STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505024	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spokane Falls Care	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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 27590 Based on interview and record review, the facility failed to investigate an allegation of potential verbal abuse for 1 of 1 sampled residents (Resident 8), reviewed for abuse and/or neglect. This failure placed all resident at risk for abuse and a diminished quality of life. Findings included . A facility assessment, dated 01/24/2025, showed Resident 8 had diagnoses which included a history of a stroke which affected their left side. The resident was able to make their needs known. During an interview on 03/14/2025 at 2:30 PM, Resident 8 was laying in bed with a hospital gown on. The resident stated Staff I came into their room and hollered and screamed at them. Staff I was telling Resident 8 what to do and argued with everything the resident said and then told Staff I to leave the room. Resident 8 stated there was another staff member in the room during the incident and the higher ups came into their room and asked why they told Staff I to get out of their room. In a follow up interview on 03/20/2025 at 1:35 PM, Resident 8 stated they weren't fearful of Staff I but it made them upset. The resident said they didn't need to deal with stress and had to call a family member to calm down. Per review of the facility incident log, there was no documentation to show the incident had been investigated. On 03/20/2025 at 1:54 PM, Staff E, Nursing Assistant (CNA), stated they were in Resident 8's room when Staff I came into the room and talked to Resident 8 about their dressing changes. Staff E stated Resident 8 liked to push boundaries and the conversation turned into an argument between the two. In a follow up interview on 04/03/2025 at 10:30 AM, Staff E stated they felt Staff I escalated the argument, when they should have left the room, and felt it was to the point of verbal abuse. Staff E went on to say they immediately went to the Director of Nursing (DNS) and reported the incident. During an interview on 03/25/2025 at 12:26 PM, Staff H, Administrator, was asked if they had information about Resident 8 being yelled at by Staff I. Staff H stated they had only been told Resident 8 no longer wanted Staff I in their room and was unaware Staff I yelled at Resident 8. The DNS at the time of the incident no longer worked at the facility. Reference: WAC 399-97-0640(6)(a)(b)(c)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505024	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spokane Falls Care	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 27590 Based on observation, interview, and record review, the facility failed to ensure 5 of 6 dependent residents (Residents 1, 3, 4, 5, 6), reviewed for Activities of Daily Living (ADL's), received the appropriate number of baths per week. In addition, the facility failed to provide grooming for 4 of 6 dependent residents (Residents 1, 2, 4, and 5), reviewed for nail care. This placed residents at risk for poor hygiene and diminished quality of life. Findings included . SHOWERS <Resident 1> Review of a facility assessment, dated 03/07/2025, showed Resident 1 was admitted with diagnoses which included cancer of the blood and multiple fractures. The resident was able to make their needs known and required substantial to maximum assistance for showers and partial to moderate assistance for hygiene. During an interview on 3/14/2025 at 1:10 PM, Resident 1 was observed laying in bed. The resident stated they had gotten a bed bath, not a shower, because the pain they had when being moved. Review of the resident's shower record from 02/28/2025 to 04/03/2025 showed the resident had a partial sponge bath 03/04/2025 and seven days later 03/11/2025. The next partial sponge bath was 03/18/2025, seven days later. A bed bath was done 03/21/2025 and the next partial sponge bath was done 04/01/2025, eleven days later. <Resident 3> Review of a facility assessment, dated 01/28/2025, showed the resident was admitted with diagnoses which included Diabetes and lung disease. The resident was able to make their needs known and required partial to moderate assistance with showers. Review of the resident's shower record from 01/21/2028 to 01/31/2025 showed the resident refused a bath on 01/23/2025, 01/28/2025, 1/30/2025 and received a shower 01/31/2025, eleven days after admission. <Resident 4> Review of an assessment, dated 01/15/2025, showed the resident was admitted with diagnoses which included Diabetes and malnutrition. The resident was able to make their needs known and required substantial to maximum assistance with showers and supervised assistance for hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505024	