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	11/12/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a complete and thorough investigation of an allegation of abuse for 1 of 3 sampled residents (Resident 3) whose records were reviewed for accident hazards. This failure placed the residents at risk for continued abuse or neglect.Findings included.Review of the October 2015 Nursing Home GUIDELINES or the Purple Book showed that the thoroughness of the investigation was a critical component of any investigation. The guidelines showed that for the facility to provide evidence of the thoroughness of the investigation, the information must be recorded. Each phase of a thorough investigation included two steps, data collection (which answered Who? What? and When? of the event) and data analysis (which summarized and analyzed the facts gathered to either establish reasonable cause for the incident or establish the need for further investigation). Within the first 24 hours of the allegation, part of the initial investigation included interviewing caregivers in the immediate area. Evidence collected during the facility's investigative activities included written, signed and dated witness statements by the individual providing the statement on a one-to-one basis, and as soon as possible after an incident/event, to avoid the witness becoming confused by hearing other accounts of what occurred. The statements described as much detail as possible of what the witness observed. The facility staff who received the statements signed and dated the document. Blank areas on the paper of such statements were crossed out and initialed.Review of a 09/22/2025 admission assessment showed Resident 3 admitted to the facility on [DATE] with medically complex conditions, including muscle weakness, difficulty walking and right foot drop (a condition where the muscles that lift the front part of the foot are weakened or paralyzed resulting in an inability to raise the foot, causing the toes to drag or slap on the ground while walking). The assessment showed the resident had intact cognition and was dependent on the staff for bed mobility and transfers. Review of Resident 3's care plan showed an instruction to the staff to provide substantial/maximal assistance of two persons, with the use of a sit-to-stand (a mechanical lift) for transfers between surfaces and for turning, repositioning, and bed mobility tasks (Date Initiated - 09/16/2025).In an interview and observation on 10/30/2025 at 12:41 PM, Resident 3 stated that when they first arrived at the facility, two staff assisted with transfers and bed mobility. Resident 3 stated that in the process of being assisted back to bed by Staff H, Nursing Assistant (NA), on 10/27/2025, they experienced pain. Resident 3 said Staff H grabbed their legs and, had them up in the air, pushing and trying to turn me with my legs up and pushing towards the windows. It was wrenching on my back and pelvic area. I yelled out. Resident 3 continued, [Staff H] was yelling at me telling me I was supposed to turn towards the window, but I can't turn the other way. I said, 'No.' [Staff H] just kept hollering, 'No, you keep going against me,' and kept yelling at me. Resident 3's family member was present during the interview, and both stated the family member was in the room and witnessed the 10/27/2025 incident with Staff H. Resident 3 said the 10/27/2025 incident with Staff H left them feeling with a combination of angry and hurting, physically hurting [residual right sided groin pain].In an interview on 11/03/2025 at 10:05AM, a Collateral Contact (CC) stated they heard Resident 3 issue a blood curdling scream as they approached their room on 10/27/2025. When the CC entered Resident 3's room they found Staff H in the room along with Resident 3 and another family member. The CC stated they visited Resident 3 daily, multiple times throughout the day. When asked how many staff they observed transfer and assist the resident with bed mobility, the CC stated, It's bad. I have never seen two people in there with [the resident] and I come down there quite often.In an interview on 10/31/2025 at 3:40 PM, Staff H stated they did not ask other staff to assist them with the lift transfer or position Resident 3 in bed and that they usually transferred or completed bed mobility for Resident 3 by themself, Always one person since taking care of [the resident]. Review of a 10/27/2025 schedule showed Staff H and Staff N, Licensed Practical Nurse (LPN), were assigned to Mountain View Unit, where Resident 3 resided. Review of an undated facility investigation showed the facility interviewed Resident 3, the CC, Staff H, other residents and other staff. The investigation showed the facility reviewed Resident 3's care plan and would provide staff education on bed mobility. The investigation concluded that the pain Resident 3 experienced was from bed mobility and/or positioning and that the way Staff H adjusted their legs resulted in pain. Staff H did not respond with professionalism and will be educated.Review of staff interviews showed no documentation the facility obtained a statement from Staff N. The facility interviewed 10 staff; all of the interviews were unsigned and undated and only one interview showed the title of the staff member. The interviews asked the staff three questions, What would you

