On 07/30/2024 (14 days after their admission) Resident 1 reported they were missing approximately $500, staff searched Resident 1's room but were unable to locate the missing money. On 07/31/2024, Resident 1 reported $526 missing from their room which they kept rubber banded together with gift cards and all their credit cards and stored in the top drawer of their locking nightstand, but the lock did not work. Staff searched the room again and located a pair of shorts with credit cards, gift cards, and $100 rubber banded together. Resident 1 explained they admitted to the facility with $726, they gave $200 to their personal care giver to purchase requested items, had the remaining $526 missing from their room, Resident 1 requested a friend bring them in an additional $100 because they no longer had cash available. Social Service staff verified the top drawer of Resident 1's nightstand was not locking, a new functioning key was obtained and provided to Resident 1, Resident 1 had their credit cards, blank check, gift cards, and $100 locked in the top nightstand drawer. The facility contacted Resident 1's POA who confirmed Resident 1 was given $726 on 07/17/2024 per their request and an additional $100 was given to Resident 1 on 07/30/2024. Review of the 08/06/2024 facility incident investigation report showed on 08/01/2024 staff were informed Resident 1 had a large amount of cash, debit card, credit card, gift cards, and a blank check in their nightstand. Two staff members removed the items from Resident 1's room, completed an inventory list, items were placed in a zip lock bag and white legal envelope, sealed, placed in the facility safe, and copy of inventory list given to Resident 1. The included inventory list showed: $900 cash in $100 bills, four blank checks, three $500 gift cards, six debit/credit cards, driver's license, insurance cards, and a disabled parking placard. A 08/08/2024 facility check showed Resident 1 was reimbursed $1426, and a 08/12/2024 receipt showed Resident 1 was reimbursed for three $500 gift cards. The incident investigation contained an undated handwritten statement that showed Resident 1 had $100 and a gift card, the handwritten statement indicated the facility would not be responsible if the items were lost or missing and was initialed by Resident 1. In an interview on 08/12/2024 at 2:55 PM, Resident 1's POA acknowledged Resident 1 had money missing on two different occasions within approximately a week. The first time, Resident 1 had $526 missing from the top drawer of the nightstand that Resident 1 was unable to lock due to having the incorrect key. POA stated Resident 1 was given the correct nightstand key after the $526 went missing. POA explained after the first incident, Resident 1 had a friend take them on a personal outing and returned to the facility with $900 in $100 bills, three $500 gift cards, credit cards, driver's license, and check books; facility staff removed the items from Resident 1's room and placed them in the facility safe where they went missing a few days prior to Resident 1's discharge. Resident 1's POA acknowledged Resident 1 was informed the facility would not be responsible for lost or missing items after the $526 went missing but the facility reimbursed the missing gift cards and cash. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/22/2024 at 10:34 AM, Staff B, Nursing Assistant (NA), stated the facility completed an inventory sheet upon admission that should list all items brought into the facility including any items of value. Staff B stated every resident room had a locking nightstand drawer that was checked and verified for proper functioning. Staff B further stated if a resident reported a missing item staff would review the inventory sheet, search for the missing item, contact the resident representative for additional information, if unable to find an item listed on the inventory sheet, then the facility would replace but if the item was not listed on the inventory sheet, then the facility was not responsible for replacing the item. Staff B was unaware Resident 1 was missing $526 on 07/31/2024 or missing $900, blank checks, debit/credit cards, or three $500 gift cards missing from the facility safe on 08/06/2024. In an interview on 08/22/2024 at 10:57 AM, Staff C, Registered Nurse (RN), stated residents were allowed to keep personal possessions including money, bank cards, credit cards, identification cards, or insurance cards, items listed on the inventory sheet for tracking, residents and/or resident representatives should be encouraged to update the inventory sheet if/when items were brought in or removed from the facility. Staff C further stated each room had a locking drawer that should be checked for proper function, but residents were strongly encouraged to take items of value home. Staff C acknowledged the facility should not ask a resident to waive potential facility liability from loss or theft because the facility should track resident items. Staff C acknowledged Resident 1 reported $526 missing from their room and management completed an investigation. In an interview on 08/22/2024 at 11:41 AM, Staff D, Social Service Director (SSD), stated a resident inventory sheet was completed upon admission and remind families during the care conference to update the inventory sheet if/when items were brought in or removed from the facility. Staff D further stated residents were allowed to keep their personal possessions including money, bank cards, credit cards, checks, or insurance cards, and items should be listed/updated on the resident inventory sheet. Staff D stated residents were provided with a locking drawer and if large sums of money were observed then residents were offered other alternatives for securing their valuables. Staff D was unsure if the facility should ask a resident to waive potential facility liability for losses of personal items. Staff D acknowledged on 07/31/2024 Resident 1 reported $526 missing from their room, through the investigation it was confirmed Resident 1 admitted with $726, and the missing $526 was reimbursed. Staff D explained Resident 1 had additional cash [NAME] into the facility after the $526 went missing from their room, facility staff noted the additional cash and gift cards, items were inventoried, removed from Resident 1's room, secured in the facility safe on Thursday 08/01/2024, and noted to be missing from the facility safe on Tuesday 08/06/2024. In an interview on 08/22/2024 at 12:19 PM, Staff E, Resident Care Manager, acknowledged Resident 1 had $526 missing from their room then had gift cards and almost a thousand dollars missing from the facility safe. In an interview on 08/22/2024 at 2:52 PM, Staff A, Administrator, acknowledged Resident 1 had $526 missing from their room on 07/31/2024, staff noted additional money was brought into the facility with gift cards, staff inventoried items, removed items from Resident 1's room, locked them in the facility safe, and items were noted missing from the facility safe upon Resident 1's discharge. Staff A stated Resident 1 was reimbursed for the missing items. <Resident 2> (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission assessment, dated 07/10/2024, showed Resident 2 admitted to the facility on [DATE] with diagnoses including severe protein-calorie malnutrition and failure to thrive. Resident 2 was cognitively intact and able to verbalize their needs. The assessment further showed it was very important for Resident 2 to take care of their personal belongings and somewhat important to have a place to lock items for safety, while in the facility. Review of the 07/08/2024 resident preference evaluation showed it was very important for Resident 2 to take care of their personal belongings and somewhat important for to have a place to lock items for safety. Review of the 07/10/2024 personalized care care plan showed it was very important for Resident 2 to take care of their personal belongings and somewhat important to have a place to lock items for safety. Review