

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  08/21/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on interview and record review, the facility failed to ensure N-95 mask (a type of mask used to protect the wearer from particles or from liquid contaminating the face) fit testing (a test conducted to verify that a N-95 mask provides the user with the expected protection) was performed in accordance with applicable federal regulations for 103 of 103 employees. This failure placed employees and residents at risk of exposure to COVID-19 (a highly contagious respiratory virus). Findings included .In an interview on 08/21/2025 at 2:58 PM, Staff A, Administrator, stated the facility was out of compliance with N-95 fit-testing. They stated the last time N-95 fit-testing was done, building wide, was in the Spring of 2024, and although they had a plan in place, they had not yet started the process of getting all employees N-95 fit-tested. On 8/21/2025 at 3:55 PM, when asked for a list of employees who had been N-95 fit-tested Staff B, Infection Preventionist stated they were unable to provide the information because it did not exist. Staff B stated they had received certification to administer N-95 fit-testing the prior week and would be initiating N-95 fit-testing for the facility employees the following week. Reference: WAC 388-97-1320 (1)(a)</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
---	-------	-----------