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spokane Falls Care	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's shower record from 02/19/2025 to 04/01/2025 showed the resident received a bed bath on 02/19/2025 and the next bed bath was 10 days later on 03/01/2025. The resident went from 03/01/2025 to 03/11/2025, 10 days without a shower, and 9 days later received a bed bath on 03/20/2025. <Resident 5> Review of a facility assessment, dated 01/31/2025, showed the resident was admitted with diagnoses which included Diabetes and a stroke with right sided weakness. The resident was able to make their needs known and required substantial to maximum assistance for showers and partial to moderate assistance for hygiene. Review of the resident's shower record from 02/27/2025 to 04/03/2025 showed the resident received a partial bed bath on 03/10/2025 and 14 days later received their next partial bed bath on 03/24/2025. There was no further bed bath or shower documented from 03/24/2025 to 04/03/2025. <Resident 6> Review of an assessment, dated 03/09/2025, showed Resident 6 was admitted with diagnoses which included Diabetes and a surgical repair of their leg. The resident was able to make their needs known and required substantial to maximum assistance for showers and supervised assistance for hygiene. On 03/20/2025 at 1:35 PM, Resident 6 was laying in bed in a hospital gown. The resident stated they had been at the facility for about 3 weeks and was supposed to have showers on Tuesdays and Fridays. Resident 6 stated they had only been offered a bed bath once, on evenings, and they refused because they preferred to have baths and/or showers in the morning. Review of the resident's shower record from 03/02/2025 to 04/03/2025 showed the resident received 1 shower on 04/01/2025, almost 4 weeks after admission. A nurses note dated 03/18/2025 at 8:56 PM, documented the resident was offered a shower and had refused. There was no further documentation on refusals. On 04/01/2025 at 10:50 AM, Staff AC, Nursing Assistant (CNA), stated the facility did not have a shower aide so they had to do showers themselves. Staff C stated they could not get all their showers done, especially when they were assigned 4 showers on a shift. Staff C stated the most they could do was 2 maybe 3 because of the acuity of the residents. Staff C stated the Residents were upset they weren't able to get showers consistently and commented one of the resident's hadn't gotten one since they were admitted . If a resident refused a shower, they were to sign a refusal form and it was given to the nurses. On 04/01/2025 at 11:28 AM, Staff E, CNA, stated there were times they couldn't get all their showers done, especially when only 4 aides were working. If a resident refused, a form was put in the shower book or they would let the nurses know. Staff E stated if showers weren't done, Saturdays could be make up days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505024	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spokane Falls Care	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/01/2025 at 1:40 PM, Staff F, Resident Care Manager (RCM), stated showers should be done twice a week. The staffing coordinators made the shower schedule. When asked if the schedule was done based on acuity, Staff E stated they thought it was done based on room number. Staff F stated if a resident refused a shower, a form was filled out which would be given to the nurses. On 04/03/2025 at 10:30 AM, Staff D, CNA, stated the floor aides were the ones to do resident showers. Staff D stated they were told there would only had to do 2 showers in a shift but sometimes they were given 4 that needed done. The staff were told if they couldn't do a resident's shower then give the resident a bed bath. Staff D stated some residents hadn't stepped foot in a shower since admission which wasn't right. GROOMING <Resident 1> Review of a facility assessment, dated 03/07/2025, showed Resident 1 was admitted with diagnoses which included cancer of the blood and multiple fractures. The resident was able to make their needs known and required substantial to maximum assistance for showers and partial to moderate assistance for hygiene. Review of the resident admission assessment, dated 02/28/2025, documented the resident was admitted with long, yellow toenails. On 03/20/2025 at 1:05 PM, Resident 1 was laying in bed with a hospital gown on. The resident stated they did not receive nail care at the facility and was observed with long finger nails and commented they liked their nails short. Resident 1 stated their daughter had asked staff to assist them in nail care and their son had brought in a nail file for the resident to use. When asked about their toenails, Resident 1 stated they had not been