of July 2024 nursing progress notes showed Resident 2 admitted to the facility on [DATE] at 4:48 PM and their wallet was identified as missing on 07/09/2024 at 3:10 PM, 22.5 hours after Resident 2 admitted to the facility. On 07/10/2024 Resident 2 was visibly upset yelled at staff and family, refused medications, meals, and fluids. On 07/11/2024 Resident 2 told their child if you don't get me out of here, I'm going to kill myself, potentially harmful objects were removed for the room, and Resident 2 was placed on 15-minute visual checks for suicidal ideation (when someone thinks about killing themselves, thoughts may or may not include a plan). On 07/14/2024 Resident 2 reported they had not slept in five days, since 07/09/2024. Review of the 07/12/2024 care conference care planning meeting assessment showed a care conference was held on 07/10/2024 with Resident 2 and their representative/s where resident rights were reviewed, and no concerns or issues were discussed. Review of May 2024 through July 2024 grievance log showed Resident 2 reported a missing brown wallet on 07/09/2024, the day after their admission to the facility. Review of the facility 07/09/2024 praise, concern, suggestion form showed Resident 2 reported a missing brown wallet. The form showed Resident 2's family was contacted, and confirmed $340 from the wallet was taken home, the wallet and contents were left with Resident 2. The family listed the wallet contents as two debit cards, two silver credit cards, one home equity card, various insurance cards, one photo identification card, checks, one veteran card, and military discharge paperwork containing Resident 2's social security information. On 07/12/2024 the facility informed Resident 2's child they were unable to find the missing wallet and would reimburse the cost of a new wallet if a receipt was submitted but the facility could not do anything about the loss of cards. In an interview on 08/22/2024 at 11:41 AM, Staff D, Social Services Director, acknowledged Resident 2 reported a missing wallet on 07/09/2024, family confirmed they took $340 home upon admission but left various bank cards and wallet with Resident 2, staff searched for the missing items, but they were not located. <Resident 3> (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission assessment, dated 06/03/2024, showed Resident 3 admitted to the facility on [DATE] with diagnoses including bilateral below knee amputations and enterocolitis (inflammation that occurs throughout the intestines). Resident 3 was cognitively intact and able to verbalize their needs. The assessment further showed it was not very important for Resident 3 to take care of their personal belongings or to have a place to lock items for safety, while in the facility. Review of the 05/30/2024 resident preference evaluation showed it was somewhat important for Resident 3 to take care of their personal belongings and to have a place to lock items for safety. Review of the 05/30/2024 personalized care care plan showed it was somewhat important for Resident 3 to take care of their personal belongings and to have a place to lock items for safety. Review of May 2024 through June 2024 grievance log showed Resident 3 reported a missing US [NAME] Corps money clip with approximately $75 on 05/30/2024, two days after their admission to the facility. Review of the facility 05/30/2024 praise, concern, suggestion form showed Resident 3 reported a missing US [NAME] Corp money clip with $75. The results of the investigation section showed numerous facility locations were searched but staff was not able to locate the money clip or the $75. Resident 3 stated they believed their money clip and money was discarded with a pair of pants related to numerous episodes of stool incontinence. On 06/13/2024 at $75 credit for lost items in skilled nursing was added to Resident 3's account. Review of the 06/02/2024 care conference care planning meeting assessment showed a care conference was held on 05/31/2024 with Resident 3 and their representative where resident rights were reviewed, and no concerns or issues were discussed. In an interview on 08/12/2024 at 3:06 PM, Resident 3's child acknowledged Resident 3 reported a missing money clip, stated Resident 3 was a pretty good historian and might recall the incident. In an interview on 08/12/2024 at 3:35 PM, Resident 3 acknowledged a money clip about the size of a half dollar with the [NAME] Corp emblem containing approximately $100 went missing, the facility was unable to locate the money clip and/or money and credited $70 to their account. In an interview on 08/22/2024 at 10:34 AM, Staff B, NA, stated they did not have knowledge of Resident 3's missing money clip or money. In an interview on 08/22/2024 at 10:57 AM, Staff C, RN, denied having knowledge about Resident 3's missing money clip or money. In an interview on 08/22/2024 at 11:41 AM, Staff D, SSD, stated Resident 3 reported a missing money clip with money shortly after their admission, Resident 3 believed the money clip and money was accidently discarded in a pair of pants when they experienced numerous episodes of stool incontinence, and was reimbursed $75. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/22/2024 at 2:52 PM, Staff A, Administrator, stated residents were highly discouraged from keeping money, bank cards, insurance cards, credit cards or other items of value in their possession and given locking drawers to secure items because theft was a crime of opportunity. Staff A further stated each missing item situation was investigated individually and residents reimbursed according to the investigation findings. Staff A acknowledged it appeared as if there was a pattern of missing items. Reference WAC 388-97- 0640 (2)(a), (3)(c)(d) Refer to F609 for additional information

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review the facility failed to identify and report potential misappropriation of resident property to the State Survey Agency as required for 2 of 3 sampled residents (Resident 2 and 3), reviewed for missing property. This failure placed residents at risk of further misappropriation of personal possessions and diminished quality of life. Findings included . Reivew of the undated facility policy titled, Personal Property Policy showed residents were encouraged to bring personal belongings to provide familiarity and a homey atmosphere. The policy showed the facility would not ask a resident to waive their rights including the right to collect payment for lost or stolen articles. The policy showed a personal inventory sheet would be completed and updated whenever items were brought into or removed from a resident's possession. Reimbursement for missing items may depend upon verification of the presence of the item. The policy further showed it would not be reasonable or prudent for a resident to maintain cash in their possession; the resident is vulnerable to theft of cash and there was little to spend money on inside the community. For an item to be considered for replacement, missing items must be promptly reported, a search would be conducted, if the loss was deemed to be the responsibility of the community, the community would replace the item. Review of the undated facility policy titled, Grievance Policy showed a grievance was a formal or informal written or verbal complaint made by a resident, their representative, family member, or staff member about quality of care, treatment, or concerns related to the facility. The grievance officer was responsible for overseeing the grievance process, documenting and tracking grievances, conducting investigations, and maintaining confidentiality. The policy showed a praise, concern, suggestion form may be used if a concern was NOT an allegation of abuse or neglect, those concerns were to be reported to the director of nursing or administrator immediately. If a grievance involved potential abuse, neglect, or exploitation, the policy instructed staff to follow mandatory reporting procedures. Review of the facility