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Form Approved OMB
No. 0938-0391

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 08/13/2024

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 0550

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46033

Based on observation, interview and record review, the facility failed to ensure residents were provided care in a dignified manner for 3 of 4 sampled residents (4, 58, 67) reviewed for resident rights. Specifically, Resident 4 was referred to as a feeder, and Residents 58 and 67 required use of urinary catheters (a tube inserted into the bladder that allowed urine to drain) and the urine collection bags were not covered and were visible to the public. This failure put the residents at risk for embarassment and decreased quality of life.

Findings included .

<Resident 4>

A 06/04/2024 quarterly assessment documented Resident 4 had diagnoses including traumatic brain injury (TBI), and spastic hemiplegia (muscles on one side of the body are in a constant state of contraction) affecting their left dominant side. Resident 4 was moderately cognitively impaired and was dependent on staff for most activities of daily living (ADLs).

The comprehensive care plan documented Resident 4 was at nutritional risk and required adaptive equipment at meals. Staff were instructed to provide feeding assistance, monitor for signs of choking or swallowing difficulties, use sponge-handled utensils, a blue lipped plate, and feeder cups.

A 03/01/2024 annual nutrition evaluation by the Registered Dietician documented Resident 4 ate 76-100% of their meals, their appetite was good, and they required feeder cups with their meals.

On 08/01/2024 from 11:27 AM to 12:28 PM, the noon meal was observed in the main dining room. Residents gathered around tables and staff began distributing coffee or other drinks. Resident 4 was assisted to the dining room in their wheelchair and seated at a table with another male resident. At 11:54 AM, a staff member, later identified as Staff L, MDS Coordinator (MDS, a tool used to assess resident care needs), called the staff in the dining room together and instructed the nursing assistants to remember to serve everyone at the same table, then serve the feeders last. Staff L stated once staff put a plate in front of the feeders they would have to sit down with them, so do them last.

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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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Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During an interview on 08/09/2024 at 12:10 PM, Staff N, Nursing Assistant, who had been present in the dining room on 08/01/2024, stated she had worked at the facility for [AGE] years and the residents were like family. When asked what a feeder cup was, Staff N stated they did not call them that; they did not like that term. Staff N stated they referred to the cups as sippy cups. These were cups with handles and a lid so that a resident did not spill their drink. Staff N stated they did not like the term feeder, it was not a dignified way to refer to a resident. Staff N referred to residents that needed fed as residents needing assistance.

During an interview on 08/13/2024 at 10:41 AM, Staff M, Resident Care Manager, observed Resident 4's care plan with the surveyor. When asked what a feeder cup was, Staff M stated, if it was what they thought, it was a cup with handles, like a sippy cup. Staff M stated feeder was not a term they used to refer to residents and they were a little taken aback. They stated it was not dignified.

During an interview on 08/13/2024 at 12:35 PM, Staff L stated they remembered talking to staff in the dining room on 08/01/2024. Staff L stated they used the term feeder because they were unaware what the correct term was for those residents who needed assistance being fed.

<Resident 58>

A review of the 05/29/2024 admission assessment documented Resident 58 had diagnoses including benign prostatic hyperplasia (BPH, prostate gland enlargement that can cause urination difficulty) and neurogenic bladder (bladder function is disrupted by injury or disease). Resident was cognitively intact and had an indwelling urinary catheter.

During the noon meal observation on 08/01/2024 beginning at 11:27 AM, Resident 58 was observed seated in their motorized wheelchair. They entered the dining room and positioned themself at one of the tables. Resident 58 was wearing a pair of shorts and the collection bag for their urinary catheter was observed hanging on the frame of their wheelchair between and behind their legs. The collection bag was not covered and urine was visible. The bag remained in this manner throughout the meal.

During an interview on 08/06/2024 at 11:37 AM, Resident 58 was observed with a cloth cover over their urine collection bag. Resident 58 stated his urine collection bag had not been covered when they ate in the dining room on 08/01/2024. Resident 58 stated urine had leaked on the cover they used and the cover had been sent to the laundry to be washed. They stated they did not have another cover, so they had to go to the dining room without one. Resident 58 stated it bothered them; they did not feel like everyone needed to see their urine and the cover gave them some privacy. They stated it would have been helpful to have a second one available.

46115

<Resident 67>

Per the 06/28/2024 admission assessment, Resident 67 had diagnoses which included prostate cancer and chronic urinary retention and utilized a urinary catheter.