trimmed. Per observation, the resident had long, yellow toenails. Review of the resident's nail care record from 02/28/2025 to 04/01/2025 showed no nail care had been completed. <Resident 2> Review of a facility assessment, dated 12/30/2024, showed Resident 2 had a mental illness. The resident was able to make their needs known and required set up assistance for hygiene. On 03/20/2025 at 11:30 AM, Resident 2 was asked about nail care. Resident 2 stated they clipped their own finger nails but was not able to do their toe nails. The resident's feet were observed. Their toe nails were long and the right great toe nail was jagged. Review of the resident's nail care record showed no nail care from 03/02/2025 to 04/03/2025 had been done. On 04/01/2025 at 1:40 PM, Staff F, RCM, went to Resident 2's room with the surveyor and confirmed their nails were long and jagged. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505024	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spokane Falls Care	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 4> Review of a facility assessment, dated 01/15/2025, showed the resident was admitted with diagnoses which included Diabetes and malnutrition. The resident was able to make their needs known and required substantial to maximum assistance with showers and supervised assistance for hygiene. On 03/20/2025 at 12:28 PM, Resident 4 was laying in bed and stated they had been in the facility since January. The resident was asked about nail care and stated no one did their nails at the facility. The resident stated they had a special nail clipper at home but hadn't brought it with them. Per observation, the resident's toe nails were long and yellow. The resident's most recent care plan showed the resident had Diabetes. The resident was to be referred to a podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails. There resident's record was reviewed and there was no documentation to show the resident had been referred to a podiatrist. <Resident 5> Review of a facility assessment, dated 01/31/2025, showed the resident was admitted with diagnoses which included Diabetes and a stroke with right sided weakness. The resident was able to make their needs known and required substantial to maximum assistance for showers and partial to moderate assistance for hygiene. On 04/01/2025 at 12:18 PM the surveyor entered Resident's 5's room. The resident was not in the room but the resident's roommate, Resident 7, was sitting in their wheel chair. Resident 7 stated they were able to do their own nail care but their roommate, Resident 5, couldn't. Resident 7 stated Resident 5 wanted them to cut their toe nails. Resident 7 stated they looked at Resident 5's toe nails and stated they were long and thick and told the resident they would not cut them. They need to go to a podiatrist. Resident 7 stated they wore a larger shoe than Resident 5 and would loan their shoes to the resident so they didn't have pain from the toe nail hitting the ends. At 04/01/2025 at 12:36 PM, Resident 5 was interviewed. They stated they had been told by the facility someone was going to come in and trim their nails but no one had. At 12:57 PM, Resident 5 stated the surveyor could look at their toe nails on the right foot, and stated their left foot had a partial amputation of their toes. Staff A, Licensed Practical Nurse (LPN), came into the room with the surveyor and Resident 5's shoe was removed. The resident's right big toe had a long, pointed nail that was thick. The resident's other toe nails were straight and long. Resident 5 commented when they put shoes on it caused their foot to be sore because of the long nail. Staff A stated nail care was done during showers or the nurses trimmed toe nails if they were Diabetic. Staff A stated some of the resident's needed to see a podiatrist. Staff A stated the former RCM had been working on getting a podiatrist to come to the facility and was not sure where that was at. Review of the resident records showed a consent for podiatry form dated 02/20/2025. There was no documentation to show an appointment had been made for the resident to be seen by a podiatrist. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505024	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spokane Falls Care	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/25/2025 at 1:50 PM, Staff B, LPN, stated the nurse aides did nail care during showers, both finger and toe nails. If a resident was Diabetic then the nurses could cut the nails or the resident would be sent to a podiatrist. On 04/01/2025 at 10:50 AM, Staff C, CNA, stated nail care was to be done during the resident's showers unless they were Diabetic. Staff C stated it was just not done because they didn't have enough time to do it. On 04/01/2025 at 1:40 PM, Staff E, RCM, stated nail care should be done during showers, to include toe nails, unless the resident was Diabetic. If residents were Diabetic, nail care was done on the weekends by the nurses. Staff E stated the facility was supposed to contract for a podiatrist to come to the building. Reference WAC 388-97-1060(2)(c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505024	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spokane Falls Care	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27590 Based on observation, interview, and record review, the facility failed to assess, monitor, and/or measure non-pressure related skin conditions for 2 of 3 sampled residents (Resident 1 and 5), reviewed for skin conditions. This failure placed residents at risk for worsening skin conditions and a decreased quality of life. Findings included . Review of a facility policy titled Wound Prevention and Treatment, dated 02/03/2023, showed the policy included the following wounds; surgical wounds, pressure injuries, stasis ulcers (open sores that occur due to poor blood flow in the veins, leading to fluid buildup and skin breakdown, typically in the lower legs and ankles), venous/arterial ulcers (chronic, open wounds that develop on the lower legs due to poor blood circulation), and Diabetic ulcers (open sores or wounds on the feet of people with diabetes, often caused by nerve damage and poor circulation). These wound types were to be monitored weekly and documentation of size, color, odor, healing progression, and notifications to physicians were to be documented in the electronic medical record (EMR). <Resident 1> A facility assessment, dated 03/07/2025, showed Resident 1 was admitted with diagnoses to include cancer of the blood and multiple pathological (fractures due to a disease process not trauma) fractures. The resident was able to make their needs known and required substantial to maximum assistance with activities of daily living (ADL's). Review of the hospital transfer orders, dated 02/28/2025, showed Resident 1 had skin impairments which included the Gluteal Cleft (grooved area between buttocks), right inner ankle, front of the left lower leg, groin ulcer, and the resident's gastric tube (G-Tube; a flexible, hollow tube inserted through the abdomen into the stomach) insertion site had Moisture-Associated Skin Damage (MASD; inflammation and erosion of the skin caused by prolonged exposure to moisture sources such as wound drainage). The admission assessment from the facility, dated 02/28/2025, showed the resident was identified with wounds on their abdomen, groin, right lower front leg, and left lower leg. There was no documentation to show the type of wound, measurements, or appearance (color, presence of drainage, etc.) of the wounds. Review of the resident's care plan, dated 03/04/2025, showed the resident was at risk for pressure ulcers. Staff were to apply moisturizer to the skin and use mild cleansers for peri-care. If the resident had a change in skin status then the appearance, color, wound healing, wound size and signs and symptoms of infection was to be documented. There was no documentation to show the resident's current wounds or treatment to be done. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505024	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spokane Falls Care	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's Treatment Administration Record (TAR) for February 2025 showed staff were to monitor the G-tube site to include marking the tube at insertion, on admission, and verify with each medication/tube feeding administration. There was no treatment orders for the resident's wounds on the February TAR The March 2025 TAR showed on 03/05/2025, wound care for the resident's G-Tube site was started and staff were to swab the area with iodine, apply an antifungal powder on surrounding tissue, and dab on an antibiotic ointment. The G-Tube site was to be covered with a sponge dressing. A facility form titled Total Body Skin Evaluation, dated 03/11/2025, identified a skin issues on the resident's abdomen and front of left and right lower legs. There was no further documentation to describe the type of wound, measurements, or appearance. The facility skin evaluation forms dated 03/13/2025 and 03/19/2025 had no skin issue identified. On 03/14/2025 at 8:30 AM, a Collateral Contact (CC) had concerns the staff were not properly cleaning the resident's G-Tube and when the provider came in, they showed staff how it was to be cleaned. The resident was also having quite a bit of bloody draining around the tube when they first arrived to the facility. During an interview on 03/14/2025 at 1:10 PM, Resident 1 stated when they first were admitted to the facility, it took awhile for the staff to change their dressing around their G-Tube. Resident 1 said they