

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505024	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER Spokane Falls Care		STREET ADDRESS, CITY, STATE, ZIP CODE 6021 North Lidgerwood Spokane, WA 99207	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27590</p> <p>Based on observation and interview, the facility failed to maintain a quiet, comfortable, homelike environment for the residents in 4 out of 4 Hallways (Southwest, Southeast, Northwest, and Northeast) during construction. This failure placed all residents at risk for fatigue, unwanted noise, and a non-homelike environment.</p> <p>Findings included .</p> <p><Southwest hall></p> <p>During an Observation on 9/11/2024 at 8:45 AM Construction workers were observed using an air compressor and automatic nail gun to hang wood trim above residents doors. The noise was very loud with the air compressor running and when the nails were being placed. Residents were in the rooms where the construction was occurring. The hose of the nail gun was across the hallway, a resident in a wheel chair was in the hall and wanted to go through, the hose was moved by the worker.</p> <p>During an interview on 09/11/2024 at 8:57 AM, Resident 3 was in their room on the Southwest hall in a wheel chair. The resident stated the noise was loud and but said there was nothing they could do about it.</p> <p>During an interview on 09/11/2024 at 10:18 AM, Staff G, Maintenance Director, stated when the construction crew was in the building it was usually very loud, especially when they sanded around the metal door frames.</p> <p>During an observation on 09/24/2024 at 9:30 AM, and 09/25/2024 at 11:26 AM workers were observed painting doors and door frames in the Southwest hall. Residents were in the rooms being painted.</p> <p>During an interview on 9/25/2024 at 12:26 PM, Resident 7 and 8 were in their room on the Southwest hallway. The residents stated the construction was taking too long and it was loud. The residents stated the halls had tools in them and they had to ask workers to move things to get around.</p> <p><Southeast hall></p> <p>During an observation on 09/25/2024 at 11:26 AM, workers were painting door frames and doors, rooms were occupied by residents.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><Northwest hall></p> <p>During an observation on 09/11/2024 at 9:00 AM, the hallway was observed with new construction. [NAME] was above the doors and some painting of door frames had been done. The end of the hallway had construction workers with carts full of tools and supplies. There was no active construction during the observation.</p> <p>During an interview on 09/11/2024 at 9:29 AM, Resident 4 was laying in bed on the Northwest hall. Resident 4 stated construction had been so loud they got migraine headaches more frequently. Resident 4 stated sometimes the construction was in the morning, sometimes all day. Resident 4 stated they didn't have a great sense of smell but the other day the fumes were so strong they could smell them.</p> <p>During an interview on 09/11/2024 at 9:55 AM, Staff B, Licensed Practical Nurse (LPN), stated the residents complained about the noise when they were doing construction in the Northwest hallway.</p> <p>During an observation and interview on 09/24/2024 at 10:20 AM, Resident 5 as in their room on the Northwest hall. When asked about the construction in the hall, they stated I am about done with this s**t going on. The resident went on to say since construction started, the call lights didn't work and they couldn't call out for help because it was too loud in the halls.</p> <p>During an observation and interview on 09/25/2024 at 12:46 PM, Resident 6 was in their room on the Northwest hall, sitting in their wheel chair. Resident 6 stated the construction had been going on for awhile and it was very noisy when they were working on their hallway. There were tools and supplies in the hallway but staff were good about moving them for residents.</p> <p><Northeast hall></p> <p>During an observation on 9/11/2024 at 8:54 AM. Construction workers were observed using an electric [NAME] sanding down metal door frames. The noise was extremely loud. A resident occupied the room being sanded. The [NAME] was connected to a vacuum, fine dust was on the floors.</p> <p>During an interview on 09/11/2024 at 10:00 AM, Staff C, (LPN), confirmed residents had complained about the noise level during construction.</p> <p>During an interview on 09/25/2024 at 1:38 PM, Staff I, Resident Care Manager (RCM) stated the construction had been very noisy. The door frames were being sanded down to the metal. Staff I stated several residents had made complaints about the noise.