On 08/01/2024 at 9:25 AM, Resident 67 was observed sitting in a chair in their room. The urine collection bag of their catheter was lying on the floor, not covered by a privacy bag.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional observations of the collection bag without a privacy bag were observed on 08/01/2024 at 1:58 PM, 08/02/2024 at 9:50 AM, 08/06/2024 at 8:31 AM and 2:13 PM and 08/07/2024 at 10:33 AM. In an interview on 08/07/2024 at 3:14 PM, Staff D, Nursing Assistant, stated urinary catheter bags needed to be stored in privacy bags and this was a dignity issue. Staff D added the resident transferred themself and their catheter would be found on the floor often. During an interview on 08/13/2024 at 8:57 AM, Staff B, Director of Nursing stated the urine collection bag should have been placed in a privacy bag and it was a dignity issue. Reference: WAC 388-97-0180 (1-4)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 46115 Based on interview and record review, the facility failed to investigate a fall for 1 of 3 sampled residents (285), reviewed for falls. This failure placed the resident at risk of further falls, injury, and a diminished quality of life. Findings included . Review of the 05/17/2021 facility policy titled, Fall Response and Management documented nursing staff was to complete a post fall investigation, notify the physician, and communicate the event and intervention changes to the staff. According to the 08/04/2024 admission assessment, Resident 285 required partial to moderate assistance with activities of daily living such as transferring and toileting and was able to make their needs known. In an interview on 08/06/2024 at 8:44 AM, Resident 285's family member stated the resident had fallen on 08/02/2024 when staff had assisted him to the toilet. The family member stated the resident was standing in the bathroom, fell back and hit their hip on the toilet and experienced a lot of pain and was not getting any better. During an interview on 08/08/2024 at 8:38 PM, Staff D, Nursing Assistant, stated Resident 285 stood at the bars in the bathroom and as they turned, they stiffened and fell backwards, hitting their tailbone on the back of the toilet seat. Staff D denied this was a fall as the resident did not hit the ground. In an interview on 08/08/2024 at 8:47 PM, Staff E, Licensed Practical Nurse, stated Resident 285 had no falls since admission to the facility. Staff E stated the resident had an x-ray related to complaints of pain after hitting their hip on the toilet and it was negative for any type of injury. A review of the accident and injury log for August 2024 found no entry for a fall for resident 285. Per record review, the physician's assistant was not notified of the fall until 08/07/2024, five days after the fall occurred. During an interview on 08/12/2024 at 12:39 PM, Staff B, Director of Nursing, stated a fall is an unintentional change in position and should have been reported and investigated after the occurrence. Reference WAC: 388-97-0640 (6)(a)(b)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 37544 Based on interview and record review, the facility failed to ensure 1 of 5 sampled residents (23) reviewed for Pre-Admission Screening and Resident Review (PASARR, an assessment completed to determine whether a resident with a diagnosis of a serious mental illness needed specialized mental health services) was completed accurately and prior to admission as required. In addition, the facility failed to ensure a new PASARR assessment was completed when Resident 23 had changes in their mental health diagnoses. These failures placed the resident at risk for unmet care needs. Findings included . <Resident 23> Resident 23's admission record documented the resident admitted to the facility with a mental health diagnosis of paranoid personality disorder, a mental health disorder characterized by irrational and persistent beliefs that people were trying to harm, deceive or exploit them. Review of Resident 23's record showed a PASARR was completed by Staff G, Social Worker, on 06/26/2023, four days after the resident was admitted to the facility. Section 1A of the assessment documented Resident 23 had no serious mental health indicators and the box for personality disorders was unchecked. Additional review of Resident 23's record documentation that additional mental health diagnoses of anxiety and depression were added on 11/04/2023 after the resident experienced changes in their mental health. Further record review found no documentation that the PASARR had been redone to assess if the resident needed specialized mental health services. In an interview on 08/06/2024 at 3:11 PM, Staff B, Director of Nursing stated PASARR needed to be completed prior to admission to the facility and updated when changes occurred. Reference (WAC): 388-97-1915 (1)(2)(a-c)

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

37544

Based on observation, interview and record review, the facility failed to ensure care plan interventions were implemented for 3 of 19 sampled residents (1, 283, 4) reviewed for care planning. Failure to ensure nutritional interventions for Residents 1 and 4, and vascular ulcer interventions for 283 were followed placed the residents at risk for poor nutritional intake, potential skin breakdown, unmet care needs, and a diminished quality of life.

Findings included .

<Resident 1>

The 07/08/2024 annual assessment documented Resident 1 was able to make their needs known to staff, had impaired range of motion to an upper extremity on one side of their body, and needed set up or clean up assistance from nursing staff to eat.

On 08/01/2024 at 10:15 AM, Resident 1 was observed lying in their bed in their room talking with their representative. The representative stated Resident 1 was at risk for choking, would put too much food on the spoon when eating and the staff were supposed to supervise for safety, but it wasn't being done. In response to the comment, Resident 1 made a thumbs up gesture with their left hand, said yes, and shook their head up and down.

Review of the ADL care plan documented Resident 1 tended to eat too quickly, took bites of food that were too big, and then would choke. Interventions were implemented on 08/25/2020 and instructed nursing staff to monitor the resident for safety, and cue as necessary to ensure proper intake. A revision on 07/05/2023 instructed nursing staff that Resident 1 needed assistance with the first bite, and then was able to feed themself.

Review of the nutrition care plan informed nursing staff that Resident 1 was at risk for choking. A revision to the interventions on 01/22/2014 instructed nursing staff to serve the resident one food item at a time to avoid choking from eating too fast, and staff were to provide supervision and assistance at meals.

On 08/01/2024 at 11:38 AM, Resident 1 was observed sitting in their wheelchair in their room with the beside tray table placed in front of them. When asked if they were ready for lunch, Resident 1 made a thumbs up gesture.

On 08/01/2024 at 11:59 AM, Resident 1 was served their lunch tray in their room and began eating independently. The tray contained a tuna sandwich, shredded lettuce salad, soup with soda crackers, milk and coffee. No nursing staff were present in the room, and no nursing staff were supervising the resident eat.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/01/2024 at 12:05 PM Staff W, Nursing Assistant, was asked if Resident 1 needed assistance or supervision when eating. Staff W stated no, the resident was able to eat/feed themselves independently and did not need assisted or supervision. When asked how they knew what type of assistance or care needs a resident had, Staff W stated the residents care plans informed them. At 12:11 PM, Staff S, Nursing Assistant, asked Resident 1 how they were doing, Resident 1 made the thumbs up gesture, and Staff S then left the room. When asked if Resident 1 needed assistance or supervision during meals, Staff S stated Resident 1 needed set up assistance, but was able to feed themself. Resident 1 continued to eat alone in their room without assistance or supervision until 12:17 PM. On 08/06/2024 at 11:48 AM, Resident 1 was observed sitting in their wheelchair in their room. An unidentified nursing staff entered the room and placed Resident 1's lunch tray on the bedside tray table in front of them, then left the room, and Resident 1 began to eat. The tray contained mashed potatoes without gravy, ground meat, shredded lettuce salad with cheese on top, canned peaches, milk, and coffee. During the continuous observation from 11:48 AM until Resident 1 stated they were finished with the meal at 12:03 PM, a time of 15 minutes, none of the nursing staff assisted or supervised Resident 1. In an interview on 08/13/2024 at 2:02 PM, when informed of the meal observations and the lack of assistance and supervision for Resident 1, Staff B, Director of Nursing, stated the expectation was that care plan instructions and interventions were followed. 46033 <Resident 4> A review of the record showed Resident 4 had diagnoses including hemiplegia affecting the left dominant side (paralysis affecting one side of the body), difficulty swallowing, and nutritional deficiency. The 06/04/2024 quarterly assessment documented Resident 4 was moderately impaired cognitively, had no behaviors, did not reject care and had weight loss but was not on a prescribed weight loss regimen. The 12/06/2023 Activity of Daily Living (ADLs) Care Plan documented Resident 4 had a self-care deficit. The care plan instructed that Resident 4 needed to be out of their room for all meals and in the dining room as they were able to tolerate. Resident 4 required assistance of one staff for eating and if unable to tolerate the dining room, staff were to ensure the resident was provided supervision in the hallway. Staff were to monitor for signs of difficulty chewing or swallowing. Provider orders dated 07/22/2024 documented Resident 4 was to receive a regular diet with level 3 advanced textures (moist foods in bite-sized pieces, and without hard, sticky or crunchy foods) . A 07/23/2024 Diet Requisition Form completed by Staff FF, Speech Therapist, documented Resident 4 inconsistently received the Level 3 diet, and at times had regular textures. Resident 4 was appropriate for the Level 3 diet because of poor safety awareness and increased impulsivity. The form highlighted with an asterisk that Resident 4 needed to be in the hall for meals, not in their room. (continued on next page)

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

A review of nursing progress notes from 07/14/2024 to 08/12/2024 documented Resident 4 refused to get out of bed for breakfast once, on 07/26/2024.

