STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 38527 Based on interview and record review, the facility failed to ensure professional standards of practice were followed when discontinuing medications for 1 of 3 sampled residents (Resident 3) reviewed for medication management. This failure placed the resident at risk of not receiving correct medications, adverse health effects, and diminished quality of life. Findings included . Per the Washington State Board of Nursing (https://nursing.wa.gov/faq/can-registered-nurse-be-delegated-enter-medication-prescriptions-electronic-health-system-or-call; retrieved 07/31/2024) a registered nurse may enter medication prescriptions into an electronic health system under the direction of an authorized health care practitioner. Review of the 07/03/2024 hospital transfer orders for Resident 3 showed a medical provider at the hospital ordered the medication tizanidine (a muscle relaxant) daily at night and L-Lysine (an over-the-counter supplement) daily. Review of Resident 3's July 2024 MAR showed the tizanidine was not provided to the resident from 07/03/2024 through 07/07/2024. Per the MAR the order for tizanidine was discontinued on 07/08/2024. The L-Lysine was not provided to the resident from 07/03/2024 through 07/08/2024. Per the MAR the order for the L-Lysine was discontinued on 07/09/2024. (See F-755 Pharmacy Services for additional information.) The July 2024 progress notes for Resident 3 showed no documentation regarding either the tizanidine or the L-Lysine. A provider note dated 07/08/2024 showed the resident's care was reviewed; no medication changes were listed. A provider note dated 07/11/2024 showed the resident's care was reviewed and the provider discontinued the following medications/supplements: naproxen (pain medication), melatonin (supplement), magnesium citrate (supplement), hydroxyzine (antihistamine medication), and calcium carbonate (supplement). Uploaded into Resident 3's electronic medical record was a handwritten physician order dated 07/11/2024 which was signed by the nurse and the medical provider. The orders to discontinue naproxen, melatonin, magnesium citrate, hydroxyzine, and calcium carbonate matched the provider note. Orders related to the resident's tizanidine and L-Lysine were not included. (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
	505099	A. Building B. Wing	07/29/2024

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

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/29/2024 at 1:10 PM Staff A, Director of Nursing, stated they were not aware of the circumstances surrounding the discontinuance of the orders for Resident 3's tizanidine and/or L-Lysine. Staff A reviewed the resident's electronic record and stated that both orders were discontinued by nursing staff. Per Staff A, if orders were not electronically signed (by an authorized health care practitioner) then medical records staff should have copies of the handwritten orders confirmed/signed by the medical providers. In an interview on 07/29/2024 at 1:54 PM, Staff E, Medical Records, stated all current provider orders were scanned into residents' electronic records and they did not have unscanned (paper) orders for any residents. Staff E reviewed the (paper) orders and notes for the past month in both the medical records office and on the unit where Resident 3 resided and confirmed there were no unscanned orders for the resident. At 2:16 PM the same day Staff A stated there was a signed provider order for Resident 3 in the electronic record dated 07/11/2024 (see above). After reviewing the signed order Staff A confirmed the L-Lysine and tizanidine were not included and stated they would have to follow-up with nursing staff for additional information. No additional information was provided. Reference: (WAC) 388-97-1620 (2)(b)(i)(ii), (6)(b)(i); -1260 (4)(b)

