

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 11/15/2024
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>27590</p> <p>Based on observation, interview, and record review, the facility failed to ensure 1 of 5 sample residents (Resident 1), reviewed for abuse, remained free from mental abuse when Resident 2 made sexually inappropriate comments towards Resident 1. Failure to implement adequate interventions and supervision for Resident 2, placed all residents at risk for psychosocial harm and potential mental abuse.</p> <p>Findings included .</p> <p>Review of a facility assessment, dated 09/22/2024, showed Resident 1 had diagnoses of chronic pain and depression. The resident was alert and oriented and was able to make their needs known. Resident 1 was independent with most Activities of Daily Living (ADL's).</p> <p>Review of a facility grievance by Resident 1, dated 09/16/2024, showed the resident documented inappropriate sexual comments had been ongoing from Resident 2. Resident 1 wrote Resident 2 had told Resident 1 he would like to perform lewd, sexual acts on Resident 1. The resident requested one of them be moved to another room. When Social Services followed up, Resident 1 explained how uncomfortable it made them feel. The concern was taken to a meeting with Administration and it was recommended to separate the residents in a timely manner.</p> <p>Review of the facility incident log, there was no investigation related to the allegation of mental abuse from the 09/16/2024 grievance.</p> <p>Review of a facility investigation, dated 10/30/2024, showed on 10/29/2024 Staff A, Licensed Practical Nurse (LPN), reported an argument between Resident 1 and Resident 2. Resident 1 yelled at Resident 2 and stated how many times have you said you will suck my d .k . Staff A intervened and Resident 2 left the room. Resident 2 was to be moved to Resident 3's room. Resident 3 was told about Resident 2 being their roommate and Resident 3 refused. Resident 3 stated Resident 2 had made statements they would rape Resident 3 and they were afraid.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/07/2024 at 11:35 AM, Resident 1 was laying in bed with a hospital gown on. Resident 1 stated they had a roommate who was problematic. Resident 1 said Resident 2 was very inappropriate with sexual comments which occurred several times a day. Resident 1 stated they reported the comments to staff several times and wanted to be moved or have Resident 2 moved. Resident 1 stated I was afraid he would come over and do something, it was scary. Resident 1 stated nothing had been done until last week.</p> <p>On 11/07/2024 at 2:15 PM, Resident 3 was interviewed and stated Resident 2 constantly made lewd sexual comments to them a in common area where several residents met. Resident 3 did not report the comments because they didn't feel threatened until Resident 2 said they would rape them. When Resident 3 was told Resident 2 would be moved into their room, Resident 2 refused and reported Resident 2 had threatened to rape them.</p> <p>During an interview on 11/15/2024 at 2:30 PM, Staff B, Social Services Director (SSD), stated they received the grievance from Resident 1 in September and reported it to Staff D, Administrator. The concern was discussed in a meeting and it was determined to move one of the residents. Resident 1 reported several incidents about being uncomfortable with Resident 2, SSD informed administration, and nothing was done. Resident 1 requested a room change 09/26/2024 and Resident 2 was not moved until 10/29/2024.</p> <p>During an interview on 11/15/2024 at 3:10 PM, Staff G, Director of Nursing, had been hired after Resident 1 had made allegations Resident 2 was sexually inappropriate and wanted moved. Staff G explained they thought the first it had been reported was 10/29/2024 when Resident 1 and Resident 3 reported Resident 2 stated they would rape the two residents.</p> <p>Reference: WAC 388-97-0640(1)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>27590</p> <p>Based on interview, and record review, the facility failed to thoroughly investigate allegations of abuse and/or neglect for 2 of 6 residents (Residents 1 and 5), reviewed for abuse and/or neglect. This failure placed residents at risk for abuse and/or neglect and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility policy: Prevention and Reporting: Resident mistreatment, Neglect, Abuse . Misappropriation of Resident Property, dated 08/2022, showed there was to be an investigation of all allegations of abuse and/or neglect to include resident interview, resident observation, staff interviews and other resident interviews. The investigation was to include a summary to rule out abuse and neglect.</p> <p><Resident 1></p> <p>Review of a facility assessment, dated 09/22/2024, showed Resident 1 had diagnoses of chronic pain and depression. The resident was alert and oriented and was able to make their needs known. Resident 1 was independent with most Activities of Daily Living (ADL's).</p> <p>Review of a facility grievance by Resident 1, dated 09/16/2024, showed the resident documented inappropriate sexual comments had been ongoing from their roommate, Resident 2. Resident 1 wrote Resident 2 had told Resident 1 he would like to perform lewd, sexual acts on them. The resident requested one of them be moved to another room. When Social Services followed up, Resident 1 explained how uncomfortable it made them feel. The concern was taken to a meeting with Administration and it was recommended to separate the residents in a timely manner.</p> <p>Review of the facility incident log, there was no investigation related to the allegation of sexual abuse from the 09/16/2024 grievance.