On 08/02/2024 at 9:03 AM, Resident 4 was observed lying in bed in a hospital gown after they had eaten breakfast. When asked about breakfast, Resident 4 requested more coffee, and held up four fingers.

On 08/06/2024 at 8:31 AM, Resident 4 was observed sitting in bed. The head of the bed was elevated, and Resident 4's head bent forward so that their chin was positioned almost on their chest. A nursing assistant sat to the right side of the resident and was feeding the resident. Resident 4 was also observed in bed being assisted with their breakfast on 08/09/2024 at 9:12 AM, and on 08/12/2024 at 8:22 AM.

During an interview on 08/12/2024 at 10:49 AM, Staff M, Resident Care Manager, stated they were new to their position and were unsure why Resident 4's care plan instructed staff to ensure the resident was in the dining room for meals. They were unsure if it was because the resident refused to get up, or if it was because the resident was at risk for aspiration (when food or fluid enters the airway or lungs by accident).

During a follow-up interview on 08/13/2024 at 10:02 AM, Staff M stated it was possible staff had not gotten Resident 4 out of bed because of a history of being verbally aggressive. If the resident refused to get out of bed, it was to be documented in the progress notes. Staff M stated the care plans were updated quarterly and any of the nurses were able to update the care plans.

46115

<Resident 283>

The 07/15/2024 admission assessment documented Resident 283 was able to make their needs known to staff and had ulcers to their left lower extremity.

The 08/02/2024 care plan, instructed nursing staff to off load the pressure (keep the lower extremities from resting on a surface) from Resident 283's heels.

During an observation on 08/06/2024 at 11:58 AM, Resident 283 was resting in bed with their heel resting on the mattress, no offloading of the lower extremity was provided.

Subsequent observations of Resident 283's left lower extremity without offloading were made on 08/06/2024 at 2:15 PM, 08/07/2024 at 10:35 AM, 08/07/2024 at 1:10 PM, 1:35 PM and 3:02 PM, 08/08/2024 at 8:29 AM and 08/12/2024 at 5:32 AM.

During an interview on 08/08/2024 at 2:24 PM, Staff GG, Licensed Practical Nurse, stated Resident 283 moved themselves in bed and needed reminders and checked on to ensure their lower extremity was offloaded.