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

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 38527 Based on observation, interview, and record review the facility failed to ensure pharmacy services were provided to meet the needs of 3 of 3 sampled residents (Resident 1, 2, and 3) reviewed for medication management. The failure to ensure medications were acquired and administered as ordered, and follow facility processes for medications not available, placed residents at risk for adverse events related to missed medications. Findings included . <Resident 1> Review of the 07/01/2024 admission assessment showed Resident 1 had a diagnosis of anemia (deficiency of healthy red blood cells that can cause fatigue and unexplained weakness) and required staff assistance with activities of daily living (ADLs). Review of a provider progress note dated 07/09/2024 showed Resident 1's representative reported the resident's nephrologist (doctor who specializes in kidney care) recommended continuing an anemia treatment the resident had been receiving prior to admission to the facility; Procrit injections. The note documented the resident's family would provide the medication given the cost. In a telephone interview on 07/26/2024 at 2:21 PM a representative for Resident 1 stated the facility had refused to provide the resident with their Procrit due to the cost, so the resident was not receiving the medication at the facility even though their blood count was low. The representative stated they had to arrange for the resident to be transported to their nephrologist's office to receive their ordered medication. Review of Resident 1's Medication Administration Record (MAR) for July 2024 showed an order for Procrit once daily every 14 days, beginning on 07/11/2024. On 07/11/2024 and 07/25/2024 a code NN was listed in the space where staff were to sign for administration of the injection. In an interview on 07/29/2024 at 10:24 AM Staff B, Registered Nurse (RN), stated the code NN on the MAR indicated that a medication was not given due to the medication being unavailable. Staff B stated they were filling in for the usual nurse for Resident 1 and did not have additional information about the resident's Procrit injection. In a telephone interview on 07/29/2024 at 12:25 PM a representative of the facility's pharmacy, Omnicare of Spokane, stated the facility had requested Resident 1's Procrit, and the billing department had sent over forms for the facility to complete as the pharmacy could not fill the order without additional information. Per the representative, the pharmacy had not received a response from the facility and the resident's Procrit order had not been filled as of that date. (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/29/2024 at 1:10 PM Staff A, Director of Nursing (DNS), stated it was not the facility's policy to refuse medications due to cost, and that high-cost medications requiring facility authorization were filled out and faxed to the pharmacy. Staff A stated they authorized Resident 1's Procrit but did not keep copies of the authorization and/or fax confirmation. Staff A stated once the resident's representative arranged for them to receive the medication from their nephrologist office they did not follow-up further with the pharmacy about filling the medication. <Resident 2> Review of the 07/18/2024 admission assessment showed Resident 2 had a diagnosis of diabetes (a metabolic disorder that affects how the body uses blood sugar) and used insulin to treat their condition. Review of the hospital transfer orders, dated 07/18/2024, showed Resident 2 was to use glargine (a long-acting insulin) daily at bedtime and lispro (a short-acting insulin) at mealtimes. Review of Resident 2's July 2024 MAR showed NA each day 07/18/20204 to 07/28/2024 in the space where staff were to sign for administration of the glargine. In an interview on 07/29/2024 at 10:17 AM Resident 2 stated they were not sure if they were getting all their medications. The resident stated they took glargine at home and that the nurses brought them some insulin, but they were not sure which ones. Observation on 07/29/2024 at 1:26 PM with Staff B, RN, showed Resident 2's short-acting insulin lispro was available on the medication cart, but the long-acting insulin glargine was not. Staff B and the surveyor also observed the medication room where extra medications were stored, including the refrigerator, and no glargine for Resident 2 was found. Staff B reviewed the resident's electronic record and stated the resident had an active order for glargine daily at bedtime, but they could not see that it had been ordered from the pharmacy. In an interview at 1:10 PM the same day, Staff A, DNS, stated if a resident's ordered medication was not available in the facility staff were to check the Omnicell (an automated medication dispensing cabinet, stocked with the most frequently used medications) first to see if it was stocked, and if not then call the pharmacy to see if it could be expedited. Staff A stated the pharmacy received medication orders electronically from the facility's computer system except for specific medications that required additional follow-up. Staff A stated they were not aware Resident 2's glargine was not available in the facility. In a follow-up interview at 2:16 PM Staff A stated Resident 2's order for glargine was present on admission and the pharmacy filled all other admission medication orders. Staff A stated the pharmacy should have sent the glargine with the resident's other medications and confirmed staff should have followed-up with the pharmacy when it was not received. Review of Resident 2's electronic record showed no documentation the provider had been notified of medication that was not available and not administered for the resident. A provider progress note dated 07/25/2024 showed the provider believed the resident was receiving glargine as ordered. <Resident 3> (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 07/08/2024 admission assessment showed Resident 3 had a diagnosis of Multiple Sclerosis (MS; a disease that affects the brain and spinal cord and causes nerve damage and communication problems) and required staff assistance with ADLs. Review of the hospital transfer orders, dated 07/03/2024, showed Resident 3 was to use tizanidine (a muscle relaxant) daily at night and L-Lysine (an over-the-counter or OTC supplement) daily. Review of Resident 3's July 2024 MAR showed the following: -On 07/03/2024 there was a blank space where staff were to document administration of the L-Lysine, code NN on 07/04/2024, 07/07/2024 and 07/08/2024, and NA on 07/05/2024 and 07/06/2024. The supplement was discontinued on 07/09/2024. -The resident's tizanidine was marked as NA on 07/03/2024, 07/04/2024, 07/05/2024, and 07/06/2024, and MR on 07/07/2024. Per the chart codes MR stood for Medication Refused. The tizanidine was discontinued on 07/08/2024. The July 2024 progress notes for Resident 3 showed no documentation regarding either the tizanidine or the L-Lysine. A provider noted dated 07/11/2024 showed the resident was requesting massage therapy for their MS (muscle stiffness and spasms occur in about 60-84% of people living with MS). In an interview on 07/29/2024 at 11:28 AM Resident 3 stated they had no idea if they were getting all the medications they were supposed to and denied refusing any medications. Resident 3 stated they took whatever medications the staff brought them and not all staff members told them what medications they were receiving. In an interview on 07/29/2024 at 12:25 PM Staff C and D, Central Supply, stated if staff needed an OTC supplement and/or medication for a resident that was not commonly stocked, they would write out a request on a clipboard. Staff C stated if a something was not available from their usual supplier they would look to see if it was available elsewhere. Staff C and D showed the surveyor the central supply room, which was stocked with common medications. Staff C stated L-Lysine was not currently stocked and had not been requested by nursing staff. Staff C and D provided a document titled, Items Needed, with dates from 07/01/20204 to 07/07/2024, which included a handwritten entry on 07/07/2024 for Lysine tablet. In a follow-up interview at 1:10 PM Staff C stated L-Lysine should come from the pharmacy. In a telephone interview on 07/29/2024 at 12:25 PM a representative of the facility's pharmacy, Omnicare of Spokane, stated Resident 3's tizanidine was not sent to the facility prior to the medication discontinuance and they did not have any notes to explain why not. The pharmacy representative stated the resident's L-Lysine had not been requested by the facility. In an interview on 07/29/2024 at 1:10 PM Staff A, DNS, stated they were not aware Resident 3 had not received their tizanidine and/or L-Lysine as ordered and were not aware of the circumstances surrounding the discontinuance of the orders for those medications/supplements. Staff A reviewed the resident's electronic record and stated that both orders were discontinued by nursing staff who were not currently in the building, and they would have to follow-up after investigating. (continued on next page)