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement interventions to prevent falls and associated injuries and injury during transfers or bed mobility for 3 of 3 sampled residents (Residents 1, 2 and 3) whose records were reviewed for accident hazards. This failure placed the residents at risk for falls, physical injury, and pain. Findings included.<Resident 1>Review of a 10/03/2025 annual assessment showed Resident 1 admitted to the facility on [DATE] with medically complex conditions including dementia with anxiety, a stroke, and pain in the right knee. The assessment showed the staff assessed the resident to be cognitively intact, did not reject care, used a wheelchair, and was dependent on the staff for toileting hygiene, bed mobility, transfers and dressing. The assessment showed the staff identified the resident was frequently incontinent of both bowel and bladder and not on a toileting program and had one fall since the prior assessment.In an interview on 10/24/2025 at 2:58 PM, Resident 1's representative (RR) stated the resident fell and hit the back of their head while participating in an activity class in the facility. The RR stated they were informed by the facility staff that the Resident 1 attempted to stand up on their own with nobody around and fell. The RR stated that this was the resident's third fall within a month. In an observation and interview on 10/27/2025 at 10:31 AM, Resident 1 sat in their wheelchair in their room. A grab bar (a sturdy mounted bar that provides support and stability for people who have difficulty with balance or limited mobility) was attached to the upper right side of the bed frame. Resident 1 stated, I hurt my back yesterday (10/26/2025) and explained they, tried going from one chair to the other and I missed, and I don't know how come I missed but I just did. It was in the dining room. Resident 1 said they fell before lunch. Observed was a one centimeter (unit of measurement) raised area about two inches above the left eye surrounded by a faint bruise. When asked if they had any prior falls, the resident stated, Once before. I pulled a wooden toy cat down on top of myself. I had a great amount of blood. I don't know if I lost my balance, I just reached for it, and it fell off and hit me in the head. The resident then said they did not fall at that time. When asked what the facility did to help prevent them from falling, Resident 1 stated They don't let me sit from one chair to the other. Resident 1 was observed wearing loose-fitting slippers and stated they did not fit well, They're bigger than they should be. Once in a while they slip off my feet.In an interview on 10/27/2025 at 10:55 AM, Staff B, Nursing Assistant (NA), stated they became aware of what interventions or assistance residents required for care by reviewing the Kardex (an abbreviated form of the comprehensive care plan with pertinent instructions and information for the NA), day to day interactions with the resident, or asking the nurse. Staff B said they were aware Resident 1 fell two or three weeks ago, and their memory was, Slipping a little, more forgetful and delusional [fixed, false beliefs that are maintained even when presented with evidence to the contrary]. Staff B stated Resident 1 would sometimes call for assistance for completion of Activities of Daily Living. In an interview on 10/27/2025 at 10:59 AM, Staff C, NA, stated they reviewed a resident's Kardex and received information from the nurse to stay updated of care plan changes. Staff C said the Nurse Managers made the staff aware when care plan changes occurred. Staff C said Resident 1 had, fallen a couple times. One [fall] from bed and one in their wheelchair reaching for something in their room. Staff C said the falls did not happen on their shift and was aware that the care plan recently changed with the instructions to the night shift aides to get the resident up at 5:00 AM if the resident chose to. In an interview on 10/27/2025 at 12:00 PM, Staff D, Licensed Practical Nurse (LPN), stated they determined a resident's risk for falls by asking the NA or observing the resident. Staff D said they witnessed Resident 1 fall once, maybe last month or this month when the resident slipped in the room. Staff D said they did not know what changed with Resident 1's care plan after the fall they witnessed, because I float throughout the facility. When asked how they became aware a resident's care plan changed, Staff D said, I really don't know and that they only worked as needed. Staff D said none of the residents in the specific unit Resident 1 resided were consistent with using the call light to ask for assistance.In an interview on 10/31/2025 at 9:15 AM, Staff E, LPN, stated that Resident 1 needed extensive assistance from the staff for transfers in and out of their bed or wheelchair, but recently I was told [the resident] got up on [their] own volition [will] out of bed. Staff E said the Night Shift staff awakened Resident 1 twice at night around midnight and 4:00 AM because the resident did not call the staff and was unaware of their need to go to the bathroom or of their incontinence. Staff E said Resident 1 seemed to more actively try to get out of bed or their wheelchair without assistance, which was new for the resident, and normally did not walk on their own. Staff E said they