</p> <p>Reference WAC 388-97-0880(1)(4)(b)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27590</p> <p>Based on observation, interview and record review, the facility failed to ensure Intravenous (IV) access devices had dressing changes completed weekly, in accordance with professional standards of practice, for 2 of 2 residents (Residents 1 and 2), reviewed for IV therapy. In addition, the facility failed to follow orders to measure the circumference of the resident's arm, measure the length of the Peripherally Inserted Central Catheter (PICC a long, thin tube that is inserted through a vein and passed through to the larger veins near the heart), and ensure normal saline flushes (a solution pushed through the catheter to help prevent blockage) were completed. These failures placed residents at risk for loss of vascular access, infection, and other complications.</p> <p>Findings included .</p> <p><Resident 1></p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses to include cellulitis (a bacterial infection that affects the skin's deeper layers) and an infection of the blood. The resident had a PICC (thin, flexible tube that is inserted into a vein) in the left chest to administer IV antibiotics. The resident was alert and oriented.</p> <p>On 09/24/2024 at 10:08 AM, Resident 1 was laying in bed. The resident stated they were at the facility to receive antibiotics. The resident pointed to their left chest and showed they had a PICC line. The resident mentioned staff had not changed their dressing since they had been at the facility. The PICC line had 2 ports, was covered with tegaderm (a clear, occlusive dressing) and dated 09/09/2024, 15 days since the last dressing change.</p> <p>Review of the resident's Treatment Administration Record (TAR) for September 2024 showed the resident had an order to have the dressing changed to the PICC line by a Registered Nurse (RN). This was to be done on admit and every 7 days. The upper arm circumference and external catheter length was also to be measured on admit and with each dressing change. There was no documentation to show the tasks had been completed.</p> <p><Resident 2></p> <p>Resident 2 had been admitted to the facility on [DATE] with diagnoses to include an infection in the bone. The resident had a PICC line in the right upper arm to receive antibiotics. The resident was able to make their needs known.</p> <p>On 09/25/2024 at 2:20 PM, Resident 2 was laying in bed. The resident had a PICC line on their right upper arm. The PICC had 2 ports and was covered with a tegaderm dressing. There was no date on the dressing. The resident was not sure if or when it had been changed.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 2's TAR for September 2024 showed the resident had an order to have the PICC dressing changed every week by a RN. On 9/24/2024 there was an 8 documented which showed there was a corresponding nurses note. The nurse progress notes were reviewed and there was no documentation found. The TAR showed an order to flush the IV PICC line every 12 hours in the unused port. The flushes were not started until 9/23/2024, 7 days after admission.</p> <p>On 09/25/2024 at 1:38 PM, Staff I, Resident Care Manager (RCM), stated care of PICC lines included Normal Saline flushes and monitoring the dressing to ensure it was clean, dry and intact. Staff I stated only Registered Nurses (RN) did the dressing changes. When asked if there were RN's readily available, Staff I stated the interim Director of Nursing and the Infection Preventionist (who worked part time) were RN's.</p> <p>On 09/25/2024 at 2:34 PM, Staff C, Licensed Practical Nurse (LPN), stated as a LPN, they would flush the ports with Normal Saline, they made sure the dressing on the PICC lines were clean, dry and intact. Staff C stated only RN's could do the dressing changes. When asked if RN's were available to do the dressing changes, they stated the DNS was an RN.</p> <p>Reference WAC 388-97-1060 (3)(j)(ii)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27590</p> <p>Based on observation, interview, and record review, the facility failed to ensure 2 of 2 medication storage rooms (North and South medication rooms) stored medications at proper temperatures. This failures placed residents at risk of receiving compromised medications and biologicals.</p> <p>Findings included .</p> <p><South medication room></p> <p>On 09/11/2024 at 9:35 am, Staff A, Licensed Practical Nurse (LPN), unlocked and entered the South medication room with the surveyor. There was a thermometer on the wall of the room that showed the maximum temperature it reached was 80 degrees Fahrenheit (F). The current reading showed slightly above 80 degrees. Staff A said the medication room got hot and the only thing that could be done was put a fan in the room and prop open the door, as long as staff were at the nurses station. When asked if a log was kept, Staff A stated they didn't log temperatures in the room.</p> <p>At 11:22 AM Staff L, Resident Care Manager (RCM), stated the temperatures were logged in the medication room. Staff L entered the room with the surveyor and was asked if the thermometer went higher than 80 degrees and they didn't think so. Staff L stated when the room was too hot the door could be opened.