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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	07/29/2024

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 2:16 PM the same day Staff A stated OTC medications and supplements could be ordered from the pharmacy if it was not available from the facility's usual suppliers. Staff A stated the L-Lysine should have been ordered from the pharmacy but was not sure if that was done and would follow-up after investigating. No additional information was provided. Reference: (WAC) 388-97-1300 (1)(a)(b)(i)(ii)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 38527 Based on interview and record review, the facility failed to ensure a system was in place in which residents' records were complete and accurate for 1 of 3 sampled residents (Resident 1) reviewed for accurate and complete medical records. The facility failed to ensure the medical record included consultant provider notes and medications administered during external provider visits. This failure to not maintain complete and accurate medical records placed residents at risk for medical complications, unmet care needs, and diminished quality of life. Findings included . Review of Resident 1's Medication Administration Record (MAR) for July 2024 showed an order for Procrit (injectable medication that stimulates red blood cell production for anemia treatment) once daily every 14 days, beginning on 07/11/2024. Per the MAR, the resident was not receiving the medication. (See F-755 Pharmacy Services for additional information.) Review of the July 2024 progress notes showed a 07/09/2024 provider progress note documenting that Resident 1's family would provide the Procrit. There were no further notes indicating that the medication was provided to the resident, either in the facility or at an external provider's office. In a telephone interview on 07/26/2024 at 2:21 PM a representative for Resident 1 stated the facility transported the resident to their nephrologist's (doctor that specializes in kidney care) office to receive the Procrit. Review of Resident 1's electronic medical record showed no documentation related to the resident's transport to an external provider and/or any treatment they received from their nephrologist. In an interview on 07/29/2024 at 1:10 PM Staff A, Director of Nursing, confirmed Resident 1 received their Procrit at their nephrologist's office, although they were not sure of the date(s). Per Staff A the facility did not receive any notes from the nephrologist's office showing care provided at the resident's visit(s). When asked how other providers would become aware of the treatments and services Resident 1 was receiving, specifically the Procrit, Staff A stated staff would have to hand-write the information into the resident's record. In an interview on 07/29/2024 at 1:54 PM, Staff E, Medical Records, confirmed the facility did not receive records from Resident 1's nephrologist's office following the resident's visit(s) while residing at the facility. Per Staff E, they had not been directed to follow-up and/or add any records to the resident's record to show the care and services they received. Reference: (WAC) 388-97-1720 (1)(a)(i)(ii), (2)(f)(m)