STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505099	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spokane Valley Health and Rehabilitation of Cascad	East 17121 Eighth Avenue Spokane Valley, WA 99016

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38527 Based on observation, interview and record review, the facility failed to ensure staff provided CPR (cardiopulmonary resuscitation) in accordance with national standards for effective CPR to one of two sampled residents (Resident 2), reviewed for death. Additionally, the facility failed to ensure two of three sampled facility staff (Staff B and D), reviewed for CPR certification, had current CPR certification credentials. These failures placed residents at risk for not receiving effective care in accordance with their decision-making if their heart stopped beating or their breathing stopped. Findings included . <Resident 2> Review of the facility policy titled, Cardiopulmonary Resuscitation, updated [DATE], showed residents with a designated CPR status of Full Code would receive CPR and all basic life support therapies in accordance with the American Heart Association (AHA) guidelines. Facility staff would call emergency medical services (EMS) and obtain the emergency cart. Per the policy, the facility would set up an emergency cart that contained the necessary equipment to provide basic resuscitation services and included a back board (a board made of wood, plastic or other material that is inserted under the torso of a person receiving CPR to provide a firm surface during chest compression). Per the AHA (https://cpr.heart.org/en/resuscitation-science/cpr-and-ecc-guidelines/adult-basic-and-advanced-life-support), resuscitation should be conducted where the resident is found and should take place on a firm surface with the resident on their back. Review of the electronic physician order dated [DATE] showed Resident 2's CPR status was Full Code. Review of a facility investigation dated [DATE] showed Resident 2 was found on the floor in their room at approximately 4:55 AM that day by a nursing assistant from an agency. Per the investigation, the resident was still breathing when the nursing assistant found them and reported the incident to Staff B, Registered Nurse (RN). The investigation report showed the resident had stopped breathing and no longer had a pulse when Staff B returned with Staff C, RN. The resident was lifted into bed and Staff B started CPR while Staff C contacted EMS. The investigation report showed when EMS personnel arrived one staff member was providing CPR, and another was standing by. EMS personnel noted that Resident 2 was on the bed with no rigid board behind them and required EMS personnel to transfer the resident back to a firm workable area. (continued on next page)

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

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 2:11 PM, Staff B stated Resident 2 was found on their knees on the floor next to their bed by a nursing assistant. Per Staff B, the resident stopped breathing during the time that additional staff were located to assist the resident back into bed. Staff B confirmed the resident was moved from the floor (firm surface) to the bed (soft surface) before CPR was started. Staff B did not provide additional information on why the resident was moved from their position on the floor to the bed before performing CPR. Additionally, Staff B stated the facility did not have an emergency cart/backboard for provision of CPR in bed. In an interview on [DATE] at 3:03 PM, Staff C stated when they responded to Staff B's request for assistance with Resident 2, the resident was laying on their left side on the floor between their bed and closet, with the nursing assistant standing over them. Staff C stated the resident was cold and limp when they picked the resident up, and they thought the nursing assistant and Staff B had found the resident already dead and had requested assistance to place them into bed for post-mortem care (after death care). Staff C stated Staff B checked on the resident's code status after they were lifted into bed and discovered they were a Full Code. Staff C stated Staff B directed them to call for EMS while Staff C and the nursing assistant began CPR. Staff C stated they knew where the emergency cart was but did not have enough time to go get it as they were calling for EMS, then opening the facility doors to direct EMS personnel to the resident's room. Per Staff C, the nursing assistant was from an agency and were not familiar with the facility. At 1:00 PM the same day, Staff A, Director of Nursing, stated an emergency cart with the required equipment was available on the unit Resident 2 resided on, and showed the surveyor an emergency cart stocked with a backboard. Per Staff A, Staff B and other staff new to the building were to be shown the location of necessary equipment such as the emergency cart on or before their first day. Staff A stated staff were expected to know the steps of effective basic CPR and to use the provided emergency cart/supplies if possible. Staff A stated the facility had identified concerns related to the provision of effective CPR to Resident 2 during the facility investigation. <CPR Certification> Review of Staff B, Registered Nurse's employee file showed they were hired on [DATE]. No CPR card was located in the employee file. Review of Staff D, Nursing Assistant's employee file showed they were hired on [DATE]. No CPR card was located in the employee file. In an interview on [DATE] at 1:00 PM, Staff A, Director of Nursing stated Staff B verbally reported they had a current CPR card but had not provided it to the facility. In a follow-up interview at 3:55 PM Staff A stated the facility had audited staff CPR credentials and noted Staff D did not have a CPR card. Staff A stated a CPR class had been provided in the facility and they would check to see if Staff D had attended that class. No additional information and/or documentation was provided. Reference: (WAC) [DATE] (1)(b); [DATE] (1)(a)