</p> <p><North medication room></p> <p>On 9/11/2024 at 10:20 am, Staff B, LPN, unlocked and entered the medication room with the surveyor. The thermometer on the wall of the room which showed the maximum temperature it reached was 80 degrees. The current reading showed it was 80 degrees in the room. Staff B commented not bad today. Staff B stated sometimes the room was extremely hot. Staff C, LPN, entered the room. Staff C stated the refrigerator temperatures were checked too. The refrigerator was opened and a thermostat showed it was 39 degrees. Staff C stated the last couple of weeks the temperatures in the room had been hot and there was no air flow in the room. Staff B and C were asked what was done if the temperatures were hot, they both stated they could prop open the door, as long as they were in the nurses station, to try and cool off the room.</p> <p>Review of a log titled Medication room and Refrigerator Temperature Log Sheet showed staff were instructed to measure the temperature, both inside and outside of the refrigerator, twice a day. It was noted temperatures out of range were to be immediately reported to the Director of Nursing (DNS) for alternate storage. There was a column available for staff to explain what they did if a temperature was out of range. Temperature parameters were provided: refrigerator 36-46 degrees F and medication room [ROOM NUMBER]-77 degrees F.</p> <p>The log for the South Medication room was reviewed for September 1 - 11, 2024. There was 1 entry on 09/01/2024 showing the room was 80 degrees in the morning and 80 degrees in the evening. There was no other entry on the log.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The log for the North Medication room was reviewed for August and September 2024:</p> <p>August 2024 log showed 27 out of 31 days temperatures were logged at least once a day. The medication room showed temperatures of greater than 77 degrees 20 out of possible 62. The highest temperature documented was 82. The column for what was done showed opened door. There was nothing to show the DNS was notified of the high temperatures.</p> <p>September 2024 log from the 1st through the 11th showed temperatures were logged at least once 8 days out of 11. All 8 days showed the temperature of 80 or had an arrow pointed up to indicate hotter than 80. There was nothing documented in the column of what was done when the temperatures were high.</p> <p>On 09/25/2024 at 3:15 PM, Staff D, Administrator, stated they were not able to find a policy for Medication Storage but said the room should be under 80 degrees. The Administrator was not aware the thermometer only went to 80 degrees.</p> <p>Refer to WAC 388-97-1300 (2)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27590</p> <p>Based on observation and interview, the facility failed to ensure dry food and refrigerated food were stored in sanitary conditions. This failure placed residents at risk for food borne illness.</p> <p>Findings included .</p> <p>The kitchen was entered on 09/11/2024 at 9:05 AM. Towels were observed on the floor, outside of the walk in refrigerator, soaked with water. The walk in refrigerator door was open and water covered the floor with food debris floating in the water.</p> <p>The dry storage room was next to the refrigerator. There was about an inch of standing water on the floor. The canned goods had water pooled on the top, the labels were coming off, and the card board boxes they were on were saturated with water. There were pipes on the wall between the refrigerator and the dry storage room. Water was dripping from the pipes and being collected into a bucket.</p> <p>At 9:10 AM Staff G, Maintenance Director, stated the leak in the walk in refrigerator and dry storage had been going on for a month or so. Staff G said they brought it to the attention of Administration and was told to shop vac the water up each day, commenting it had to be done more than once a day. Staff G stated staff had to keep towels on the floor outside of the refrigerator because of the water coming from under the refrigerator door. Earlier that morning, the pipes were spraying water in the dry storage and onto the cans. Staff G stated the facility just kept patching the pipes, which would then leak again, and needed a [NAME] to come in and fix it correctly.</p> <p>At 9:15 AM, Staff H, Dietary Manager (DM) stated the leaking had been going on about a month. Staff H had reported the problem to Staff D, Administrator, and the corporate Maintenance Director and the issue had not been fixed.</p> <p>On 09/24/2024 at 10:20 AM, Staff F, Infection Preventionist, stated they had reported to maintenance and dietary the concerns related to the pooling water in the walk in refrigerator and dry storage. Staff F stated sustained water shouldn't be in an environment with food. Staff F stated the issue had been talked about in stand up meetings and Administration was aware.</p> <p>On 09/25/2024 at 3:15 PM, Staff D, Administrator confirmed there had been a leak in the walk in refrigerator and the dry storage room. Staff D stated they tried to fix it a couple of times but it hadn't worked.