had quite a bit of drainage around the tube. In a follow up interview on 03/20/2025 at 1:05 PM, Resident 1 had a clean and dry split gauze dressing around their G-Tube insertion site. The resident was observed with a circular scab on their right inner leg, near the ankle. The resident stated when they were at home, the sore wouldn't stop bleeding, which was why they originally went to the hospital. <Resident 5> Review of a facility assessment, dated 03/09/2025, showed Resident 5 had diagnoses which included surgery after a fractured leg and Diabetes. The resident was able to make their needs known and required substantial and maximum assistance with most activities of daily living (ADL's). Review of the transfer orders from the hospital, dated 03/02/2025, showed the resident had a venous ulcer (chronic, open wounds that develop on the lower legs due to poor blood circulation) on the right shin, fragile, red skin on the right scrotum, an incision on the left ankle with a dressing and splint on, and the right outer ankle had cluster wounds. Review of the admission skin assessment, dated 03/02/2025, showed the resident was identified with a right ankle wound, front right leg wound, and Stage 2 wound (stages describe pressure wounds - Stage 1 ulcers have not yet broken through the skin. Stage 2 ulcers have a break in the top two layers of skin. Stage 3 ulcers affect the top two layers of skin, as well as fatty tissue. Stage 4 ulcers are deep wounds that may impact muscle, tendons, ligaments, and bone) on the resident's testicle. There was no documentation to show the type of wounds, measurements, or appearance (color, presence of drainage, etc.) of the wounds. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505024	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spokane Falls Care	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's care plan, dated 03/04/2025, showed the resident was at risk for pressure ulcers. Staff were to apply moisture to the resident's skin and use mild cleansers for peri-care, new skin impairments were to be monitored to include appearance, color, healing, wound size, and signs and symptoms of infection. There was no information found on the resident's current wounds. The facility form Total Body Skin Evaluation, dated 03/12/2025 and 03/24/2025, documented the resident had a wound on the front right leg and wound on the right outer ankle. No further description was found to include appearance, wound size, or if the wounds were healing. During an interview on 03/20/2025 at 1:40 PM, Resident 5 was laying in bed with a hospital gown on. The resident stated they had surgery and a rod put in their left leg. When the resident arrived to the facility they had a splint on the leg which had since been removed. In a follow up interview on 03/25/2025 at 12:45 PM the resident was up in their wheel chair in the dining room. The resident had shorts on and was observed to have several scabbed areas on the right shin. The resident had a healed incision on the left ankle. On 03/25/2025 at 11:42 AM, Staff B, Licensed Practical Nurse (LPN), stated skin checks were done each week and were also done when nurse aides gave the residents showers. Staff B stated the Resident Care Managers (RCM's) filled out the skin grid sheets with description and measurements. On 04/01/2025 at 12:11 PM, Staff A, LPN, stated skin checks were done by the nurse aides during showers and nurses did weekly skin checks. If a resident had a skin issue then it would be documented on a skin sheet with descriptions and measurements. On 04/01/2025 at 1:40 PM, Staff F, Resident Care Manager (RCM), stated nurses were supposed to do weekly skin assessments. If skin issues were identified, the nurses would document the type of wounds to include measurements and appearance. Staff F stated if a resident was admitted with wounds they would often be referred to the outside wound provider that came to the facility. Reference: WAC [PHONE NUMBER]60(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505024	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spokane Falls Care	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)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 27590 Based on observation, interview, and record review, the facility failed to ensure staff obtained timely weights, re-weighed residents to ensure accuracy, and had measures implemented to prevent significant weight loss for 1 of 3 residents (Resident 4), reviewed for nutrition. In addition, the facility failed to obtain weekly weights for a resident on enteral nutrition (nutrition through a tube into the stomach), to monitor for adequate nutrition, for 1 of 1 resident (Resident 1), reviewed for tube feedings. This failure placed residents at risk for weight loss and unmet nutritional needs. Findings