</p> <p>During an interview on 11/07/2024 at 11:35 AM, Resident 1 was laying in bed with a hospital gown on. Resident 1 stated they had a roommate who was problematic. Resident 1 said Resident 2 was very inappropriate with sexual comments which was several times a day. Resident 1 had reported the comments to staff several times and wanted to be moved or have Resident 2 moved. Resident 1 stated I was afraid the resident would come over and do something to them,it was scary. Resident 1 stated nothing had been done until last week.</p> <p><Resident 5></p> <p>Review of a facility assessment, dated 08/20/2024, showed Resident 5 was admitted with heart and lung disease. The resident was able to make their needs known.</p> <p>Review of a grievance form, dated 09/25/2024 showed Resident 5 had care concerns which included no showers the first two weeks after admit, wounds on legs not addressed by staff, and labs not properly drawn. The recommendation was for the interdisciplinary team to meet and have a care conference with the family and resident.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility incident log showed no entry the grievance had been investigated for allegations of abuse and/or neglect.</p> <p>During an interview on 11/15/2024 at 2:30 PM, Staff B, Social Services Director (SSD), stated they were the grievance officer but Staff D, Administrator, kept the grievance binder. Staff B had received the grievance from Resident 1 in September and reported it to Administration. The concern was discussed in a meeting and it was determined to move one of the residents. Resident 1 had reported several incidents that made them uncomfortable with their roommate, SSD let Administration know, inquired about the move, and nothing was done. Staff B said Resident 5 and their family wanted to have a care conference with nursing because they were upset with care. The meeting was arranged but the interim Director of Nursing (DNS) and Administrator did not attend. The resident and family were not happy because they didn't have care issues addressed.</p> <p>On 11/15/2024 at 3:10 PM, Staff D stated if there was an allegation of abuse and/or neglect it would be elevated to an incident and investigated. No investigations had been done on Resident 1 and Resident 5's allegations.</p> <p>Reference WAC: 388-97-0640 (6)(a)(b)</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>27590</p> <p>Based on interview and record review, the facility failed to ensure there was a Registered Nurse (RN) on duty at least eight hours a day, seven days a week. This failure had the potential to impact all residents present in the building.</p> <p>Findings included .</p> <p>Review of the staffing pattern from 10/01/2024 through 10/31/2024 showed no RN coverage for 18 full days. 11/01/2024 through 11/15/2024 showed no RN coverage for 10 full days.</p> <p>During an interview on 11/15/2024 at 1:20 PM, Staff C, Staffing Coordinator, confirmed the facility did not have RN coverage seven days a week. The facility had a RN that worked 16 hour shifts every Saturday and Sunday and until 11/01/2024 had a RN that worked one day during the week. Staff C stated the facility used agency staff but normally they would send Licensed Practical Nurses (LPN).</p> <p>On 11/15/2024 at 3:10 PM, Staff D, Administrator, confirmed the facility did not have the required RN coverage. Staff D stated they were in the process of hiring RN's.</p> <p>Reference: WAC 388-97-1080(3)(a)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>27590</p> <p>Based on interview and record review, the facility failed to follow physician orders, as intended, for 1 of 3 sample residents (Resident 4), reviewed for medication administration. Resident 4 had an order to receive Carvedilol (a heart medication) one tablet twice a day. On 07/11/2024, the medication was changed to once a day with no order to make the change. This failure placed the resident at risk for adverse side effects and diminished quality of life.</p> <p>Findings included .</p> <p>According to the facility assessment, dated 10/03/2024, Resident 4 had diagnoses to include heart disease. Resident 4 was able to make their needs known.</p> <p>During an interview on 10/24/2024 at 1:26 PM, Resident 4 stated they were supposed to take a cardiac medication twice a day. Resident 4 went to a cardiology appointment on 09/30/2024 and it was discovered the resident had only been getting the medication once a day since July 2024.</p> <p>Review of the Medication Administration Record (MAR) for July 2024 showed the resident took one tablet of Carvedilol twice a day since admission, 06/26/2024. On 07/11/2024, the order was discontinued and a new order was placed to give Carvedilol one tablet once a day.</p> <p>Review of progress notes, dated 07/11/2024, showed a new order for Carvedilol one tablet one time a day. The new order was identified as being below the usual dose and usual frequency.</p> <p>There was no documentation to show the resident had an order to change the medication and no documentation to show the flagged concern for the medication had been addressed.</p> <p>During an interview on 11/15/2024 at 1:47 PM, Staff E, Resident Care Manager (RCM), stated if a change was made on medication, such as putting in parameters for a blood pressure medication, staff could go into the system and make those changes. Staff E said when the change was made, the computer discontinued the prior order and placed the new order. The system would be flagged if there was an identified concern with the new order. Staff E was made aware what had happened with Resident 1's cardiac medication after they returned from their cardiology visit. Staff F, Licensed Practice Nurse (LPN), who no longer worked at the facility, had made a change to the medication and the system flagged it was below dose and frequency but no one addressed it. The resident went from 07/11/2024 to 09/30/2024 with the lower dose.</p> <p>Reference: WAC 388-97-1060(3)(k)(iii)</p>		