</p> <p>Reference: WAC 388-97-1100(3)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>27590</p> <p>Based on observation and interview, the facility failed to ensure proper personal protection equipment (PPE's) was used during a COVID outbreak, in accordance with Centers for Disease Control (CDC) guidelines, by 1 of 4 staff (Staff E), when reviewing infection control practices. This failure placed residents and the staff at risk for contracting COVID-19, a respiratory disease caused by a virus.</p> <p>Findings included .</p> <p>At the beginning of the complaint investigation on 09/11/2024, Staff D, Administrator, stated there was 12 residents that were in isolation for COVID-19. The residents were spread through out the facility on different units.</p> <p>According to the April 2024 Washington State Department of Health COVID-19 preparedness and outbreak control checklist for long term care showed staff were required to wear N95 respirators, gowns, gloves, and eye protection and be donned, prior to entering a COVID-19 room.</p> <p>On 09/24/2024 at 9:35 AM, Staff E, Housekeeper, was observed exiting a room in isolation. The staff member had a gown on with gloves. The staff was wearing a surgical mask, pulled down below their nose, and no eye protection. Staff E doffed the gown and gloves and threw them in the housekeeping cart garbage. Staff E was asked what PPE's should be worn when entering an isolation room. Staff E stated the gown he had on and gloves, Staff E pulled up their surgical mask over the nose. When asked about a N95 mask, they stated it was difficult to breathe when they wore them so didn't.</p> <p>During an interview on 09/24/2024 at 10:20 AM, Staff F, Infection Preventionist, stated the facility currently had 4 residents in isolation. Staff F stated all managers in the departments were given a check list on what type of PPE's were required when going in isolation rooms. Staff were to wear gowns, gloves, eye shields, and N95's. Staff F stated there were a few newly hired employees that needed to be fit tested for N95 but all other employees were completed. Staff F stated if a staff member didn't pass the fit test, which was rare, they would need to go to a physician for an exemption and would not provide any direct care. Staff F confirmed Staff E had a fit test 06/2024 and passed.</p> <p>Reference: WAC 388-97-1320(2)(b)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27590</p> <p>Based on observation and interview, the facility failed to ensure there were functioning call lights in 10 resident rooms out of 13 rooms observed (room [ROOM NUMBER], 30, 34, 37, 38, 39, 62, 79, 81, and 85). The facility was undergoing construction which had caused the call lights to not function correctly. This failure placed the residents at risk for unmet care needs, and the inability to call for assistance.</p> <p>Findings included .</p> <p>In an interview on 09/11/2024 at 9:18 AM, Staff G, Maintenance Director, stated the call lights went out all the time. Staff G said the system was very old, needed to be replaced, and was always going out.</p> <p>On 09/11/2024 at 9:29 AM, Resident 4, in room [ROOM NUMBER], had a bell at their bedside. The resident was asked about the bell and stated they had it when the call light went out. It had happened on several occasions, the last time it hadn't worked since. The resident had a call light box on the wall, the light on the box was red but the light wasn't on outside their door in the hall.</p> <p>On 09/11/2024 at 9:55 AM, Staff B, Licensed Practical Nurse (LPN) stated the call lights went out a lot. Staff can give residents bells to use but sometimes they don't know they had gone out until a resident was yelling for help. Staff B stated maintenance was notified when they went out.</p> <p>During an interview on 09/11/2024 at 10:20 AM, Resident 5, room [ROOM NUMBER], stated the call lights didn't work anymore because the construction crew cut the wire or something. Resident 5 stated they would call out for help but with the noise in the halls, no one heard them.</p> <p>On 09/24/2024 at 10:08 AM, Resident 1, in room [ROOM NUMBER], was asked about their call light. They stated they had been waiting about an hour for their light to be answered. The call light box on the wall had a red light on but there was no light outside the room in the hallway. The resident stated they didn't have a bell to use when the call lights went out.</p> <p>On 09/24/2024 at 10:10 AM, Staff J, Nursing Assistant (NAC), was working with Resident 1's roommate at the time of the conversation about the call lights. Staff J stated the call lights come and go, currently they aren't working. Staff J stated they gave residents bells to use, if they wanted them, but it was hard to hear them in the hall. Staff J said the call light boxes in the rooms light up but don't work out in the hall. Staff J stated they made more frequent rounds to ensure the residents got helped or could look at the nurses station call light board.</p> <p>On 09/24/2024 at 10:41 AM the call light board at the South hall nurses station was sounding. The board showed call lights were on in Rooms 88, both beds, and 53, both rooms were not occupied. room [ROOM NUMBER]'s light had been on 14 minutes, room [ROOM NUMBER] showed the light had been on an hour, and room [ROOM NUMBER] the light had been on 5 minutes. The hallway was observed and only 1 room had a light lit up out in the hallway, room [ROOM NUMBER].