policy titled, Abuse Policy dated 2023, showed abuse was prohibited and must be reported in a timely manner to allow for proper investigation and implementation of measures to prevent recurrence or retaliation. The policy defined an allegation as a statement, or a gesture made by someone (regardless of capacity or decision-making ability) that indicated abuse, neglect, exploitation, or misappropriation of resident property may have occurred and required a thorough investigation. Abuse included sexual abuse, mental abuse, physical abuse, and exploitation. The policy defined financial exploitation as illegal or improper use of the property, income, resources, or trust funds of the vulnerable adult by any person for any person's profit or advantage. The policy further showed all alleged violations of abuse, neglect, mistreatment, and/or exploitation must be reported to the administrator, director of nursing or their designee and reported to the State Survey Agency hotline. The policy showed staff were mandatory reporters, trained to identify and report allegations including disappearance or misappropriation of resident's personal property, and expected to understand individual responsibilities as a mandatory reporters. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 2> Review of the admission assessment, dated 07/10/2024, showed Resident 2 admitted to the facility on [DATE] with diagnoses including severe protein-calorie malnutrition and failure to thrive. Resident 2 was cognitively intact and able to verbalize their needs. Review of May 2024 through July 2024 grievance log showed Resident 2 reported a missing brown wallet on 07/09/2024, the day after their admission to the facility. Review of the July 2024 facility reporting incident log showed no entries for Resident 2's report of a missing wallet. Review of the facility 07/09/2024 praise, concern, suggestion form showed Resident 2 reported a missing brown wallet. The form showed Resident 2's family was contacted, and confirmed $340 from the wallet was taken home, the wallet and contents were left with Resident 2. The family listed the wallet contents as two debit cards, two silver credit cards, one home equity card, various insurance cards, one photo identification card, checks, one veteran card, and military discharge paperwork containing Resident 2's social security information. On 07/12/2024 the facility informed Resident 2's child they were unable to find the missing wallet and would reimburse the cost of a new wallet if a receipt was submitted but the facility could not do anything about the loss of cards. In an interview on 08/22/2024 at 10:34 AM, Staff B, Nursing Assistant (NA), stated they did not have knowledge of Resident 2's missing wallet containing debit/credit cards and social security information, but that incident should have been reported to the State Survey Agency and investigated as an incident of potential misappropriation. In an interview on 08/22/2024 at 10:57 AM, Staff C, Registered Nurse (RN), denied knowledge of Resident 2's missing wallet containing debit/credit cards and social security information. Staff C stated that incident should have been reported to the State Survey Agency and investigated as an incident of potential misappropriation because bad things could happen when unauthorized individuals had access to that type of sensitive information. In an interview on 08/22/2024 at 11:41 AM, Staff D, Social Service Director (SSD), reviewed documentation for Resident 2's 07/09/2024 missing wallet incident. Staff D acknowledged the incident was not identified, reported or investigated as potential misappropriation but should have been because of the wallet contents. <Resident 3> Review of the admission assessment, dated 06/03/2024, showed Resident 3 admitted to the facility on [DATE] with diagnoses including bilateral below knee amputations and enterocolitis (inflammation that occurs throughout the intestines). Resident 3 was cognitively intact and able to verbalize their needs. Review of May 2024 through June 2024 grievance log showed Resident 3 reported a missing US [NAME] Corps money clip with approximately $75 on 05/30/2024, two days after their admission to the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the May 2024 through June 2024 facility reporting incident log showed no entries for Resident 3's report of a missing US [NAME] Corp money clip with approximately $75. Review of the facility 05/30/2024 praise, concern, suggestion form showed Resident 3 reported a missing US [NAME] Corp money clip with $75. The results of the investigation section showed numerous facility locations were searched but staff was not able to locate the money clip or the $75. Resident 3 stated they believed their money clip and money was discarded with a pair of pants related to numerous episodes of stool incontinence. On 06/13/2024 at $75 credit for lost items in skilled nursing was added to Resident 3's account. In an interview on 08/12/2024 at 3:06 PM, Resident 3's child acknowledged Resident 3 reported a missing money clip, stated Resident 3 was a pretty good historian and might recall the incident. In an interview on 08/12/2024 at 3:35 PM, Resident 3 acknowledged a money clip about the size of a half dollar with the [NAME] Corp emblem containing approximately $100 went missing, the facility was unable to locate the money clip and/or money and credited their account $70. In an interview on 08/22/2024 at 10:34 AM, Staff B, NA, stated if a resident reported a missing item staff would review the inventory sheet, search for the missing item, contact the resident representative for additional information, if unable to find an item listed on the inventory sheet, then the facility would replace but if the item was not listed on the inventory sheet, then the facility was not responsible for replacing the item. Staff B was unable to state the difference between a missing item and potential misappropriation of resident property. Staff B stated they did not have knowledge of Resident 3's missing money clip or money but that incident should have been reported to the State Survey Agency and investigated as an incident of potential misappropriation. In an interview on 08/22/2024 at 10:57 AM, Staff C, RN, denied having knowledge about Resident 3's missing money clip or money but acknowledged the incident should have been considered potential misappropriation, reported, and investigated as such. In an interview on 08/22/2024 at 11:41 AM, Staff D, SSD, stated Resident 3 reported a missing money clip with money shortly after their admission, Resident 3 believed the money clip and money was accidently discarded in a pair of pants when they experienced numerous episodes of stool incontinence. Staff D acknowledged the incident was not identified or investigated as potentially misappropriation because of how Resident 3 reported the incident but it should have been. In an interview on 08/22/2024 at 2:52 PM, Staff A, Administrator, stated residents were highly discouraged from keeping money, bank cards, insurance cards, credit cards or other items of value in their possession and given locking drawers to secure items because theft was a crime of opportunity. Staff A further stated each missing item situation was investigated individually depending on the incident and residents reimbursed according to the investigation findings. Staff A acknowledged Resident 2's or Resident 3's missing items were not identified as instances of potential misappropriation. Staff A further stated items of value were at high risk of theft or potential misappropriation and it appeared there was a pattern of missing items. Reference WAC 388-97- 0640 (5)(a) Refer to F602 for additional information

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	505498	A. Building B. Wing	08/22/2024