In an interview on 08/12/2024 at 12:46 PM, Staff B, Director of Nursing, stated offloading needed to be provided for any resident with wounds unless they declined to so and that needed to be documented.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: WAC 1020(1), (2)(a)(b)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 46115 Based on interview and record review, the facility failed to complete a discharge summary, including a recapitulation of the resident's stay as required, for 1 of 1 sampled residents (19), reviewed for discharge. This failure placed the resident at risk for having an incomplete medical record. Findings included . The 07/08/2024 quarterly assessment documented Resident 19 was cognitively intact to make decisions regarding care and needed set up assistance from staff to complete activities of daily living. A record review documented Resident 19 was admitted to the facility for physical and occupational therapy, following a urinary tract infection and sepsis (a life-threatening complication of an infection). A review of the progress note on 07/30/2024 documented Resident 19 was discharged to another facility. The 07/30/2024 discharge summary completed by Staff F, Physician Assistant, documented the resident discharged but did not state where to, nor did the summary provide a recapitulation of the care and services the resident received while at the facility. In an interview on 08/12/2024 at 12:35 PM, Staff B, Director of Nursing, stated a recapitulation of stay/discharge summary needed to be done by the provider when a resident discharged from the facility. Reference: WAC 388-97- 0080 (7)(a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 37544 Based on observation, interview, and record review, the facility failed to consistently provide bathing and/or grooming for 3 of 3 sampled residents (1, 43, 5), reviewed for activities of daily living (ADLS). This failure placed the residents at risk for poor personal hygiene, unmet care needs and a diminished quality of life. Findings included . <Resident 1> The 07/08/2024 annual assessment documented Resident 1 had diagnoses which included paraplegia, a condition that caused the loss of muscle function in the lower half of the body. In addition, the assessment documented the resident was dependent on nursing staff to complete activities of daily living for bathing and personal hygiene such as shaving. On 08/01/2024 from 9:37 AM to 9:50 AM, Resident 1 was observed lying in bed in their room. The resident's hair was greasy in appearance and there was long facial stubble present. When asked if they were being bathed, and assisted to shave, the resident stated no, and made a thumbs down gesture. Resident 1's representative was present at the time and stated it had been about three weeks since the resident had been bathed, and staff should be shaving the resident, but it wasn't being done. The representative stated they had purchased an electric razor as well as safety razors for the resident, and opened the mirrored cabinet above the sink in the resident's room which contained the shaving supplies. Subsequent observations throughout the day on 08/01/2024 from 09:50 through 1:15 PM remained unchanged, with Resident 1's hair being greasy and long facial stubble present. On 08/06/2024 at 8:36 AM, Resident 1 was observed lying in bed, no facial stubble was present, and their hair appeared greasy. When asked if they had been shaved, the resident made a thumbs up gesture. When asked if they had also received a bath, the resident laughed and stated no. At 10:44 AM and 3:48 PM, the resident was observed to still have greasy hair. On 08/09/2024 at 8:27 AM, Resident 1 was observed lying in bed eating breakfast. The resident stated they had been shaved, but still had not been bathed. Review of the 01/02/2014 ADL care plan documented Resident 1 needed assistance with bathing and shaving, was to be bathed up to twice a week, and as needed. The interventions also instructed nursing staff that the resident was to be shaved when bathed, and as needed. Review of the bathing/grooming records for the last 30 days from 07/08/2024 through 08/09/2024 found no documentation that Resident 1 had been bathed. A review on 08/09/2024 of the Documentation Summary Report for tasks found the following: June 2024, the resident was bathed on 06/01/2024, and 06/12/2024; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	July 2024, the resident was bathed on 07/24/2024, and 07/31/2024; and August 2024, the resident had been bathed on 08/07/2024. In an interview on 08/12/24 at 7:52 AM, Staff V, Nursing Assistant, stated there used to be a bath team that did the resident's bathing, some residents took 40 minutes to bathe properly, and the aides tried their best to get the resident's bathed twice a week, but it was difficult to get residents bathed, and complete all other assigned tasks and care needs. <Resident 43> The 07/11/2024 quarterly assessment documented Resident 43 needed assistance from nursing staff to complete activities of daily living such as bathing. In an interview on 08/06/2024 at 3:58 PM, Resident 43 stated they were not getting bathed as often as they would like. When asked how often they were bathed, Resident 43 stated once a week would be nice, but that wasn't happening. Review of the 10/17/2023 ADL care plan documented Resident 43 needed moderate assistance from one nursing staff for bathing, and showers were to be given twice a week. Review of the bathing/shower record for the past 30 days from 07/11/2024 through 08/01/2024 documented Resident 43's scheduled bath days were on Monday and Thursday. No documentation was found that the resident had been bathed. A review on 08/09/2024 of the Documentation Summary Report for tasks found the following: June 2024, the resident was bathed on 06/19/2024 and 06/26/2024 for a total of two times out of eight times scheduled. July 2024, the resident was bathed 07/03/2024, 07/06/2024, 07/17/2024, and 07/24/2024 for a total of four times our of the nine times scheduled; and August 2024, the resident had been bathed on 08/07/2024. In an interview on 08/12/24 at 07:59 AM, Staff W, Nursing Assistant, stated the residents were not getting bathed, it can take anywhere from 30 to 40 minutes to bathe a resident and there wasn't enough time to be able to do bathing with all the other cares and tasks that needed to be done. In an interview on 08/13/2024 at 2:00 PM, when informed of the lack of bathing for residents 1 and 43, Staff B, Director of Nursing, stated they were aware there were some issues with bathing not being done, but was not aware of the scope of the problem. <Resident 5> (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 07/25/2024 quarterly assessment documented Resident 5 had diagnoses including obesity and candidiasis of skin and nails (a yeast infection). Resident 5 was cognitively intact, had impairments of both upper and lower extremities, and was dependent on staff for toileting, showering/bathing and personal hygiene. The 12/18/2023 care plan documented Resident 5 had a self-care deficit related to decreased mobility. Staff were instructed to provide the resident a shower up to two times per week and as needed and provide a bed bath if the shower was refused or not tolerated. Resident 5 required assistance of one staff for bathing. A review of the bathing/shower record for the past 30 days from 07/08/2024 to 08/06/2024 showed Resident 5 had received a shower on Monday 07/29/2024, and on Monday 08/05/2024. A 04/30/2024 physician progress note documented they had a routine visit with Resident 5. There were no concerns other than the resident wanted showered two times a week. On 08/01/2024 at 9:21 AM, Resident 5 was observed resting in their bed. Resident 5 stated they were supposed to get their showers on Mondays and Thursdays, but over the past few months had not been getting them. Resident 5 produced a small notepad, and stated they had been keeping track of the days they were showered. A review of Resident 5's notebook showed they had been given showers on the following days: -04/04/2024, a span of 8 days from their previous shower, -04/14/2024, a span of 10 days, -04/21/2024, a span of 7 days, -04/29/2024, a span of 8 days, -05/06/2024, a span of 8 days, -05/14/2024, a span of 9 days, -05/31/2024, a span of 17 days, -06/08/2024, a span of 9 days, -06/27/2024, a span of 19 days, -07/04/2024, a span of 8 days, and -07/10/2024, a span of 6 days from their previous shower. (continued on next page)

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 08/13/2024
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/13/2024 at 10:00 AM, Staff N, Nursing Assistant, stated there was a schedule in the shower room that showed what residents were to be showered each day. Staff N stated each aide was responsible for providing the showers to their assigned residents and if they were unable to complete it, they notified the next shift. During an interview on 08/13/2024 at 10:22 AM, Staff M, Resident Care Manager, stated if showers were missed, staff asked the next shift to make them up. Shower refusals were to be documented. Staff M had not heard that Resident 5 had not gotten their showers, but stated they were not surprised to learn that Resident 5 kept track. Staff M observed a copy of Resident 5's notepad and agreed that the resident had not received showers twice weekly. Staff M stated it was important that residents received their showers; it kept their skin clean and dry, prevented infections, and it was a good time to view the skin for any areas of breakdown. Reference: WAC 388-97-1060(2)(c) 46033

