

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 11/06/2024
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	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>38527</p> <p>Based on observation, interview, and record review, the facility failed to ensure 1 of 8 sample residents (Resident 1) reviewed for abuse, was free from sexual abuse from another resident (Resident 2). This failure placed Resident 1 and other residents at risk for psychosocial harm and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the 09/09/2024 annual assessment showed Resident 2 was severely cognitively impaired, wandered one to three days of the assessment period, had delusions (false belief about external reality despite evidence to the contrary) and was able to walk with supervision.</p> <p>Review of the care plan initiated 09/06/2023 showed Resident 2 had poor physical boundaries with others and required staff to monitor their behavior.</p> <p>Per the 09/04/2024 quarterly assessment Resident 1 was severely cognitively impaired and independent with walking.</p> <p>Review of a 09/17/2024 facility investigation showed Staff D, Nursing Assistant, was walking down the hallway at approximately 2:45 PM that day and found Resident 2 in Resident 1's room. Per the report, Resident 1 was lying on their bed under the blankets and Resident 2 was next to the bed with one hand on Resident 1's (clothed) breast and the other hand under the blankets. Staff D told Resident 2 to stop and to leave; the resident responded with aggression towards Staff D and required two additional staff to assist in separating the residents. The investigation report showed Resident 1 stated they did not invite Resident 2 into their room.</p> <p>Observation on 09/30/2024 at 3:52 PM showed Resident 2's room was at the end of the hallway, furthest from the nurse's station. Resident 1's room was on the same side of the hallway, directly next to Resident 2's room. Resident 2 was in their room seated in their recliner with the door closed. When interviewed, the resident gave clear but incorrect answers to simple questions such as how long they had been residing in the facility. Resident 2 denied ever going into any other resident rooms and denied any inappropriate interactions with other residents.</p> <p>(continued on next page)</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
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 3:57 PM the same day Resident 1 was observed seated in the dining room conversing with other (unidentified) residents. Resident 1 was interviewed and stated they did not feel safe around too many people as they were used to living in the country with less crowding, however they did not have any concerns with the other residents at the facility. Resident 1 was pleasantly confused and did not recall the incident with Resident 2.</p> <p>In an interview on 09/30/2024 at 4:04 PM Staff C, Registered Nurse, stated Resident 2 had a history of wandering into other resident rooms and could be aggressive. Staff C stated they assisted to remove Resident 2 from Resident 1's room on 09/17/2024 due to the resident's aggression with Staff D. Staff C stated neither resident remembered the incident and Resident 1 had not had any changes in behavior afterwards.</p> <p>In an interview on 10/16/2024 at 10:25 AM Staff D stated on 09/17/2024 they began their shift on the unit Resident 1 and 2 resided on at 2:00 PM and were doing their initial checks on the residents when they found Resident 2 in Resident 1's room at 2:45 PM. Staff D stated Resident 1 was lying in their bed awake and unmoving while Resident 2 was seated in a chair next to the bed with their right hand on Resident 1's breast and their left hand under the covers in the area of Resident 1's genitalia. Staff D stated after they told Resident 2 to leave the resident responded that they were talking to Resident 1 and Staff D should mind their own business. Staff D stated Resident 1 did not have any changes in their behavior the night of the incident and had no negative responses to questioning about the incident. Per Staff D, Resident 2 had a prior history of wandering into female residents' rooms and staff were responsible to monitor the resident.</p> <p>Reference: (WAC) 388-97-0640 (1)</p>		

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>38527</p> <p>Based on interview and record review, the facility failed to ensure that direct care staffing information was accurate upon submission to the Centers for Medicare and Medicaid Services (CMS) for Quarter 1 of 2024 (January 1, 2024 through March 31, 2024) reviewed for Payroll Based Journal (PBJ - mandatory reporting of staffing information based on payroll data) submission. This failure caused CMS to have inaccurate data related to facility staffing levels and had the potential to impact resident care and services.</p> <p>Findings included .</p> <p>Review of the Certification and Survey Provider Enhanced Reports (CASPER) PBJ Staffing Data Report showed the facility reported data for Quarter 1, 2024 at a level lower than required by mandated staffing levels.</p> <p>In an interview on 10/16/2024 at 3:15 PM Staff B, Director of Nursing, stated the facility was having a lot of change during Quarter 1, 2024 and they did not think hours were being reported correctly.</p> <p>On 11/14/2024 at 8:10 PM Staff A, Operations Director, documented the facility had additional staffing data from Quarter 1, 2024 that was not reported. Per Staff A the missing staffing data related to staff who worked for external staffing agencies and provided invoices from the pertinent agencies.</p>		