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	11/18/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure adequate supervision for 1 of 3 sampled residents (Resident 1), reviewed for elopement (leaving the premises or safe area without authorization). The resident left the facility, unattended, after being identified with poor memory and safety awareness. This failure placed the resident at risk for possible injury and being in an unsafe situation. Findings included . Review of a facility assessment dated [DATE] showed Resident 1 was admitted with diagnoses to include a stroke and heart disease. The resident was independent and/or required supervision with Activities of Daily Living (ADL's) to include mobility. Review of the facility admission assessment, dated 05/23/2025, showed the resident was not identified as an elopement risk at the time of admission. Review of an admission assessment by Staff A, Nurse Practitioner, dated 05/27/2025, showed the resident had significant encephalopathy (brain not functioning properly) and cognitive decline (a gradual loss or decline in mental abilities, such as memory, attention, reasoning, and problem-solving). Staff A documented the resident had limited insight and no capacity to make appropriate medical decisions independently.On 05/29/2025 a therapy progress note titled therapy to nursing showed the resident was seen by therapy for moderate to severe cognitive impairment. The resident demonstrated difficulty with reasoning, problem solving, orientation, and insight. It was noted the resident attempted to mask their difficulties with sarcasm and humor.A nurses note on 06/04/2025 by Staff G, Resident Care Manager (RCM), showed they followed up with the resident because staff on evening shift had concern the resident was more confused. At times, the resident would go into the bathroom, become disoriented, and wander out of their room into the hallway to look for their bed. The resident required frequent reorientation, and staff stated the resident tried to go out the door at the end of the hallway to look for their room.Review of the care plan, revised on 06/05/2025, showed no information the resident cognitive decline, difficulty reasoning/problem solving, and disorientation. On 06/27/2025 at 12:00 AM, Staff B, Licensed Practical Nurse, (LPN), documented the resident was not present in the facility at the start of their shift. Staff B reviewed the sign out log, the resident signed themselves out, and the log indicated the resident had expected to return at 8:00 PM. Staff B contacted the resident's family, but they reported they hadn't seen him. A call was placed to Staff E, Director of Nursing (DNS), who advised Staff B to contact law enforcement to report the incident. The LN was informed by law enforcement the family had already contacted them. In a follow up note from Staff B, the resident returned to the facility at 3:05 AM from the hospital. The resident stated they went to the hospital because they had chest pain.On 06/27/2025 a note from Staff A showed the resident had signed themself out of the facility around 11:30 AM and had not returned by midnight. Staff A wrote while the resident was out of the facility, they developed chest pain and went to the emergency room (ER). Staff A documented with the resident's wandering, poor recall and cognition there was concern for their safety and being out of the facility for extended periods of time. Staff A wrote the resident may require tracking device vs wander guard for safety with their poor memory and ability to return to the facility when leaving independently. On 07/03/2025 Staff A documented the resident had worsened confusion when they missed doses of blood pressure medication which resulted in going to the ER after they left without an escort. The resident was now unable to leave without a staff escort. Review of the resident's record showed no updated elopement risk assessment or care plan related to the risk of leaving the facility independently.On 08/29/2025 a progress note by Staff B at 3:22 AM showed the resident returned to the facility at approximately midnight and exhibited signs of intoxication. There was no further documentation to show when the resident left or how long they had been out of the facility. Review of the facility resident sign out form showed the resident had not signed out of the facility on 08/28/2025 or 08/29/2025.On 08/29/2025 at 4:27 PM, Staff H, LPN, wrote the resident went out to the smoking area frequently. The resident required constant redirection and education related to leaving the facility due to the resident being confused and forgot their whereabouts. On 09/08/2025 Staff D, Social Services Director (SSD) documented the resident was made an elopement risk due current cognitive impairment because of a stroke and related to impaired safety awareness. Staff D tried to place a wander guard and the resident refused. Review of the resident's record showed no updated elopement risk assessment and no care plan related to being at risk for elopement.On 09/24/2025 at 1:35 PM Staff C, Nursing Assistant (NAC), stated Resident 1 got confused and would forget where their room was. Resident 1 did go out to the smoking area independently but didn't leave the facility by themselves. The resident either