included . Review of a facility policy titled Weight Monitoring, revised 11/2022, showed the facility required measured and recorded weights to assure accuracy and to provide information for the assessment of clinical status unless clinically contraindicated. The residents would be weighed by the Nursing Assistants (CNA) or designee, and the Licensed Nurses (LN's), were responsible to document the resident's weight in the Electronic Medical Record (EMR). Residents were to be weighed within 24 hours of admission, weekly for four weeks and/or until the weight was determined to be stable, and then weighed monthly. The LN's would verify accuracy of the weight by comparing the weight with the most recently recorded weight, supervise re-weighs by the CNA to assure an accurate process was followed, and if the weight changed with a gain or loss of 5% or greater. Nutritional services were to review weight alerts daily to assure all residents with significant weight changes were reviewed and assessed. <Resident 4> Review of a facility assessment, dated 01/15/2025, showed Resident 4 had diagnoses to include liver disease and Diabetes. The resident was able to make their needs known. The resident's care plan for nutrition, dated 01/14/2025, showed the resident was at nutritional risk. The goal for the resident was to have no unplanned significant weight changes. The resident's weight was anticipated to fluctuate related to being on diuretic therapy (medication to reduce extra fluid in the body). Review of Resident #4's admission nutritional assessment, dated 01/14/2025, by Staff G, Registered Dietician (RD), showed the resident was at risk for malnutrition and their current weight was 130 pounds (lbs). Staff G noted the resident's weight at the hospital was 288 lbs and due to the discrepancy, a re-weigh was requested. The resident's nutritional needs were calculated based off the current listed weight (130 lbs) which may be inaccurate. The goals were to have no unplanned significant weight changes. Weight was anticipated to fluctuate related to edema (build up of fluid in the body) and being on diuretics. Review of the resident's weights showed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505024	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spokane Falls Care	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)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 01/08/2025 had 2 weights documented, 286 lbs and 130 lbs. The 130 lbs was later struck out on 01/22/2025 as being inaccurate. - 01/15/2025 and 01/22/2025 268 lbs (18 lbs since admission). - 01/29/2025 and 02/02/2025 271 lbs - 02/03/2025 and 02/19/2025 average weight was 266 lbs - 02/27/2025 to 03/05/2025 246 lbs (a weight loss of 40 lbs in almost 2 month, 13% loss) - 03/10/2025 236 lbs (an additional weight loss of 5 lbs). - 03/26/2025 to 03/28/2025 232 lbs (a weight loss of 54 lbs in almost 3 months or 18%). A nutrition at risk meeting on 01/22/2025 showed the resident weighed 268 lbs, a -3.0% weight change from their last weight. The resident had slight swelling in their legs and typically took 51-100% of their meals. It was noted the resident's weight loss was possibly attributed to weight error on admission or fluid weight loss. Weight was anticipated to fluctuate related to edema and diuretic therapy. The resident's intake was fair to good and there was no nutritional concerns. Review of the resident's Treatment Administration Record (TAR) for February and March 2025 showed the resident was monitored for edema based on a scale (the severity of the swelling based on the indentation left when pressing on the swollen area and how long it took to rebound, ranging from 1+ - 4+) There was 1 day, 02/15/2025, the resident had 2+ edema (slight indent that disappeared in 10 - 15 seconds), and all other entries were 0 - 1+ (slight indent that disappeared immediately) On 02/05/2025 a nutrition at risk meeting showed the resident weighed 265 lbs, a -5.0% weight change in a month. It was noted the resident had slight edema and took about 76 - 100% of meals. The resident was currently on vitamins and weight loss was likely a combination of true body weight loss and fluid weight loss. The resident also consumed excessive calories at home with alcohol consumption. No nutritional concerns identified. On 03/05/2025 it was documented the resident's last weight was 247 lbs, a -5% weight change in the last month (a weight loss of 39 lbs, -13% weight loss since admission). The same interventions were in place with no nutritional concerns. On 03/12/2025 the resident weighed 236 lbs, a loss of another 11 lbs since 03/05/2025. The same interventions were in place with no nutritional concern noted. 