</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 09/24/2024 at 10:45 AM, Resident 9 was in their wheel chair in room [ROOM NUMBER]. The resident stated they hoped construction was almost done. Resident 9's main concern was the call lights malfunctioned and so don't get answered. When asked how long they had to wait, Resident 9 commented one time it was so long they had forgotten why they put it on. Resident 9 said they didn't have use of their right leg and needed help to go into the bathroom. When asked if they had a bell to ring, they stated they didn't know they could have one. The resident stated they had to raise their voice at times to get help but it was hard for the staff to hear them. The resident's light was not lit outside in the hallway but the call light box in the room had a red light on.</p> <p>In a follow up interview on 09/25/2024 at 11:40 AM, Resident 1 stated the facility had fixed their call light. The surveyor asked for them to push their button. The red light on the wall unit lit up but there was no light on in the hallway.</p> <p>On 09/25/2024 at 12:46 PM, Resident 6 was in room [ROOM NUMBER] sitting in a wheel chair. The resident was in the Northwest hallway and explained their call light did not work when the construction workers had worked on the wiring. Resident 6 said they had been fixed for about a week. Resident 6 stated one time the light went out and they didn't know it. It was a Friday morning and they put their call light on at 9:00 AM, by 10:00 AM the light hadn't been answered and figured it wasn't working. Resident 6 started to pound on their bell for help. A staff member immediately came in to help them and reported the issue to Administration. The resident then stated they also went to administration to ensure the call lights would be fixed before the weekend. They were told they would but no one was called in until Saturday morning. The resident stated the staff could look at the call light board at the nurses station to show whose call light was on.</p> <p>In a follow up interview with Resident 4 on 09/25/2024 at 1:00 PM, the resident's call light cord had been pulled out from the call light box on the wall. The red button was on but the light in the hallway remained off. They stated they were told the bulb was burned out in the hallway. Resident 4 had told staff the call light had been pulled out and staff told them it didn't matter either way because the light was broken. They did state they used the bell at times but it was hard to hear in the hall.</p> <p>On 09/25/2024 at 1:15 PM the call light board in the North nurses station was observed. The system was sounding and the screen showed room [ROOM NUMBER]'s light had been on 14 minutes, room [ROOM NUMBER]'s light had a time of 7:25 AM when it turned on, room [ROOM NUMBER] had been on 9 minutes and room [ROOM NUMBER] on 18 minutes. The halls were observed and no rooms had lights on out in the hallway. A staff member came to the nurses station, looked at the board, and went to answer a light.</p> <p>On 09/25/2024 at 1:23 PM, Staff K, NAC, stated the call lights had not been working the last couple of weeks. Staff were told they were fixed but some of them still weren't working, like Resident 4's in room [ROOM NUMBER]. Residents could use a bell that staff would provide. Staff K stated they checked on the residents with non-working call lights more often.</p> <p>On 09/25/2024 at 12:26 PM, Resident 7 and 8, in room [ROOM NUMBER], stated their call lights didn't work and you never knew when it would be. Resident 7 stated they sometimes wondered if they weren't working or if staff just don't want to answer them. Resident 8 put on their call light and commented they were working now. The call light box lit up with a red light but in the hallway the light was not on. They stated the issue started with construction and they messed up the wiring.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505024	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER Spokane Falls Care		STREET ADDRESS, CITY, STATE, ZIP CODE 6021 North Lidgerwood Spokane, WA 99207	

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 09/25/2024 at 1:38 PM, Staff I, Resident Care Manager (RCM), stated they thought the construction work was what caused the call light problems and the system was old. When staff discovered a call light not working they reported it to the Administrator. The residents could use a bell and staff looked at the call light screen in the nurses station to see if a call light was on.</p> <p>On 09/25/2024 at 3:15 PM, Staff D, Administrator, stated when the call lights didn't work the call light panel at the nurses station would still sound. Staff D stated they thought the South panel stopped sounding but found out the monitor had been turned down. Staff had been instructed to listen for the sound and look at the call light panel.</p> <p>Reference: WAC 388-97-2280 (1)(a)</p>