

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  05/13/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>27590</p> <p>Based on interview and record review, the facility failed to identify and report potential allegations of abuse and/or neglect to the State Survey Agency as required for 3 of 5 sampled residents (Resident 1, 2, and 4), reviewed for abuse and/or neglect. This failure placed the residents at risk for further abuse and/or neglect and a diminished quality of life.</p> <p>Findings included .</p> <p>&lt;Resident 1&gt;</p> <p>Review of a facility assessment, dated 04/16/2025, showed Resident 1 was admitted with diagnoses to include an amputation of their lower leg. The resident was able to make their needs known.</p> <p>Review of the facility grievance log from January 2025 through April 2025 showed on 04/24/2025, Resident 1 filed a grievance which was noted as a nursing concern.</p> <p>Review of the facility's Grievance Summary Report, dated 04/24/2025, showed Resident 1 reported staff had not changed their roommate (Resident 2) from 7:00 PM to 6:30 AM. The resident wrote Resident 2 had to sit in their own feces all night, take care of people like they are your family!</p> <p>Review of the facility reporting incident log showed Resident 1's allegation of potential neglect had not been logged or called to the State Survey Agency, as required.</p> <p>During an interview on 04/25/2025 at 10:15 AM, Resident 1 was up in their wheel chair in the room. The resident stated they had filed a grievance about Resident 2, their roommate, not being changed all night. Resident 1 stated they were independent and could get to the bathroom, but their roommate wasn't. Resident 1 stated there were other incidents where it took up to 2 hours for staff to change Resident 2.</p> <p>&lt;Resident 2&gt;</p> <p>Review of a facility assessment, dated 03/16/2025, showed Resident 2 had Diabetes and Depression. The resident was able to make their needs known.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility grievance log from January 2025 through April 2025 showed on 04/21/2025, Resident 2 filed a grievance which was noted as a nursing concern.</p> <p>Review of the facility's Grievance Summary Report, dated 04/21/2025, showed Resident 2 reported they were on a bed pan from 9:30 AM and not checked on again until evening shift. Resident 2 then stated they were changed that evening at 8:00 PM and didn't see staff again until 9:00 AM the following morning. Resident 2 documented they needed to be changed regularly due to skin breakdown when wet.</p> <p>Review of the facility reporting incident log showed Resident 2's allegation of potential neglect had not been logged or called to the State Survey Agency, as required.</p> <p>&lt;Resident 3&gt;</p> <p>Review of a facility assessment, dated 04/29/2025 showed Resident 3 was admitted with diagnoses which included spine surgery. The resident was able to make their needs known.</p> <p>Review of the facility grievance log from January 2025 through April 2025 showed on 04/21/2025, Resident 2 filed a grievance which was noted as a concern for nursing.</p> <p>Review of the facility's Grievance Summary Report, dated 04/21/2025, showed the resident had a concern with a call light light response time and when someone finally answered, they shut off the call light and light in the room, and turned their back on the resident. When interviewed by Staff A, Administrator, Resident 3 additionally stated their pain medication wasn't available on admission for several hours.</p> <p>Review of the facility reporting incident log showed Resident 2's allegation of potential neglect had not been logged or called to the State Survey Agency, as required.</p> <p>During an interview on 05/13/2025 at 12:55 PM, Resident 3 was laying in bed. The resident stated it took an hour and 15 minutes for someone to answer their call light. When the staff did answer, they turned the call light off and left the room. It was another 20 minutes before they actually received help. Resident 3 also stated when they were admitted they had to wait for pain medication. The resident stated they had spine surgery, their pain was a 10 out of 10 (pain scale is 0 - 10, 0 no pain, 10 worst pain), and was told the facility had run out of their medication.</p> <p>During an interview on 05/13/2025 at 3:20 PM, Staff B, Regional Director of Operations, stated Staff A was no longer at the facility. Staff B stated they had identified issues with the grievance process and if their was allegations of potential abuse and/or neglect, they should be logged and called to the State Agency and then an investigation would be done.</p> <p>Reference: WAC 388-97-0640 (5)(a), (6)(a)(c)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 27590</p> <p>Based on observation, interview, and record review, the facility failed to provide necessary pain management for 2 of 3 sampled residents (Resident 1 and 3), reviewed for pain. Resident 1 and 3 each experienced harm when the facility did not treat their pain timely, after the residents rated their pain as a 10 (0 is no pain and 10 is the most intense pain) on admission to the facility. This failure placed residents at risk of uncontrolled pain and diminished quality of life.</p> <p>Findings included .