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review the facility failed to accurately reflect the resident's status as of the assessment reference date (ARD) for 1 of 3 sampled residents (Resident 4), reviewed for assessment accuracy. This failure placed residents at risk of unmet care needs and diminished quality of life. Findings included . The website Dermnet.org - in which derm refers to dermatology (medical field that focuses on conditions that affect skin) - with regard to structure of normal skin showed the layers of the skin from top to bottom, consist of 3 layers: epidermis, dermis, and subcutis Epidermis is the uppermost or epithelial layer of skin. It acts as a physical barrier, preventing loss of water from the body, and preventing entry of substances and organisms into the body. Its thickness varies according to the body site Dermis is the fibrous connective tissue or supportive layer of the skin Subcutis is the fat layer immediately below the dermis and epidermis. It is also called subcutaneous tissue. The subcutis mainly consist of fat cells (adipocytes), nerves and blood vessels. The website nih.gov - in which nih refers to national institute of health- with regard to the revised National Pressure Ulcer Advisory Panel pressure injury staging system showed a pressure injury is localized damage to the skin and underlying soft tissues usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion [flow of fluid or blood to cells and tissues], comorbid condition [medical conditions that coexist and affect health and treatment], and condition of the soft tissue . Stage 1 pressure injury: intact skin with a localized area of non-blanching erythema [redness that does not disappear when pressure is applied to the area] . Stage 2 pressure injury: partial thickness [involving epidermis and/or dermis] loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister Stage 3 pressure injury: full thickness [wound that extends below the epidermis and dermis into the subcutaneous tissue or deeper] skin loss, in which adipose (fat) or granulation [new connective tissue] tissue is visible in the ulcer Stage 4 pressure injury: full thickness skin and tissue loss with exposed or directly palpable fascia [connective tissue], muscle, tendon [strong cords of tissue that connect muscle to bones], ligament [bands that connect bones and joints], cartilage [tough, flexible connective tissue that protects bones and joints, and provides structure to the nose and ears], or bone in the ulcer . unstageable pressure injury: full thickness skin and tissue loss in which the extent of the tissue damage within the ulcer cannot be confirmed because it is obscured by slough [dead skin or tissue that can appear in a wound] or eschar [dead tissue that forms over healthy skin and eventually falls off] . Deep Tissue Pressure Injury [DTPI]: intact or nonintact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration, or epidermal separation reveling a dark wound bed or blood filled blister It is essential that the intended staging or classification system be used for each type of injury to ensure appropriate treatment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Centers for Medicare and Medicaid Services Long Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.18.11 revised October 2023, showed the RAI consisted of three basic components: the Minimum Data Set (MDS), the Care Area Assessment (CAA) and the RAI utilization guidelines. The utilization of the three component of the RAI yields information about a resident's functional status, strengths, weaknesses, and preferences, as well as offered guidance on further assessment once problems were identified. The intent of Section M: Skin Conditions, was to document the risk, presence, appearance, and change of pressure injuries. A complete skin assessment should be performed focusing on bony prominences and pressure-bearing areas such as sacrum (large triangular bone in the lower spine), buttocks, heels, and ankles. The skin assessment was essential to an effective pressure injury prevention and skin treatment program. It was imperative to determine the etiology of all wound and lesions because it would determine and direct the proper treatment and management of a wound. The care planning process should include efforts to stabilize, reduce, or remove underlying risk factors; to monitor the impact of interventions; and to modify the interventions as appropriate. For the MDS assessment, initial numerical staging of pressure injuries or deep tissue injury (DTI) should be coded in terms of what was assessed during the seven-day look-back period. For pressure injuries, at admission, code based on the findings from the first skin assessment that was conducted on or after and as close to the admission as possible. A DTI should be coded as an unstageable pressure injury. For each pressure injury, determine if the injury was present at the time of admission and not acquired while the resident was in the care of the nursing home by reviewing the medical record for pressure injury history, location and staging at time of admission. If a pressure injury was present on admission and subsequently increased in numerical stage during the resident's stay, the pressure injury was to be coded at the higher stage and should not be considered as present on admission. A DTI may indicate severe damage and precede the development of a stage 3 or stage 4 pressure injury even with optimal treatment. Identification and management of a DTI was imperative and required more vigilant monitoring because of the potential for rapid deterioration, such monitoring should be reflected in the care plan. Assessment findings should be clearly documented in the resident's medical record. Facilities should be aware that a resident was at higher risk of having the area of a closed pressure injury open up due to damage, injury, or pressure, because of the loss of tensile strength (maximum stress before breaking) of the overlying tissue. Facilities should put preventative measures in place that will mitigate the opening of a closed ulcer due to the fragility of the overlying tissue. The section for MDS correction showed once completed, edited, and accepted, providers may not change a previously completed MDS assessment as the resident's status changes during the course of the resident's stay- the MDS must be accurate as of the ARD. Review of the unmodified admission assessment, dated 02/12/2024, showed Resident 4 admitted to the facility on [DATE] with diagnoses including muscle weakness and ischemic cardiomyopathy (heart muscle cannot pump well because of damage from lack of blood supply to the muscle). Resident 4 was cognitively intact, able to verbalize their needs, and frequently incontinent of bowel. The assessment further showed Resident 4 was at risk for pressure injury development, admitted to the facility no pressure injuries and did not use pressure reduction devices in their wheelchair or bed, and was not on a turning/repositioning program. Review of the modified admission assessment, dated 02/12/2024, showed Resident 4 was at risk of pressure injury development, admitted to the facility with two unstageable and two Stage 3 pressure injuries but did not use pressure reduction devices in their wheelchair or bed, and was not on a turning/repositioning program. Resident 4 was dependent on staff for toileting, toileting hygiene, bed mobility, and transfers. The assessment further showed it was modified on 04/15/2024, three days after Resident 4 discharged . (continued on next page)

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	505498	A. Building B. Wing	08/22/2024

