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	03/04/2026

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** Based on interview, and record review, the facility failed to assess, monitor, and document non-pressure skin conditions for 1 of 3 sampled residents (Resident 1), reviewed for skin conditions. The inconsistent skin assessments and monitoring of identified skin issues placed the residents at risk of unmet needs and potential worsening skin conditions. Findings included .The revised 02/03/2026 facility policy titled Wound Prevention and Treatment documented wounds included diabetic ulcers, significant skin tears, and other skin conditions. These types of wounds were to be monitored weekly and documented in the electronic medical record with size, color, odor, healing progression, notifications, and other pertinent information related to the skin conditions. The facility's Skin Grid form was completed on admission on [DATE]. It showed Resident 1 had cellulitis on both lower legs, which wrapped around the calf, and was 1.5 feet long. No further Skin Grid forms were found in the residents record to be completed for cellulitis.Resident 1's care plan, dated 12/15/2025, documented the resident had cellulitis on both lower legs, and the area was to be assessed/recorded/monitored weekly and as needed. The nurses were to measure the length, width, and depth where possible, assess and document the status of the wound perimeter, wound bed, and healing progress. On 12/19/2025 the care plan was updated to include a skin tear to the resident's left lower calf. Nursing was to monitor/document the location, size and treatment of the skin tear. The provider was to be notified of any signs and symptoms of infection, failure to heal or any abnormalities.The facility's Total Body form, dated 12/16/2025, showed Resident 1 had a 3 centimeter (cm), round open skin tear on the left lower leg. There was no further documentation to show further assessments of the skin tear had been completed and there were no other Total Body forms in the resident's record.The 12/26/2025 admission assessment documented Resident 1 was admitted with diagnoses to include cellulitis (a bacterial infection that affects the skin's deeper layers, causing red, swollen, painful and warm skin) and diabetes. The resident was able to make their needs known. The 01/02/2026 nurse progress note documented Resident 1's wound on their left lower leg was red, without odor or drainage, was painful and the surrounding skin was scaley. The progress note did not refer to which wound was being assessed, cellulitis or skin tear, which were both on the left lower leg.In an interview on 02/26/2026 at 1:40 PM, Staff A, Resident Care Manager (RCM), stated the nurses filled out a weekly Total Body form to show if the resident had any new skin issues. If the resident had a skin issue, a Skin Grid was done weekly until healed. The skin condition would be assessed, measured, and evaluated for worsening or improvement. In an interview on 03/04/2026 at 1:30 PM, Staff B, Licensed Practical Nurse (LPN) stated if a resident had a non-pressure skin issue, like a skin tear, the nurse would fill out the facility risk management form, assess, measure, clean and dress the area. The physician would be notified of a treatment order which would be placed on the Treatment Administration Record (TAR). When asked about weekly documentation to show the area was assessed and monitored, Staff B stated the nurses observed the wound during the dressing changes and if the wound showed it had worsened or became infected, the provider would be notified. In an interview on 03/04/2026 at 2:10 PM, Staff C, Director of Nursing (DNS), stated if a resident had a non-pressure skin issue the nurse would fill out the facility risk management form, call the physician (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to get treatment orders if needed, and place the orders on the TAR. The area would be assessed to show if it is improving or not and would include measurements and description of the wound. Staff C stated this process would include a resident with cellulitis as well. Reference: WAC 388-97-1060(1)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to administer medications as intended by the provider for 2 of 3 sampled residents (Resident 1 and 2), reviewed for medication administration. This failure placed the residents at risk of adverse side effects, worsening infection, and diminished quality of life. Findings included .<Resident 1>The admission assessment, dated 12/26/2025, documented Resident 1 was admitted with a diagnosis of diabetes. The assessment showed the resident took insulin (an injection to help regulate blood sugar) daily to manage their diabetes. Resident 1 was able to make their needs known. The 12/12/2025 admission orders documented Resident 1 was to be given long-acting insulin (a slow-release, injectable diabetes medication that controls blood sugar levels for 16 to 42 hours), 26 units, twice a day. A short acting insulin (an insulin that starts to work 30-60 minutes after administered and is used to control blood sugar, particularly after meals), and 20 units three times a day with meals plus a sliding scale short acting insulin that was given based on the current blood sugar reading (a reading which shows the amount of sugar present in the blood). On 12/16/2025, the orders were changed from 20 units of short acting insulin with meals, to 10 units short acting insulin with meals, plus the sliding scale. The new order had parameters to hold the insulin if the blood sugar reading was less than 110 milligrams per deciliter (mg/dl). The December 2025 Medication Administration Record (MAR) documented the short acting insulin was given nine times when the blood sugar reading was less than 110 mg/dl. The January 2026 MAR documented the short acting insulin was given five times when the blood sugar reading was less than 110 mg/dl. In an interview on 02/26/2026 at 1:40 PM, Staff A, Resident Care Manager (RCM), stated if a resident was on short acting insulin, the usual parameters would be to hold the insulin if the blood sugar readings under 70 mg/dl unless the physician wrote a different parameter for a specific resident. For Resident 1, Staff A stated the staff should have held the insulin when their blood sugar readings were under 110.In an interview on 02/27/2026 at 2:05 PM, Staff D, Administrator, stated they reviewed Resident 1's record and confirmed the insulin had not been held when the resident's blood sugar was under 110.<Resident 2>The 03/06/2026 quarterly assessment documented Resident 2 was admitted with diagnoses to include kidney disease and diabetes. The resident was able to make their needs known.The 02/02/2026 physicians note documented the resident complained of blurry vision in their left eye. The eye appeared red and was tearing. An antibiotic eye drop was ordered to be administered in the left eye, twice a day for 10 days. The 02/05/2026 physicians note documented the resident reported their vision had improved in the left eye but the physician noted the right eye now had yellow discharge. The antibiotic eye drop order was changed to administer in both eyes, four times a day, for 10 days.The February 2026 MAR documented the antibiotic eye drops were started on 02/02/2026 in the left eye, twice a day for 10 days. The documentation showed the resident did not receive the eye drops 3 out of 6 possible doses. On 02/05/2026 the medication was changed to antibiotic eye drop to be given in both eyes, four times a day, for 10 days. Documentation showed the resident missed 7 out of 40 possible doses. In an interview on 02/27/2026 at 2:10 PM Staff D stated Resident 2's MAR had been reviewed and confirmed doses of the antibiotic drops had not been given. Reference: WAC 388-97-1060(3)(k)(iii)