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 46115 Based on observation, interview and record review, the facility failed to ensure 1 of 1 sampled residents (25) reviewed for activities, received an ongoing program of activities that met their interests. This failure placed the resident at risk for boredom and diminished quality of life. Findings included Per the 06/24/2024 quarterly assessment, Resident 25 was moderately cognitively impaired, was able to make some needs known, and had diagnoses which included dementia and depression. The assessment documented it was very important to the resident to be involved in activities that included: books, music, animals, religion, spending time outdoors, doing things with groups of people and participating in their favorite activities. Per the 03/22/2023 care plan, Resident 25 was at risk for activity deficits related to cognitive and physical deficits, difficulty with balance and memory, required encouragement to participate due to difficulty initiating stimulation and socialization. The goal for the resident was to participate in varied group and individual activities such as church service, devotions, exercise, trivia, arts and crafts three to five times a week. Review of the activities task from 07/18/2024 through 08/05/2024 documented Resident 25 participated in arts and crafts twice, had attended a music activity, an outside activity and entertainment activity once and had their nails painted. During an observation on 08/06/2024 at 11:09 AM, Staff I, Activity Director pushed a resident in their wheelchair into the dining room and stated they were frazzled because their assistant called in and could not come to work. Staff I stated there were two people working in the activities department about half of the time. In an observation on 08/08/2024 at 11:24 AM, an activity was held in the dining room in which Resident 25 sat at another table and was not involved. During an observation and interview on 08/08/2024 at 1:20 PM, Resident 25 was lying in bed. Resident 25 stated they liked to play the piano, liked singing, going for walks and loved animals. In an observation and interview on 08/09/2024 at 9:32 AM, Resident 25 was lying in bed staring out the window and stated there was nothing else to do. The resident was told there was going to be a bean bag toss at 10 AM and they stated they would probably not attend. The resident stated if it was bowling, basketball or softball they would have attended. The resident was told about the movie that was planned for the afternoon and stated they would probably attend that. Resident 25 added they liked to sew and used to make wedding dresses. During an observation on 08/09/2024 at 2:44 PM, Resident 25 was sitting in the dining room visiting with other residents. The regular television was on, and no movie was played. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/09/2024 at 10:06 AM, Staff J, Nursing Assistant, stated activities on that unit were not provided often. Staff J stated the residents do a lot of puzzles and are not interested in them. Staff J stated they have music the third Thursday of each month and the residents love it. Staff J added the residents on that unit needed more hands-on activities that would stimulate them. During an interview on 08/09/2024 at 10:14 AM, Staff K, Registered Nurse, stated there were not enough activities on the unit and the residents needed more things to do. In an interview on 08/09/2024 at 10:17 AM, Staff I agreed that Resident 25 was bored and felt there could be more activities on the unit. Staff I stated they had difficulty keeping an activities assistant in the department and had been short staffed. Staff I stated they could have reached out to the community to provide more music for the residents. During an interview on 08/12/2024 at 12:42 PM, Staff B, Director of Nursing, stated there was room for growth to include more activities on the unit. Staff B added they were in the process of getting spiritual services started. Reference : WAC 388-97-0940(1)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 46033 Based on observation, interview and record review, the facility failed to ensure pressure relieving interventions were implemented for 1 of 4 sampled residents (4) reviewed. Specifically, Resident 4 did not have their pressure relieving foam boot applied consistently when in bed and an area where the resident had a history of pressure on their left heel reopened. This failure placed the resident at risk of further deterioration of their heel, pain, infection, and decreased quality of life. Findings included . <Resident 4> A review of the record showed Resident 4 had diagnoses including traumatic brain injury (TBI), hemiplegia (paralysis) affecting the left dominant side of the body, and Stage 3 pressure ulcer of the left heel, (full thickness loss of skin without exposure of muscle, tendon, or bone). The 06/04/2024 quarterly assessment documented Resident 4 was moderately cognitively impaired and was dependent on staff for most activities of daily living (ADLs) including rolling from side to side, personal hygiene and toileting. The resident was at risk for pressure ulcers, had no unhealed pressure ulcers and used a pressure relieving device for their bed. The 12/06/2023 care plan documented Resident 4 had a potential/actual impairment to skin related to fragile skin and had a Stage 3 pressure ulcer to the left heel. Staff were instructed to use an air overlay mattress to protect skin while in bed, reposition the resident every 2-3 hours and float heels while in bed as Resident 4 allowed. Resident 4 used a pressure relieving cushion and a boot for their left foot to protect it while up in their wheelchair. A weekly skin evaluation dated 07/26/2024 documented Resident 4 had no new skin issues. The 08/01/2024 at 11:47AM nursing progress note documented Resident 4 had a 2.5 centimeter (cm) x 2.0 cm wound noted to their left heel. The wound was covered with black eschar (dead tissue) that was firm to touch. The area was cleansed and treated with skin prep, a tacky clear skin protectant and the Resident Care Manager and the wound team was notified. The 08/05/2024 wound consultant Nurse Practitioner progress note documented they saw the resident for a wound on the left heel likely due to pressure and sheering forces. Per staff reports, the resident had a wound in the same area previously that had been healed for over a month, and the present wound was noted a week ago. A treatment and dressing was ordered, and it was recommended that staff used specialty boots to float heels to remove any pressure to the area. A follow-up progress note dated 08/12/2024 documented the left heel wound was healing well. Prevention strategies and recurrence of the wound was discussed with staff and they stated understanding. On 08/06/2024 at 11:02 AM, Resident 4 was observed in the common area of the nursing unit in their wheelchair. The resident was seated on a cushion and had a foam boot on their left foot. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/07/2024 at 9:24 AM, Resident 4 was observed lying in bed on their back. The resident was not wearing a protective boot, and their heel was resting on the mattress. A white adherent dressing was observed covering the left heel. Additionally, Resident 4 was observed in bed with no protective boot on or pillows under their legs to raise the heels off the mattress on 08/08/2024 at 10:58 AM, and on 08/12/2024 at 10:21 AM. On 08/12/2024 at 10:49 AM, Resident 4's left heel was observed with Staff M, Resident Care Manager. The wound had an area in the center that was dark red colored, similar in size to a nickel and had a scant amount of drainage present. The skin surrounding this was similar in size to a fifty-cent piece and was red in color. When interviewed concurrently, Staff M stated they had done a full facility skin check on each resident in July 2024, and there had been nothing on Resident 4's heel at the time. Staff M stated the resident had a foam boot that they wore when they were out of bed in their wheelchair, but when the resident was in bed, it took reminding the staff to get the resident's heels up and put the boot on. Staff M stated at times, staff placed pillows under Resident 4's legs to elevate them off the mattress but acknowledged that there had been no pillows present under Resident 4's legs presently. During an interview on 08/13/2024 at 1:00 PM, Staff HH, Nursing Assistant, stated they provided care for Resident 4 often. Staff HH stated when the resident went to bed their heels were supposed to be elevated. Staff HH stated Resident 4 was able to move their right leg more than their left. The staff tried to put pillows under Resident 4's legs to elevate the heels, but the resident used their right leg and kicked the pillow out from under them. Staff HH stated when Resident 4 had their foam heel protector on, they left it alone and did not try to kick it off. Staff HH stated that Resident 4 seemed to understand that the boot helped their heel. Reference: WAC 388-97-1060(3)(b)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 46115 Based on observation, interview, and record review, the facility failed to provide consistent, ongoing communication and collaboration with the dialysis facility for 1 of 1 sampled resident (65), reviewed for dialysis. These failures placed the residents at risk for unmet care needs and medical complications. Findings included . The 06/27/2024 admission assessment documented Resident 65 was able to make decisions regarding their cares, and had diagnoses which included kidney disease, and diabetes (a disease caused by the inability of the body to convert the food we eat into sugar needed for the cells to use as energy). In addition, the assessment documented the resident received dialysis (a procedure that removes waste products and excess fluid from the blood when the kidneys stopped working properly). Review of the 01/25/2024 agreement between the facility and the dialysis center documented care of residents receiving dialysis was to be coordinated between the facility and the dialysis center, to ensure continuity of care and the resident's well-being. Per the 06/28/2024 dialysis care plan, nursing was instructed to send the dialysis communication record to every visit and validate that it had been returned with the resident and to process any needed changes to the resident's care. Review of Resident 65's record, documented there were no dialysis communication forms between the facility and the dialysis clinic on 07/08/2024, 07/12/2024, 07/15/2024 and 07/17/2024. In addition, there were no dialysis communication forms sent from the facility to the dialysis center on 07/22/2024, 07/24/2024, 07/26/2024, 07/29/2024 and 07/31/2024. In an interview on 08/07/2024 at 3:20 PM, Staff E, Registered Nurse, stated a communication form was sent to the dialysis clinic and did not always return with the resident. Staff B added if the resident had not returned with the form the clinic needed to be contacted and this was important because they needed to know if something happened during the resident's treatment. During an interview on 08/12/2024 at 12:45 PM, Staff B, Director of Nursing, stated the facility communicated with dialysis by using the dialysis communication forms and they should have been sent with the resident and received upon their return. Staff B stated it was important for the collaboration of care. Reference: WAC 388-97-1900 (1), (6)(a-c)