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure adequate staffing was maintained to provide consistent and required assistance during bed mobility and use of a mechanical lift (a device that uses mechanical means, like gears, chains, or cables driven by a motor, to raise and lower persons and moving individuals with limited mobility safely) for 1 of 3 sampled residents (Resident 3) reviewed for accident. In addition, the facility failed to ensure the Director of Nursing maintained a license that authorized them to work as a Registered Nurse (RN) in the State of [NAME]. These failures placed the resident at risk for unmet care needs.Findings included.<Insufficient Staffing> Review of a [DATE] admission assessment showed Resident 3 admitted to the facility on [DATE] with medically complex conditions, including muscle weakness, difficulty walking and right foot drop (a condition where the muscles that lift the front part of the foot are weakened or paralyzed resulting in an inability to raise the foot, causing the toes to drag or slap on the ground while walking). The assessment showed the resident had intact cognition and was dependent on the staff for bed mobility and transfers. Resident 3's care plan instructed the staff the resident required substantial/maximal assistance of two persons, with the use of a sit-to-stand (a mechanical lift) for transfers between surfaces and for turning, repositioning, and bed mobility tasks (Date Initiated - [DATE]). In an interview and observation on [DATE] at 12:41 PM, Resident 3 stated that in the process of being assisted back to bed by Staff H, NA, on [DATE], they experienced pain. The resident stated Staff H transferred them from the wheelchair to the bed with the use of a EZ lift (a sit-to-stand mechanical lift that helped the person from a sitting to a standing position). Additionally, Staff H helped the resident from the seated position at the edge of the bed and into bed by themself. Resident 3 stated, I can't help with my upper body, and I flop to my left side, and I can't move my shoulder. Resident 3 said Staff H grabbed their legs and, had them up in the air, pushing and trying to turn me with my legs up and pushing towards the windows. It was wrenching on my back and pelvic area. I yelled out. In an interview on [DATE] at 10:05AM, a Collateral Contact (CC) stated they heard Resident 3 issue a blood curdling scream as they approached their room on [DATE] and found only Staff H in the room assisting the resident with positioning in bed. The CC stated they visited Resident 3 daily, multiple times throughout the day. When asked how many staff they observed transfer and assist the resident with bed mobility, the CC stated, It's bad. I have never seen two people in there with [the resident] and I come down there quite often. Review of an [DATE] census form showed Resident 3 resided in the Mountain View Unit. The census showed 14 residents living in the unit. Review of Staff Schedule sheets from [DATE] to [DATE] showed one nurse and one NA were assigned to the Mountain View Unit on all three eight-hour shifts. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 3:40 PM, Staff H stated two people were required when mechanical lifts were used, but with a sit-to-stand not always. It just happens that way. Staff H said she did not ask other staff to assist them with the lift transfer or help Resident 3 position in bed and that they usually transferred Resident 3 by themself. Staff H stated they cared for 15 to 18 residents in the Morning View Unit, including providing their assigned two or three showers. Staff H said they did not have enough staff to care for the residents in the Mountain View Unit, because the nurse was busy with meds [medications] and they're pretty busy doing what they're doing. Staff H said that on [DATE], when Resident 3 required transfers and bed mobility assistance, they didn't ask the nurse for help because the nurse, was nowhere to be found. I find myself doing two- person transfers alone. Staff H said, You know, I thought the mechanical lifts was supposed to be two persons [assistance] but there's times where it's not. In an interview on [DATE] at 3:16 PM, Staff J, who wished to remain anonymous, said that when they could not find anyone to help them transfer a resident, they would physically pick them up and put them in bed but only if they were semi-mobile. Staff J said that every once in a while they would transfer a resident in a sit-to-stand by themself and, It all depends on if the nurse is available or the nurse is nice. Usually, we have to go to one of the other halls then ask the other aides for help and if they're not too busy, to come help. Staff J said they were assigned to 14 residents in the Mountain View