</p> <p>&lt;Resident 1&gt;</p> <p>Review of a facility assessment, dated 04/16/2025, showed Resident 1 was admitted on [DATE] and had diagnoses which included a below the knee amputation (BKA). The resident was able to make their needs known.</p> <p>Review of the admission assessment, dated 04/09/2025 at 2:30 PM, showed Resident 1 answered yes to being fatigued and it was noted the resident complained they were tired and had pain. The pain assessment showed the resident was currently in pain and their pain was described as throbbing, stabbing, burning, which occurred with movement and at rest. The resident was asked to rate their pain over the last five days and they responded 10.</p> <p>Review of the Medication Administration Record (MAR) for April 2025 showed Resident 1 had an order for Tylenol 500 milligrams (mg) to be given every four hours, as needed for pain, and Oxycodone (a narcotic pain medication) one tablet if they rated their pain 1 - 5, and two tablets if they rated their pain 6 - 10, every four hours as needed for pain. The MAR showed the resident had received Tylenol 500 mg at 8:05 PM and Oxycodone 2 tablets at 9:02 PM which was around six hours after admission.</p> <p>During an observation and concurrent interview on 04/25/2025 at 10:15 AM, Resident 1 was sitting in their wheel chair in their room. The resident had a compression bandage on the end of their left BKA stump. Resident 1 stated they were admitted after surgery for rehabilitation. The resident stated on admit, their pain was a 10. The resident asked for pain medication and it was not administered until several hours later. They stated it was awful and it took a long time to get their pain controlled.</p> <p>During an interview on 05/13/2025 at 1:50 PM, Staff D, Licensed Practical Nurse (LPN), stated they had admitted Resident 1 at the end of their shift. Staff D could not remember if the resident had significant pain and stated they had not given the resident any pain medication. Staff D was asked the process if medications for a new admit had not arrived to the facility. Staff D stated they would call pharmacy to confirm the order and the pharmacy could give the nurses a code to get the medication out of their Cubex (a medication dispensing machine).</p> <p>&lt;Resident 3&gt;</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a facility assessment, dated 04/29/2025, showed Resident 3 was admitted to the facility on [DATE] with diagnoses which included spine surgery. The resident was able to make their needs known.</p> <p>Review of the vitals and pain only form, dated 04/23/2025 at 3:00 PM, Resident 3's current pain was rated at a 10. The resident described their pain in their lower back and down their right leg. The admission assessment showed the resident had two surgical wounds, one on the lower back and one on their left side.</p> <p>Review of the resident's MAR for April 2025 showed Resident 3 had an order for Morphine Extended Release (ER) tablet to be given every 12 hours, as needed for pain, a muscle relaxant every eight hours, as needed for pain, and Oxycodone every four hours as needed for pain and they were to receive one tablet if they rated their pain 1 - 5, and two tablets if they rated their pain 6 - 10. On 4/23/2025 at 6:30 PM, the resident received Morphine ER and Oxycodone two tablets for their pain which was over three hours after admission.</p> <p>On 04/24/2025, a grievance was filed for Resident 3 after concern of care were expressed during a care conference. Staff A, Administrator, went to talk to Resident 3 about the care concerns and during the conversation, the resident reported it took several hours for their medications to come to the facility after they were admitted and they were not happy.</p> <p>During an observation and concurrent interview on 05/13/2025 at 12:55 PM, the Resident 3 was lying in bed. They stated when they were admitted after spine surgery, they had to wait several hours for pain medication. The resident said their pain level was a 10 out of 10. Resident 3 stated they were told the facility ran out of their pain medication. Resident 3 was asked if any other type of pain medication had been offered or any non-medication interventions, such as repositioning, and the resident stated no.</p> <p>During an interview on 05/13/2025 at 1:50 PM, Staff D, Licensed Practical Nurse (LPN), was asked the process if medications for a new admit had not arrived to the facility. Staff D stated they would call pharmacy to confirm the order and the pharmacy could give the nurses a code to get the medication out of their Cubex.</p> <p>During an interview on 05/13/2025 at 2:50 PM, Staff E, Resident Care Manager (RCM), stated the floor nurses did the admission assessments, which included the pain assessment. If a resident rated their pain a 10 and their medication wasn't available from pharmacy, the staff could call the pharmacy and get a code to pull the medication from the Cubex. When asked what should be done if a resident rated their pain a 10 on admit, Staff E stated they would have offered the resident pain medication.</p> <p>During an interview on 05/13/2025 at 3:20 PM, Staff A, Regional Direction of Operations, confirmed if a resident had a pain rated at a 10 they should have been offered pain medication.</p> <p>On 05/20/2025 at 3:25 PM, Staff B, Director of Clinical Education, stated if a resident had rated their pain at a 10, medication should be offered to the resident.</p> <p>Reference: WAC 388-97-1060(1)</p>		