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F 0712

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that the resident and his/her doctor meet face-to-face at all required visits.

37544

Based on interview and record review, the facility failed to ensure residents were seen by the physician within the required timeframes for 2 of 8 sampled residents (5, 59) reviewed. This failure placed residents at risk for unmet medical needs and decreased quality of care.

Findings included .

<Resident 59>

The 07/12/2024 annual assessment documented Resident 59 was able to make decisions regarding their care and had diagnoses which included kidney disease.

On 08/01/2024 at 12:23 PM, Resident 59 was observed sitting upright in bed. When asked if they had any concerns about their care, Resident 59 stated there was a new team of doctors at the facility and they had asked to see one, but it hadn't happened. Resident 59 further stated they had chronic urinary tract infections, had just finished antibiotics, and would like to speak to the doctor.

Review of Resident 59's record found documentation that showed Staff R, Physician's Assistant, visited the resident on 06/18/2024, 07/03/2024, 07/09/2024, 07/15/2024, 07/25/2024, and 08/06/2024.

A provider progress note on 06/12/2024 by Staff X, Physician, documented they visited Resident 59 at the facility and care was being transferred to the facility provider. No other documentation was found to show Resident 59 had been seen by a physician since that date.

Additional record review found that prior to the 06/12/2024 visit from Staff X, the last time Resident 59 had been seen by a physician occurred eight months ago on 09/18/2023, when Staff Y, Physician, visited.

In an interview on 08/13/2024 at 11:55 AM, Staff Z, Medical Records, stated a physician needed to see a resident every three months. After review of Resident 59's record, Staff Z, stated a physician visit was not due until September.

<Resident 5>

A 07/25/2024 quarterly assessment documented Resident 5 had diagnoses including generalized anxiety disorder and insomnia. Resident 5 was cognitively intact and was dependent on staff for most activities of daily living (ADLs).

On 08/01/2024 at 9:33 AM, Resident 5 was observed resting in their bed. Resident 5 stated provider groups had changed. They preferred when Staff R, Physician Assistant, saw them. Resident 5 stated one of the physicians had decreased their anti-anxiety medication by half and they had experienced sleeplessness and shaking, and this was why they preferred Staff R.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 07/06/2024 Staff R progress note documented they saw the resident for a 60-day federally mandated visit. The note documented Resident 5 continued to take chronic benzodiazepines for anxiety and sleep, had been on those medications for years, and had been intolerant of gradual dose reductions in the past. A review of provider progress notes documented Resident 5 was seen by a physician at the following intervals: -On 10/18/2023 when the resident requested the visit in regard to eye drops. -On 01/31/2024 for routine follow up; a period of greater than 90 days from the 10/18/2023 visit, and -On 4/30/2024 for routine follow up; a period of 90 days from the 01/31/2024 visit. The most recent physician visit for Resident 5 was on 06/10/2024, which was within 60 days of the previous physician visit. During an interview on 08/13/2024 at 10:39 AM, Staff M, Resident Care Manager, stated they thought residents had to be seen by the physician every 90 days, but was uncertain. Staff M stated the medical records department kept track of who had been seen and who needed to be seen by the physician. During an interview on 08/13/2024 at 2:42 PM, Staff B, Director of Nursing, stated they believed the residents were to be seen every 60 or 90 days by the physician but was unsure. Staff B stated they would review the timeframes with the medical records department. Reference: WAC 388-97-1260(4)(c) 46033

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 37544 Based on interview and record review, the facility failed to complete a yearly performance review on 3 of 3 sampled nursing assistants (AA, BB, CC) as required. This failure placed residents at risk of receiving care from inadequately trained staff. Findings included . Review of the following Nursing Assistant (NA) personnel files found the following: - Staff AA was hired on 05/03/2022. No documentation was found to show an annual performance evaluation had been completed as required. - Staff BB was hired on 07/01/2023. No documentation was found to show an annual performance evaluation had been completed as required. - Staff CC was hired 07/13/2023. No documentation was found to show an annual performance evaluation had been completed as required. In an email correspondence on 08/12/2024 at 6:34 AM, a request for the annual performance reviews for the above nursing assistants was sent to Staff B, Director of Nursing. On 08/13/2024 at 8:18 AM, Staff B replied that no annual performance reviews had been completed. Reference (WAC): 388-97-1680(2)(b)

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F 0740

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident must receive and the facility must provide necessary behavioral health care and services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46033

Based on observation, interview and record review, the facility failed to ensure behavioral health services were provided for 2 of 2 sampled residents (7, 36) reviewed. This failure placed the residents at risk of declining mental health, escalation of their chronic mental health conditions and decreased quality of life.

Findings included .