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of 01/30/2024 through 02/06/2024 hospital notes showed Resident 4 required maximum up to dependent assistance to perform most activities of daily living and had significant range of motion impairment in all four limbs. On 01/30/2024 Resident 4 was assessed as having the following skin concerns: pressure injuries to bilateral lower buttock with comments listed as purple areas, pressure injury to the left medial (towards the middle or center) lateral (to the side of, or away from, the middle of the body) heel, pressure injury to right posterior (the back of something) medial heel, and a left lower knee abrasion (superficial rub or wearing off of the skin, usually caused by a scrape). Hospital documentation included pictures taken of identified wounds on 01/31/2024 and wound status' at time Resident 4 discharged the hospital on 02/06/2024. Review of Resident 4's 02/06/2024 admission skin assessment documentation showed: left leg with 0. 5-centimeter (cm) x 0.5cm open area above ankle, 1.2cm x 1.2 cm abrasions to lateral left foot and distal (away from the center of the body) Achilles (tendon that runs down the back of the lower leg, connects calf muscle to the heel bone), DTPI to both right and left heels, 1.5cm x 1.2 cm and 1cm x 0.5cm abrasions to the inner left buttock. Review of the 02/06/2024 baseline care plan showed Resident 4 had DTPI to both heels and skin breakdown to their groin and coccyx (small bone at the bottom of the spine) with interventions to improve or prevent skin breakdown listed as protective boots and an alternating air mattress. Review of the 02/13/2024 skin assessment documentation showed Resident 4 had two stage 2 pressure injuries to the right buttock, open ulcer to the right heel, DTPI to the left heel and above the left heel; no measurements were documented. An attached note showed Resident 4 was being followed by the wound team. Review of the 02/21/2024 skin assessment documentation showed Resident 4 had two open sores 1.5cm x 1.5cm each on the right buttock, 2cm x 2cm blister injury to the left heel, and an open unstageable pressure sore to the right heel 2.5cm x 4cm. Review of the 02/23/2024 wound teams' initial assessment progress notes showed Resident 4 had five wounds: a right heel unstageable pressure injury 2.4cm x 3.7cm, left heel DTPI 2cm x 2.3cm, right buttock stage 3 pressure injury 4.8cm x 1.2cm x 0.1cm, sacrum stage 3 pressure injury 0.5 cm x 0.3cm x 0.1cm, and a left posterior ankle abrasion 0.8cm x 0.7cm. The right buttock wound was identified as deteriorating. Resident 4's spouse stated Resident 4 spent majority of their time in bed on their back instead of on their side. Review of the 03/13/2024 provider progress note showed Resident 4 had stage 3 pressure injuries to the right buttock and sacrum with onset dates of 03/12/2024. In an interview on 08/22/2024 at 10:57 AM, Staff C, Registered Nurse, stated pressure injuries could occur quickly by being in a position for long periods of time and not allowing oxygen to get into the tissues. Staff C was able to explain the different stages of pressure injuries. Staff C stated a skin check was completed upon admission that should document skin conditions or wounds present upon admission, skin assessments were completed weekly thereafter, documentation should include measurements, tissue description, and enough detail to be able to assess a wound' status. Staff C reviewed Resident 4's medical record including skin check documentation. Staff C acknowledged Resident 4's wounds worsened, and they developed new wounds. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/22/2024 at 12:19 AM, Staff E, Resident Care Manager, stated wound documentation should include measurements, tissue description, odor, discomfort, and details to effectively assess a wounds' status. Staff E reviewed Resident 4's medical record. Staff E acknowledged Resident 4 admitted with DTPI to both heels, abrasions to both buttocks and left Achillies. Staff E further stated according to the documentation it appeared Resident 4's wounds worsened. In an interview on 08/22/2024 at 1:15 PM, Staff F, Wound Care Nurse, reviewed Resident 4's medical record. Staff F stated Resident 4 admitted with DTPI to their heels and abrasion to their buttock but was unable to determine if the buttock wounds worsened without observing and assessing the wounds personally. Staff F further stated an abrasion would be treated differently than a stage 2 pressure injury. In an interview on 08/22/2024 at 2:19 PM, Staff G, MDS Coordinator, explained an MDS was collective information about a resident's processes, disease, risks, treatments, and diagnoses used as a reimbursement tool for payer sources. MDS data was collected through assessments, interviews, review of nursing assistant charting, nursing progress notes, therapy notes, provider notes, and wound specialist notes. Staff G further stated the ARD was the snapshot in time, the resident observation period was up to the ARD and seven days prior, the MDS should accurately reflect a resident's status at the time of the ARD. Staff G reviewed Resident 4's medical record. Staff G stated Resident 4's 02/12/2024 was modified because of scattered pressure ulcers to bilateral heels, scrotum and lower back, section M was modified. Staff G compared the original 02/12/2024 MDS and the modified 02/12/2024 MDS, the original MDS showed Resident 4 admitted to the facility with no pressure injuries, the modified MDS showed Resident 4 admitted to the facility with two unstageable pressure injuries and two stage 3 pressure injuries. Staff G further stated a 02/06/2024 clinical assessment showed Resident 4 had ulcers but did not specify what stage they were and acknowledged they were unable to locate any wound care notes during the assessment period. Staff G further stated the 02/23/2024 wound teams' initial assessment progress notes should not be used for the 02/12/2024 MDS because it was past the ARD date, data had to be during the appropriate time frame. Staff G acknowledged the 02/12/2024 MDS did not accurately reflect Resident 4 as of the ARD. In an interview on 08/22/2024 at 2:52 PM, Staff A, Administrator, stated they expected the MDS to accurately reflect a residents' status as of the ARD. Reference WAC 388-97-1000 (1)(b) Refer to F686 for additional information

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	505498	A. Building B. Wing	08/22/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review the facility failed to consistently accurately assess, monitor, and evaluate wounds, consistently implement individualized skin interventions to prevent new and/or worsening pressure injury development, and prevent wound infection to the extent possible for 3 of 3 sampled residents (Resident 4, 5, and 6), reviewed for pressure injuries. This failure placed residents at risk of development of potentially avoidable pressure injuries, unmet care needs, and diminished quality of life. Findings included . Review of the facility policy titled, Prevention of Skin Breakdown dated 2023, defined skin breakdown as skin damage that could result in ulcers, sores, or wounds, often due to pressure, friction, or shear forces. The policy instructed staff to complete a comprehensive skin risk assessment upon admission and regularly thereafter, use assessment tools to evaluate a resident's risk level, and develop individualized care plan with interventions based on the risk assessment outcomes. The policy further showed all skin assessment, interventions, and resident responses were to be documented in the electronic health record accurately and promptly. Skin assessments were to be completed weekly with any changes in skin condition or care needs communicated promptly to the interdisciplinary team. Review of the facility policy titled, Skin Program dated 2023, showed nursing staff would complete weekly skin check documenting wound measurements, wound site, wound type, wound status, drainage, status of surrounding tissue, signs of infection, pain identified, and document findings into the electronic health record. The policy instructed staff to contact the wound care specialist if a resident had an acute or chronic wound. If a wound was found to have developed in the facility staff were instructed to assess/investigate to identify potential causes, determine what interventions were in place prior to wound development, wound identification, and identify new potential interventions to prevent further skin breakdown and/or complications. A nutrition committee regularly reviewed skin conditions, risk factors, skin assessment notes, care plans and interventions to ensure proper treatments were in place. The policy further showed all identified pressure areas would be assessed weekly to identify progress, and identify new treatments needed. All residents in the facility would have routine preventative skin care such as turning and positioning, application of pressure relieving devices, good skin care, adequate nutrition and hydration. The website Dermnet.org - in which derm refers to dermatology (medical field that focuses on conditions that affect skin) - with regard to structure of normal skin showed the layers of the skin from top to bottom, consist of 3 layers: epidermis, dermis, and subcutis Epidermis is the uppermost or epithelial layer of skin. It acts as a physical barrier, preventing loss of water from the body, and preventing entry of substances and organisms into the body. Its thickness varies according to the body site Dermis is the fibrous connective tissue or supportive layer of the skin Subcutis is the fat layer immediately below the dermis and epidermis. It is also called subcutaneous tissue. The subcutis mainly consist of fat cells (adipocytes), nerves and blood vessels. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The website nih.gov - in which nih refers to national institute of health- with regard to the revised National Pressure Ulcer Advisory Panel pressure injury staging system showed a pressure injury is localized damage to the skin and underlying soft tissues usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion [flow of fluid or blood to cells and tissues], comorbid condition [medical conditions that coexist and affect health and treatment], and condition of the soft tissue . Stage 1 pressure injury: intact skin with a localized area of non-blanching erythema [redness that does not disappear when pressure is applied to the area] . Stage 2 pressure injury: partial thickness [involving epidermis and/or dermis] loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister Stage 3 pressure injury: full thickness [wound that extends below the epidermis and dermis into the subcutaneous tissue or deeper] skin loss, in which adipose (fat) or granulation [new connective tissue] tissue is visible in the ulcer Stage 4 pressure injury: full thickness skin and tissue loss with exposed or directly palpable fascia [connective tissue], muscle, tendon [strong cords of tissue that connect muscle to bones], ligament [bands that connect bones and joints], cartilage [tough, flexible connective tissue that protects bones and joints, and provides structure to the nose and ears], or bone in the ulcer . unstageable pressure injury: full thickness skin and tissue loss in which the extent of the tissue damage within the ulcer cannot be confirmed because it is obscured by slough [dead skin or tissue that can appear in a wound] or eschar [dead tissue that forms over healthy skin and eventually falls off] . Deep Tissue Pressure Injury [DTPI]: intact or nonintact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration, or epidermal separation reveling a dark wound bed or blood filled blister It is essential that the intended staging or classification system be used for each type of injury to ensure appropriate treatment. <Resident 4> Review of the modified admission assessment, dated 02/12/2024, showed Resident 4 admitted to the facility on [DATE] with diagnoses including muscle weakness and ischemic cardiomyopathy (heart muscle cannot pump well because of damage from lack of blood supply to the muscle). Resident 4 was cognitively intact, able to verbalize their needs, was frequently incontinent of bowel, and had an indwelling urinary catheter (thin, flexible tube inserted into the bladder through the urethra and left in place to drain urine). Resident 4 was at risk of pressure injury development, admitted to the facility with two unstageable and two Stage 3 pressure injuries but did not use pressure reduction devices in their wheelchair or bed, and was not on a turning/repositioning program. The assessment further showed Resident 4 was dependent on staff for toileting, toileting hygiene, bed mobility, and transfers. Review of 01/30/2024 through 02/06/2024 hospital notes showed Resident 4 required maximum up to dependent assistance to perform most activities of daily living and had significant range of motion impairment in all four limbs. On 01/30/2024 Resident 4 was assessed as having the following skin concerns: pressure injuries to bilateral lower buttock with comments listed as purple areas, pressure injury to the left medial (towards the middle or center) lateral (to the side of, or away from, the middle of the body) heel, pressure injury to right posterior (the back of something) medial heel, and a left lower knee abrasion (superficial rub or wearing off of the skin, usually caused by a scrape). Hospital documentation included pictures taken of identified wounds on 01/31/2024 and wound status' at time Resident 4 discharged the hospital on 02/06/2024. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 02/06/2024 hospital discharge orders showed Resident 4 had an indwelling catheter in place related to urinary retention that was to remain in place until seen by a urologist (doctor that specializes in the urinary system) or monitored closely for repeat urinary retention if it was removed. The hospital discharge orders instructed staff to provide catheter management per nursing protocol and follow standard nursing protocols for wound care. Review of Resident 4's 02/06/2024 admission skin assessment documentation showed: left leg with 0. 5-centimeter (cm) x 0.5cm open area above ankle, 1.2cm x 1.2 cm abrasions to lateral left foot and distal (away from the center of the body) Achilles (tendon that runs down the back of the lower leg, connects calf muscle to the heel bone), DTPI to both right and left heels, 1.5cm x 1.2 cm and 1cm x 0.5cm abrasions to the inner left buttock. Review of the Braden scale for predicting pressure injury risk assessments showed Resident 4 was identified as being at risk for skin break down on 02/06/2024, 02/15/2024, and 02/27/2024. Review of provider orders showed a 02/06/2024 order Resident 4 had a temporary foley catheter in place for urinary retention and needed a urologist follow-up to determine discontinuation. A 02/06/2024 order instructed the nurse to ensure the catheter tubing was patent (flowing without blockages), not kinked, leg strap attached, and no signs of breakdown under tubing or leg strap. Review of the 02/06/2024 baseline care plan showed Resident 4 required assistance of two or more staff for bed mobility and transfers and had an indwelling urinary catheter. Resident 4 had DTPI to both heels and skin breakdown to their groin and coccyx (small bone at the bottom of the spine) with interventions to improve or prevent skin breakdown listed as protective boots and an alternating air mattress. Review of the 02/07/2024 self-care deficit care plan showed Resident 4 required limited to maximum assistance to perform most activities of daily living, used a slideboard (a board used to assist a person in moving from one surface to another by sliding across) for transfers, was to be up in their wheelchair for all meals, and staff were to do skin inspections during routine care reporting changes to the nurse. The 02/13/2024 bowel incontinence care plan instructed staff to check Resident 4 every two hours, assist with toileting as needed, and provide perineal care after each episode of incontinence. The 02/13/2024 urinary retention care plan showed Resident 4 had an indwelling urinary catheter in place and staff were to position the urine collection bag below bladder level, check tubing for kinks, monitor and document pain or discomfort due to the catheter. The 02/13/2024 skin integrity care plan showed Resident 4 was at risk of pressure injury development related to indwelling catheter use, immobility, and functional limitations; 02/13/2024 interventions instructed staff to complete treatments as ordered, educate the resident, family, caregivers on causes of skin breakdown, follow facility policies and/or protocols for prevention and treatment of skin breakdown, notify the resident and/or family of new skin breakdown, provide diet as ordered, instruct and assist with shifting weight in wheelchair as tolerated. Review of the 02/13/2024 skin assessment documentation showed Resident 4 had two stage 2 pressure injuries to the right buttock, open ulcer to the right heel, DTPI to the left heel and above the left heel; no measurements were documented. An attached note showed Resident 4 was being followed by the wound team. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 02/21/2024 skin assessment documentation showed Resident 4 had two open sores 1.5cm x 1.5cm each on the right buttock, 2cm x 2cm blister injury to the left heel, and an open unstageable pressure sore to the right heel 2.5cm x 4cm. Review of the 02/23/2024 wound teams' initial assessment progress notes showed Resident 4 had five wounds: a right heel unstageable pressure injury 2.4cm x 3.7cm, left heel DTPI 2cm x 2.3cm, right buttock stage 3 pressure injury 4.8cm x 1.2cm x 0.1cm, sacrum stage 3 pressure injury 0.5 cm x 0.3cm x 0.1cm, and a left posterior ankle abrasion 0.8cm x 0.7cm. The right buttock wound was identified as deteriorating. Resident 4 reported they did not like to wear offloading boots. Resident 4's spouse stated Resident 4 spent majority of their time in bed on their back instead of on their side. Review of February 2024 through April 2024 nursing progress notes showed on 02/06/2024 Resident 4 had an extensive skin assessment completed with appropriate treatments in place and had a urinary catheter to remain in place pending a urologist follow-up. Resident 4 used a wheelchair for mobility and frequently spent time lying in bed with the head of bed elevated. On 02/13/2024 a care conference was held, Resident 4 had DTPI to bilateral legs and was being followed by the wound team for excoriation (skin damage caused by mechanical injury such as scratching or rubbing) to bilateral buttocks. On 02/15/2024 treatments to skin wounds continued with no new findings or setbacks. On 02/17/2024 pressure injuries to heels and coccyx were beginning to heal. On 02/20/2024 Resident 4 continued to be followed by the wound team for bilateral buttock excoriation and DTPI to both legs. On 02/24/2024 Resident 4 had some mild redness around the urethral meatus (opening at the end of the urethra that allows urine to exit the body) and requested their catheter be removed. On 02/25/2024 Resident 4 had a pressure injury to their coccyx, needed frequent positioning in bed related to tendency to slide down in bed but was reluctant to offload pressure to coccyx. On 02/27/2024 Resident 4 had a 1.5cm linear skin spit at the urethral opening, the catheter securement device was readjusted to relieve pressure caused by the catheter and monitor urethra erosion (breakdown of outer skin layers). On 02/29/2024 Resident 4 continued to have the urinary catheter in place and had a urethral skin spit due to urinary catheter pulling. On 03/01/2024 Resident 4's urinary catheter was discontinued. On 03/02/2024 Resident 4's urethral meatus had receded about 1cm related to foley catheter use. On 03/03/2024 sacral (sacrum- large triangular bone in the lower spine) sores treated by floating hips on pillows, Resident 4 was out of bed and into their wheelchair daily. On 03/12/2024 Resident 4 had complications of skin breakdown related to poor insight to deficits and safety awareness. On 03/26/2024 pressure relief wheelchair cushion was placed. On 03/28/2024 a care conference was held, therapy expressed concern Resident 4's new motorized wheelchair seat was too hard, family requested additional cushion but were informed it would not be safe related to use of the slideboard for transfers. Resident 4 continued to use their new motorized wheelchair until they discharged the facility on 04/12/2024. Review of Resident 4's 02/26/2024 provider note showed no documentation of identified skin issues or concerns including the mild urethral meatus redness observed on 02/24/2024. Resident 4 was to continue the urinary catheter for urinary retention. Review of the 02/27/2024 skin assessment documentation showed Resident 4 had a 1.5cm urethral skin split. A left heel blister, open skin breakdown to right buttock, and a right heel sore; no measurements were documented. Review of the 03/05/2024 skin assessment documentation showed Resident 4 had small open areas near the anus (opening at the lower end of the digestive tract) and bilateral heel blisters; no measurements were documented. (continued on next page)

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	505498	A. Building B. Wing	08/22/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 03/12/2024 skin assessment documentation showed Resident 4 had bilateral heel blisters and a sore to the right buttock; no measurements were documented. Review of the 03/15/2024 wound team progress notes showed Resident 4 had six wounds: a right heel unstageable pressure injury 2.8 cm x 4.5 cm, unstageable left heel pressure injury 0.5 cm x 0.7 cm, right buttock stage 3 pressure injury 3.4 cm x 0.4cm x 0.1cm, sacrum stage 3 pressure injury 0.5 cm x 0.3 cm x 0.1cm, left posterior ankle abrasion 0.6 cm x 0.5cm, and a left lateral foot unstageable pressure injury 0.7cm x 0.8cm. Resident 4 expressed frustration related to having wounds and the length of time it was taking for them to heal. Review of 03/20/2024 provider note showed Resident 4 continued to have wound care daily to bilateral legs, sacrum, and buttocks. Resident 4 was scheduled to see an outside wound specialist provider on 03/26/2024. The note further showed stage 3 pressure injuries to the right buttock and sacrum with onset dates of 03/12/2024. Review of the 03/26/2024 outside wound specialist initial assessment progress notes showed Resident 4 had an unstageable pressure injury to the right heel, stage 4 pressure injury to the left heel, diabetic foot ulcers on the left heel and left midfoot. The notes included wound pictures at time of the wound clinic appointment. The notes instructed the facility to order a pressure relief wheelchair cushion, float heels when in bed, elevate legs as much as possible, and follow included wound care orders. Resident 4 was started on an oral antibiotic for 10 days for a wound infection. Further review of provider orders showed a 03/28/2024 order for Resident 4 to be administered an antibiotic twice daily for 10 days for a wound infection. Review of the medication administration record showed Resident 4 received an antibiotic twice daily 03/28/2024 through 04/07/2024 for a wound infection. Review of the 04/04/2024 outside provider wound specialist progress notes showed Resident 4 was seated on a regular cushion and again instructed the facility to order a pressure relief wheelchair cushion, float heels when in bed, elevate legs as much as possible, and follow included wound care orders. In an interview on 08/16/2024 at 12:55 PM, Resident 4's spouse acknowledged Resident 4's developed new and worsening wounds while at the facility. In an interview on 08/22/2024 at 10:34 AM, Staff B, Nursing Assistant (NA), stated pressure injuries were caused by unrelieved pressure for an extended period of time and preventative skin breakdown interventions included proper hygiene and a turning or repositioning schedule. Staff B further stated residents had a skin check completed upon admission to determine if there were any pressure injuries present upon admission, NAs monitor residents' skin during routine care informing the nurse if/when new skin issues were identified, and nurses monitored resident's skin via weekly skin check assessments. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/22/2024 at 10:57 AM, Staff C, Registered Nurse, stated pressure injuries could occur quickly by being in a position for long periods of time and not allowing oxygen to get into the tissues. Staff C was able to explain the different stages of pressure injuries. Staff C further stated pressure injury preventative interventions included adequate protein intake, repositioning, use of pressure relieving cushions and surfaces, and timely incontinence care. Staff C stated a skin check was completed upon admission that should document skin conditions or wounds present upon admission, skin assessments were completed weekly thereafter, documentation should include measurements, tissue description, and enough detail to be able to assess a wound' status. Staff C reviewed Resident 4's medical record. Staff C acknowledged Resident 4 had urethral meatus redness on 02/24/2024 but the urinary catheter was not removed, and they developed a pressure injury related to positioning of the tubing. Staff C reviewed Resident 4's skin check documentation; acknowledged Resident 4's wounds worsened, and they developed new wounds. In an interview on 08/22/2024 at 12:19 AM, Staff E, Resident Care Manager, stated a new admission skin assessment was completed upon admission to identify wounds and/or skin conditions present and implement proper treatment and interventions. Staff E further stated wound documentation should include measurements, tissue description, odor, discomfort, and details to effectively assess a wounds' status. Staff E reviewed Resident 4's medical record. Staff E acknowledged Resident 4 admitted with DTPI to both heels, abrasions to both buttocks and left Achillies. Staff E further stated according to the documentation it appeared Resident 4's wounds worsened. In an interview on 08/22/2024 at 1:15 PM, Staff F, Wound Care Nurse, reviewed Resident 4's medical record. Staff F stated Resident 4 admitted with DTPI to their heels and abrasion to their buttock but was unable to determine if the buttock wounds worsened without observing and assessing the wounds personally. Staff F further stated an abrasion would be treated differently than a stage 2 pressure injury. Staff F acknowledged Resident 4 developed a urethral meatus skin split potentially caused by their urinary catheter. <Resident 5> Review of the admission assessment, dated 06/30/2024, showed Resident 5 admitted to the facility on [DATE] with diagnoses including malnutrition, cervical spinal fusion (surgical procedure that joins two or more neck bones for increased stability), and need for assistance with personal cares. Resident 5 was cognitively intact and able to make their needs known. Resident 5 was at risk of pressure injury development, admitted to the facility with no pressure injuries, and used a pressure reducing device in bed. Review of the 06/24/2024 hospital discharge orders showed Resident 5 had recent cervical spine surgery and instructed Resident 5 to avoid strenuous physical activity, not lift greater that eight pounds (roughly equal to a gallon of milk) for the next six weeks and avoid repetitive bending or twisting of the neck. Review of the 06/24/2024 clinical admission assessment showed Resident 4 had surgical incisions to their neck and wore a neck collar (device that helps support the neck and limit head movement after injury or surgery) at all times. No pressure injuries were documented. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 06/25/2024 care plan showed Resident 5 had surgical incisions and instructed staff to keep skin clean, provide skin care per facility guidelines, and wound care per providers orders. The 06/25/2024 self-care deficit care plan showed Resident 5 required up to limited staff assistance to perform most activities of daily living. A 07/23/2024 skin care plan showed Resident 5 had a stage 1 pressure injury to their coccyx or potential for pressure injury development related to immobility and instructed staff to follow the facility policy and/or protocols for prevention and treatment of skin breakdown, remind, monitor, and assist with turning and repositioning at least every two hours or more often. Review of the 07/23/2024 incident report showed Resident 5 requested pain medication related to a sore buttock and reported they thought they were developing a pressure injury from lying on their back all the time. Resident 5 had a 4cm x 3cm non-blanchable redness (stage 1 pressure injury) to their right buttock. Review of June 2024 through July 2024 nursing progress notes showed Resident 5 preferred to sit in a recliner often because it was more comfortable than their wheelchair. On 07/09/2024 Resident 5 had a respiratory infection and was to remain in isolation in their room. On 07/11/2024 Resident 5 had weight loss likely due to recent illness and a high protein supplement was added. On 07/18/2024 Resident 5 had additional weight loss and was reassessed by the dietician. On 07/20/2024 Resident 5 was started on a new medication for anorexia (eating disorder that causes people to weight less than is considered healthy). On 07/23/2024 Resident 5 had a stage 1 pressure injury to their right buttock that was periodically painful, a skin barrier cream was added, and Resident 5 was educated on repositioning. On 07/26/2024 Resident 5 discharged home. <Resident 6> Review of the admission assessment, dated 05/19/2024, showed Resident 6 admitted to the facility on [DATE] with diagnoses including thoracic compression fractures (break or crack in bones of the middle back), aphasia (language disorder that makes it difficult to communicate), and need for assistance with personal cares. Resident 6 had moderate cognitive impairment and required moderate to maximum staff assistance to perform most activities of daily living. Resident 6 was at risk of pressure injury development, admitted to the facility with no pressure injuries, and used a pressure reducing device in bed. Review of the 05/13/2024 hospital discharge orders and notes showed Resident 6 had intractable back pain secondary to thoracic compression fractures, was fitted for a back brace, pain medications adjusted, and discharged work with therapy on strengthening to increase mobility. The facility was instructed to follow standard nursing protocols for skin care. Review of the 05/13/2024 admission assessment showed Resident 6 had bruising to their left thigh, no pressure injuries were documented. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 05/13/2024 self-care deficit care plan showed Resident 6 required up to limited assistance of staff to perform most activities of daily living. A 06/04/2024 care plan showed Resident 6 had a pressure injury and instructed staff to encourage resident to shift weight frequently, keep skin clean, provide skin care per facility guidelines, and educated the resident and family on proper skin care to prevent skin breakdown. The 06/11/2024 risk for impaired skin integrity care plan showed Resident 6 had redness to their right buttock and instructed staff to educate the resident and/or representative on proper skin care to prevent skin breakdown and causes of pressure injuries. Review of the 05/16/2024 provider progress note showed Resident 6 had a full skin assessment and not noted to have any skin integrity issues. Resident 6 was to wear a back brace when out of bed related to thoracic compression fractures and required continued staff assistance to complete activities of daily living because of weakness. Review of the 06/03/2024 skin assessment showed Resident 6 wore a back brace but had no skin issues noted or reported. Review of the 06/05/2024 incident report showed Resident 6 had a 2cm x 2cm stage 1 pressure injury to their right buttock. Resident 6 was alert and oriented to self only, confused, and weak. Resident 6 was started on a barrier cream, turned and repositioned every two hours while in bed. In an interview on 08/22/2024 at 2:52 PM, Staff A, Administrator, stated it was important to stage a wound appropriately upon admission and expected staff to document accurately with enough detail to be able to appropriately monitor, assess, and evaluate a wounds' status. Reference WAC 388-97-1060 (3)(b) Refer to F641 for additional information