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	03/18/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 38527 Based on interview and record review, the facility failed to notify the resident representative of an incident requiring transfer to the hospital experienced by 1 of 4 sampled residents (Resident 1), reviewed for accident hazards. This failure placed the resident at risk for delayed decisions for treatment by the legal representative. Findings included . Review of the 11/20/2024 annual assessment showed Resident 1 had significant cognitive impairments and was dependent upon staff for assistance with activities of daily living (ADLs). Per the 11/21/2024 care plan, Resident 1 had a surrogate decision-maker who was to be involved in all medical and financial decision making. Review of the December 2024 progress notes for Resident 1 showed on 12/05/2024 Staff B, Registered Nurse was notified by staff at the front desk that Resident 1 had a fall during an external appointment that day which resulted in low back pain and required a transfer to the hospital for evaluation. The note showed the resident was transferred back to the facility with no new physician orders. There was no documentation showing the resident's representative was notified of the incident. In an interview on 01/15/2025 at 11:57 AM, Resident Representative 1 (RR1) stated they were not aware Resident 1 had a fall on 12/05/2024 while at an appointment. RR1 further stated they were not aware the resident was even at an appointment and would not have agreed to the appointment due to the resident's confusion and history of refusal with the type of provider the appointment was scheduled with. In an interview on 01/15/2025 at 4:22 PM Staff A, Director of Nursing, stated a fall that occurred outside of the facility still needed to be reported to all responsible parties. Staff A reviewed Resident 1's medical record then confirmed that a fall requiring hospital transfer occurred at an external provider appointment on 12/05/2025. Per Staff A, the incident had not been reported to them and an investigation of the incident (which occurred more than a month prior to the interview) was still underway. Staff A was unable to provide additional information regarding notification to the resident's representative. Reference WAC 388-97-0320.

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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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. 38527 Based on observation, interview and record review, the facility failed to ensure 1 of 4 sampled residents (Resident 1), reviewed for accident hazards, received adequate supervision while at an appointment with an external provider. This failure placed the resident at risk of injury and unmet needs. Findings included . Review of the 11/20/2024 annual assessment showed Resident 1 had significant cognitive impairments and was dependent upon staff for assistance with activities of daily living (ADLs). Per the 11/21/2024 care plan, Resident 1 was at a high risk to fall, had a history of seizures (sudden uncontrolled electrical disturbance in the brain) and involuntary movements, and was confused. The care plan showed staff were to provide close monitoring of the resident, a specialty wheelchair that tilted back (to prevent falls from leaning forward), and required the assistance of two staff and a mechanical lift for transfers. Review of the December 2024 progress notes for Resident 1 showed on 12/05/2024 Resident 1 had an external appointment that day. Further review of the progress notes showed no documentation whether the resident was accompanied by either staff or family. Additionally, there was no documentation prior to the appointment showing an assessment was done to determine if the resident would be safe in their wheelchair, unaccompanied, out of the facility, for the duration of their appointment. In an interview on 01/14/2025 at 1:05 PM Collateral Contact 1 (CC1) stated Resident 1 arrived at their appointment on 12/05/2024 alone and confused. Per CC1, Resident 1 did not know their medical history or where they lived. Observation at 01/15/2025 at 10:29 AM showed Resident 1 was in their room on the locked memory unit. The resident was able to state their name but did not know how long they lived in the facility and was unable to recall what they ate for breakfast that day. In an interview on 01/15/2025 at 11:57 AM, Resident Representative 1 (RR1) stated they were not asked if they could accompany Resident 1 to an external appointment on 12/05/2024. RR1 further stated they were not aware the resident had an appointment scheduled that day and would not have agreed to the appointment due to the resident's confusion and history of refusal with the type of provider the appointment was scheduled with. RR1 stated they did not feel it was safe to send the resident to an external appointment alone. In an interview on 01/15/2025 at 12:10 PM Staff C, Nursing Assistant, stated Resident 1 was at high risk to fall and needed staff assistance to move in their wheelchair. Staff C stated staff could accompany residents to their appointments if they were notified in advance, but did not recall that any staff accompanied the resident on 12/05/2025. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview at 2:45 PM the same day, Staff E, Resident Care Manager, stated when the facility received notification of a resident appointment a transportation request sheet would be filled out and given to Staff D, Receptionist, for confirmation and scheduling of transportation. Staff E stated the interdisciplinary team (IDT: group of professionals from various health care disciplines) discussed upcoming appointments and if a resident was cognitively impaired, they would schedule a staff member or ask the resident's family to accompany the resident. Staff E stated they were out of the facility for a few weeks around the beginning of December, and they did not have additional information regarding Resident 1's 12/05/2025 appointment, including whether they were assessed to need supervision while out of the facility. Staff E stated Resident 1 was a high fall risk and had a fall the day prior to their appointment. At 3:13 PM the same day, Staff D confirmed they were responsible for scheduling appointments and transportation. Staff D stated they were not aware of each resident's mobility and cognitive status and relied on staff to notify them when a resident needed someone to accompany them to an appointment, which did not always occur. Per Staff D, Resident 1's 12/05/2025 appointment and transportation were scheduled by Staff E before Staff D started working at the facility. Staff D stated they were surprised the nursing staff let the resident go to the appointment when the transportation company arrived, and no one was scheduled to accompany the resident. In an interview on 01/15/2025 at 4:22 PM, Staff A, Director of Nursing, stated the facility would provide staff to accompany a resident to an appointment if it was needed, and that such information should be communicated to Staff D on the appointment/transportation form. Staff A stated they were not sure if Resident 1 needed staff to accompany them to their appointments and would defer to Staff E on the decision. Reference: (WAC) 388-97-1060 (3)(g)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 38527 Based on interview and record review, the facility failed to ensure 1 of 3 sampled residents (Resident 6), reviewed for medication administration, received medication as ordered by the physician. This failure resulted in a pattern of significant medication errors which placed the resident at risk for medical complications, unintended health consequences and diminished quality of life. Findings included . Review of the hospital discharge summary and orders dated 10/10/2024 showed Resident 6 was to receive fluconazole (oral antifungal medication) 600mg (milligrams; a unit of measurement) daily until 10/28/2024. The resident was to be closely monitored by nephrology (medical specialty that focuses on the kidneys) due to their advanced kidney disease. Per the October 2024 Medication Administration Record, Resident 6 received fluconazole 600mg twice daily on 10/11/2024, 10/12/2024, 10/13/2024, 10/14/2024, and 10/15/2024 (double the amount ordered). The resident's record showed they discharged from the facility on 10/15/2024. Review of the October 2024 progress notes showed no entries addressing the increase in Resident 6's fluconazole. In an interview on 03/18/2025 at 4:03 PM Staff F, Registered Nurse, stated when a resident discharged to the facility from the hospital their medication orders were processed by the Resident Care Manager. Staff F was unable to provide any information related to Resident 6's fluconazole. In an interview on 03/18/2025 at 4:15 PM Staff A, Director of Nursing, stated they started working at the facility in November and had identified concerns with the admission medication process shortly afterward. Staff A stated they now required two staff to review and verify the hospital discharge medication list was accurately entered into the facility's electronic system. Staff A reviewed Resident 6's record and confirmed the fluconazole administered to the resident did not match their hospital discharge orders, which constituted a medication error. Reference: (WAC) 388-97-1060 (3)(k)(iii)