<Resident 7>

A review of the record showed Resident 7 was admitted on [DATE] and had diagnoses including psychosis (disconnection from reality), schizoaffective bipolar disorder (a complex mental health condition that has symptoms of both Schizophrenia and mood disturbances) and catatonic disorder (inability to move normally).

The [DATE] quarterly assessment documented Resident 7 was severely cognitively impaired, had hallucinations and physical behavioral symptoms such as hitting and kicking, and also rejected care. Resident 7 was dependent on staff for most activities of daily living (ADLs), took antipsychotic medication daily, and had not had a gradual dose reduction attempted.

A review of the [DATE] hospital discharge summary documented Resident 7 was hospitalized for an extended period from ,d+[DATE] to ,d+[DATE] related to a decline in their mental health conditions. The resident had a history of court ordered electro-convulsive therapy (ECT, use of electric current to induce a brief seizure in the brain to treat mental health conditions). The resident's medications were adjusted, and the resident was cleared by psychiatry for discharge.

A review of the [DATE] Pre-admission Screening and Resident Review (PASARR, a screening required to be completed prior to admission to a nursing home that looked for indicators that one may have a serious mental illness) indicated Resident 7 had a serious mental illness and required a PASARR level II review (an assessment that made recommendations about specialized services needed to determine the best setting to meet a person's behavioral health needs).

The PASARR level II assessment completed [DATE] indicated Resident 7 required specialized behavioral health services while at the facility.

The [DATE] care plan documented Resident 7 used antipsychotic medication. Staff were instructed to document the number of episodes of paranoid statements, use non-pharmacological interventions to reduce target behaviors, give medications as ordered, and review the medication with the inter-disciplinary team for a gradual dose reduction as indicated. The care plan had no goals or interventions related to behavioral health needs developed for Resident 7.

A review of the facility provider group progress notes documented Resident 7 was seen by the Psychiatric Nurse Practitioner on [DATE]. There were no other behavioral health visits documented in the resident's electronic medical record.

(continued on next page)

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	08/13/2024

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:45 AM, additional psychiatric or behavioral health provider progress notes for Resident 7 were requested from Staff B, Director of Nursing. On [DATE] at 10:25 AM, Resident 7 was observed resting in bed in their room. Resident 7 spoke of school days, someone named [NAME], and that their sibling was not allowed to have the color blue in their room. The resident spoke about vegetables, that their teeth fell out when they were little, and that a sibling weighed 10 pounds at birth. The resident was unable to answer questions in a meaningful way related to a flight of ideas. On [DATE] at 1:26 PM, Staff B documented in nursing progress notes that contact was made with the local behavioral health services providers to re-establish services and an appointment had been made for Resident 7 on [DATE] at 10:00 AM. During an interview on [DATE] at 12:42 PM, Staff B stated there were no other behavioral health visits for Resident 7 after [DATE]. <Resident 36> A review of the record documented that Resident 36 had diagnoses including major depressive disorder, borderline personality disorder (a mental disorder characterized by unstable moods, behavior and relationships) and anxiety. The [DATE] quarterly assessment documented the resident was cognitively intact and had a quick depression assessment score of 7, which indicated mild depression. The resident took antipsychotic and antidepressant medications daily. The [DATE] care plan had the following care areas: -Resident 36 uses antidepressant medication; staff were instructed to document the number of episodes of signs/symptoms of depression and the interventions, provide 1 to 1 supervision, assess pain, or provide activities. -Identify potential triggers for depressive episodes and use non-pharmacological interventions to address depressive episodes, (no specific interventions for the resident were listed), give meds as ordered, monitor effectiveness and review for a gradual dose reduction as indicated. -Resident 36 uses anti-anxiety medication related to agitation; there were no goals or interventions developed. -Resident 36 uses antipsychotic medication; Staff were to identify triggers, give medications as ordered, and use nonpharmacologic person centered interventions to reduce target behaviors. There were no target behaviors listed and no person-centered interventions specified. The resident had a provider order dated [DATE] for psychiatric evaluation and treatment. The [DATE] provider progress note documented Resident 36 had non-specific cognitive impairment and depression and that it was unclear what diagnosis their antipsychotic medication was treating. This was to be monitored to determine whether the medication was appropriate based on the resident's cognitive assessment and quick depression assessment scores. (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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The [DATE] provider progress note documented the resident had major depression in partial remission and borderline personality disorder. The doses of the antipsychotic and antidepressant medications were not changed. The [DATE] provider progress note documented they saw the resident. The plan was to continue the resident's antipsychotic and antidepressant medications, and a psychiatric consult would be appreciated. A [DATE] palliative care consult was conducted. The progress note documented Resident 36 was very tearful, reported significant depression, and had been on an antidepressant medication for years without a dose adjustment. The resident reported no enjoyment in things that used to bring them joy. The tearfulness and report of depression interfered with the ability to complete the comprehensive exam. The resident refused to have their quick depression score assessment repeated. Review of Resident 36's record found no documentation regarding their mental health from Social Services. During an interview on [DATE] at 9:42 AM, Resident 36 was in bed and watched their television. The resident stated they liked it at the facility but felt sad. They stated they felt like they needed their antidepressant dose increased; their mother died on e year ago, and they blamed themself for their mother's death. Resident 36 stated they had requested to see someone, had not seen a counselor at the current facility, and someone was supposed to be setting that up for them. During a follow-up interview on [DATE] at 9:53 AM, Resident 36 stated they were still interested in speaking to a counselor but had not heard anything else about an appointment being made. On [DATE] at 1:25PM, Resident 36 stated their mother was still on their mind. They had not heard from anyone about increasing their antidepressant or getting counseling. They believed the counseling would help. During an interview on [DATE] at 11:22 AM, Staff M, Resident Care Manager stated if a provider wanted to order a referral to another provider, the request was written on a triplicate form, and a copy was given to the transportation staff to set up. Staff M had not received a behavioral health referral for Resident 36 and was not aware of the provider progress notes; this was the first they had heard of Resident 36's behavioral health concerns. During an interview on [DATE] at 2:42 PM, Staff B, Director of Nursing, stated the PASARR level II recommendations had gone to a social worker who was no longer employed at the facility. They were aware there were level II recommendations but were unaware what those recommendations had been. Staff B stated the previous provider group employed a behavioral health nurse practitioner that provided the behavioral health counseling services. The current provider group had a PA that provided behavioral health services, but at present was covering multiple facilities so only had time to make recommendations for what services they would recommend. Staff B stated the facility was working to establish services with another local counseling provider. Reference: No associated WAC

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F 0759

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure medication error rates are not 5 percent or greater.