Unit, provided showers and assisted residents to eat. Staff J said when they could not find a nurse or aide to help them with mechanical lift transfers, they would ask Staff M, Human Resources, for assistance. In an interview on [DATE] at 3:26 PM, Staff K, Registered Nurse (RN), stated they were assigned to 14 residents. Staff K stated there was not enough staff to care for the residents in the Mountain View Unit because they were assigned only one aide and Staff K had, 13 blood sugars to do and 5 major dressing changes. Staff K said they also had to help pass dinner trays and assist the residents to bed and to the bathroom or with their toileting needs. Staff K said, I have to help the aide out. It's too much for one person. I don't sit down until after report for night shift and don't get out of here until midnight or 1:00 AM and then I get in trouble because I cannot not be late. In an interview on [DATE] at 3:10 PM, Staff L, NA, said they assisted Resident 3 with no help for bed mobility. When asked if the facility had enough staff to care for the residents, Staff L said, Truthfully no. It's hard to complete the mechanical lift transfers. I try my best to go get a helper because you never know what can happen. Staff L said they took care of 14 residents, to include giving them showers and it was hard to get breaks. The above findings were shared with Staff A, Director of Nursing (DON), on [DATE] at 1:43 PM. Staff A said Resident 3 required two-person assistance for bed mobility and transfers because of weakness to the legs and decreased mobility. When asked if the staff brought concerns about staffing needs on Mountain View Unit, Staff A said, They have recently because the acuity [the severity of a resident's condition and the resources necessary to provide appropriate care] is getting pretty high. Staff A said they had no knowledge the staff needed additional staff and would provide a solution had they known. Staff A said that two months ago they provided the staff in the facility walkie-talkies so they could access and assist each other more readily and that ancillary staff like Staff M assisted the staff with cares. Staff A stated Staff M was a NA. Review of the State of [NAME] (WA) Department of Health provider credential search on [DATE] at 2:36 PM showed Staff M had a credential for a NA (Registration) that expired on [DATE]. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Registered Nurse as Director of Nursing> Review of the Idaho Department of Professional Licensing (DOPL) Online Services on [DATE] at 7:14 AM showed that Staff A's multistate registered nurse (RN) license (an agreement between states that allowed a professional to practice in all participating states with a single license from their home state) had expired on [DATE]. A Registered Nurse Temporary License was issued on [DATE], 10 days later, and was current. Review of a NURSYS (the national database for nurse licensure verification and discipline, maintained by the National Council of State Boards of Nursing, provided primary-source data from United States boards of nursing for license verifications for nurses and institutions) showed Staff A had a multi-state RN license that expired on [DATE]. In a telephone interview on [DATE] at 2:44 PM, a staff member from the Idaho Department of Professional Licensing stated that an RN temporary license only granted authority to practice in the State of Idaho, not Washington State. The staff member confirmed Staff A's license was a temporary license issued by the state of Idaho. In a telephone interview on [DATE] at 4:15 PM, a staff member from the WA Board of Nursing stated that in order for an out-of-state RN to be able to work in Washington State they must have a permanent out-of-state license and apply through the endorsement process (a request for the local state nursing board to verify the nursing credentials) or a permanent multi-state (compact) license from another state; having a temporary Idaho license did not allow an individual to practice working as an RN in Washington State. They further added that multi-state licensure was granted based on the state of residence and that a person's driver's license state of residence must match the RN license state of residence. During an interview on [DATE] at 10:54 AM, Staff A stated that when they had obtained their temporary nursing license, they were told it was a multi-state license, just as their previous license (with the same license number). When informed that temporary nursing licenses were only valid in the state they were issued by, Staff A stated they must have been misinformed. During an interview on [DATE] at 12:50 AM, Staff O, Administrator was informed that Staff A's credentials were not valid in the state of [NAME]. Staff O confirmed another staff RN to act as the Director of Nursing and provided their current credentials. During an interview on [DATE] at 10:12 AM, Staff A and Staff O acknowledged that Staff A needed either a current [NAME] or multi-state license to practice as an RN in the facility. Staff A provided a copy of their newly issued [NAME] RN license, issued on [DATE]. WAC 388-97-1080 (1)