03/12/2025 was the last NAR meeting in the resident's record. <Resident 1> A facility assessment, dated 03/07/2025, showed Resident 1 was admitted with diagnoses to include cancer of the blood and multiple pathological (fractures due to a disease process not trauma) fractures. The resident was able to make their needs known. Resident 1 was admitted with a Gastric Tube (G-Tube) for nutrition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505024	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spokane Falls Care	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)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 03/14/2025 at 1:10 PM, Resident 1 was in bed with tube feeding being infused for nutrition. The resident's most recent care plan, dated 03/06/2025, showed the resident required tube feedings due to difficulty swallowing. Tube feeding was to be administered and water flushes done, Staff were to check for tube placement prior to feeding and medication administration, place the head of the bed was to be elevated 30 degrees during and thirty minutes after tube feeding and monitor weights per orders/protocol. The physician was to be notified with significant weight loss or gain. Review of the resident's record from 02/28/2025 to 04/01/2025 showed the following weights: 03/04/2025 151 pounds (lbs) 03/19/2025 191 lbs The resident's admission assessment was reviewed and no admission weight was documented. On 03/06/2025 an admission Nutritional Evaluation was done. The evaluation showed the resident was on a nectar thick, pureed diet. The resident had poor oral intake, usually consuming 0-25% and the majority of the nutritional needs were provided by the tube feedings. It was noted the resident was not tolerating the goal rate and the rate of the tube feed was to increase each week until goal was achieved. On 03/25/2025 at 1:50 PM, Staff B, Licensed Practical Nurse (LPN), stated the nursing assistants took resident weights and then the nurses input the weights in the computer. If there was a discrepancy then nurses would let the nursing assistants know they needed to re-weigh the resident. On 04/01/2025 at 11:28 AM, Staff D, Nursing Assistant (CNA), stated the nursing assistant took the weekly weights and they now had restorative aides taking the monthly weights. The weights were then given to the nurses or the nursing assistants would enter the weight into the computer. On 04/01/2025 at 1:40 PM, Staff F, Resident Care Manager (RCM), stated Staff G, Registered Dietician (RD), visited the facility twice a week. Staff F stated the Director of Nursing (DNS) was monitoring the weights, who was no longer at the facility, and the RD would as well. There were weekly Nutrition at Risk meetings (NAR) for residents who triggered due to a weight gain or loss. Staff F stated they reviewed Resident 4 related to the significant weight loss. The team discussed the resident had a lot of empty calories prior to admitting, due to alcohol intake, which probably contributed to their weight loss. Resident 1 was on a tube feeding and when it was first started the resident was not tolerating it so the amount was adjusted. Staff F stated weights should be taken weekly and then monthly unless the RD determined a resident needed to continue to have weekly weights. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505024	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spokane Falls Care	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)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/2025 at 10:15 AM, Staff G stated they were at the facility 2 days a week. Weights were to be taken weekly x 4 and then monthly unless there was a concern with the resident's weight. The nurses enter the weights and make sure they are done. The RCM's, DNS and RD all monitor the weights. Staff G stated they had NAR meetings for residents that were determined to be at risk for a weight gain or loss, residents on tube feedings, and residents with wounds. The team comprised of RD, Dietary Manager, RCM's and invite the DNS and Administrator who would come if they were available. Staff G stated they sent emails with recommendations, such as re-weighs, and then would ensure they had been done at the next NAR meeting. Staff G was asked about Resident 4 and stated the weight lost was attributed to the first weight being an error (the 130 lbs). Resident 4's further weight loss was due to improvement of the resident's edema and they had a history of excessive calories due to alcohol consumption. Staff G confirmed Resident 4's weight loss had been significant but since their BMI (body mass index) was still high, in part, it was therapeutic. Staff G stated Resident 1 did not tolerate their tube feeds initially so they had to slowly titrate them up. Staff G said they had requested re-weighs on Resident 1 in their recommendations to the facility, which hadn't been done. Reference: WAC 388-97-1060(3)(h)