47728

Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than five percent. Five medication errors were identified for 1 of 8 sampled residents (Resident 73) observed during 40 medication opportunities, which resulted in an error rate of 12.5 percent. The failure to administer medications correctly placed the residents at risk for receiving subtherapeutic effects of their medications and possible adverse side effects.

Findings included:

During an observation on 08/12/2024 at 7:40 AM Staff E, Licsensed Practical Nurse prepared and administered multiple medications to Resident 73 which included one tablet of Mesalamine (a medication for Ulcerative Colitis, a bowel disease that causes swelling and sores in the colon and rectum), and two sprays of Azelastine (a medication for allergies) nasal spray in each nostril, but did not include Acetylcysteine (a medication for anxiety), Spiriva Respimat (a medication to improve breathing), and Ipratropium-Albuterol (a medication to improve breathing).

Per review of the current physician orders as of 8/12/2024, Resident 73 was to receive the following:

-Azelastine Nasal Solution, one spray in both nostrils twice per day.

-Mesalamine two tablets twice per day.

-Acetylcysteine one capsule twice per day.

-Spiriva Respimat Inhaler once daily

-Ipratropium-Albuterol Inhaler every 6 hours.

Administering the incorrect dose of Azelastine and Mesalamine, as well as the omission of the Acetylcysteine, Spiriva Respimat, and Ipratropium-Albuterol constituted medication errors.

In an interview on 08/12/2024 at 11:30 AM, Staff E acknowledged they had administered the incorrect dose of the Azelastine and Mesalamine, and did not administer the Acetylcysteine, Spiriva Respimat, or the Ipratropium-Albuterol. When asked why the medication errors occurred, Staff E stated Resident 73 preferred two sprays of the Azelastine, and stated, at the time of administration, they were unaware they had given the incorrect dose of the Mesalamine. They stated it was important to ensure the correct dose when administering medications to avoid medication errors which could cause harm to a resident. Staff E went on to say, they had not given the Acetylcysteine, Spiriva Respimat, and Ipratropium-Albuterol because they were out of the medications. They stated the medications had been ordered from the pharmacy for refill the prior week but had not yet been delivered.

Reference: WAC 483.45(f)(1)-1060 (3)(k)(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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46033 Based on observation and interview, the facility failed to ensure expired medications were disposed of and multi-dose vials were dated when opened in 1 of 2 medication rooms inspected, and that insulin needles were securely stored on a unit that was closed. This failure placed residents at risk of receiving expired medications and potential needlestick injuries. Findings Included . On 08/01/2024 at 8:30 AM, a team of surveyors entered the facility to conduct a recertification survey. The team was provided a workspace in a dining area on a rehabilitation unit that was no longer in use. Across the hall from the dining area, a nursing station no longer in use was located, and contained a small dorm-style refrigerator, a sink area, and multiple unlocked cabinets, and drawers. At 11:01 AM, the nursing station was inspected. Inside a middle unlocked long cabinet on an upper shelf, there were 2 boxes of insulin needles, each 2/3 full. One box of needles expired on 07/31/2024. The second box of needles had an expiration date of 01/31/2025. In an adjacent cabinet on the middle shelf, there were 14 individually wrapped 25-gauge 1 inch needles. At the time, there were no residents in the vicinity. On 08/02/2024 at 8:25 AM, upon entrance to the facility, the hairdresser's shop, located at one end of the closed rehabilitation unit was open and a resident was getting their hair styled. Shortly after, this resident was observed walking down the hall past the nurse's station towards double doors that provided access to the assisted living facility. A second resident from the assisted living facility passed through the double doors, walked past the nursing station where the unsecured needles were and went to the hairdresser. Members of the survey team remained in the area. On 08/02/2024 at 10:43 AM, the medication room on the Berryway unit was observed with Staff O, Licensed Practical Nurse. When observed, there were no current logs to record the refrigerator temperatures for the month of August 2024 for the two refrigerators in the room. Temperature logs for June 2024 and July 2024 were hanging on the refrigerators and these had multiple omissions. Upon inspection, in the larger of the two refrigerators, there was one multi-dose vial of tuberculin serum (used to test for the presence of tuberculosis, a highly contagious bacterial illness) lot number 77298, that had been opened. The vial did not have a date on it that it had been opened, as required. At the time, Staff O stated multi-dose vials were supposed to be dated once opened. The following items were also observed: -three 22-gauge, 1.5-inch needles with a manufacturer expiration date of 2022, -one zip lock baggie full of Heparin (prevents blood clots) 5 milliliter (ml) flushes with a manufacturer expiration date of 06/30/2024, -one bottle of sodium bicarbonate tablets with a manufacturer expiration date of 07/2024, and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-one bottle of B-complex multi-vitamins with a manufacturer expiration date of 06/2024. Staff O disposed of the expired medications at the time of the observation. Staff O was unsure who was responsible for reviewing the medication room and logging the refrigerator temperatures and was going to check. On 08/02/2024 at 12:14 PM, the nursing station on the closed unit was observed with Staff B, Director of Nursing. Staff B stated the unit had closed in May 2024 and they were unaware the needles had been left in the cabinet. Staff B stated it was important that all needles remain secured in case a resident wandered in the area and found the needles. Staff B stated the Resident Care Managers were responsible for maintaining the medication rooms and getting rid of expired medications. Staff B stated the refrigerators had thermometers that sent signals to the maintenance department if they fell out of range, but they still expected staff to record the temperatures. The maintenance staff were notified by Staff B and the unsecured needles were removed from the nursing station. Reference: WAC 388-97-1300(2)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47728 Based on observation, interview and record review, the facility failed to ensure dietary staff had the required qualifications (current Food Worker Cards) for one of twelve dietary staff reviewed (EE). This failed practice had the potential risk for unsafe food handling practices and placed all residents at risk for developing foodborne illness. Findings included . A review of the dietary cards showed no Washington State Food Workers card for Staff EE (hire date 6/21/2024). Staff EE did have a certificate dated 7/4/2024 from Food Handler Solutions for completing the food handler's course. Review of Food Handler Solutions website, foodhandlersolutions.com/[NAME]-food-handler-card/ showed, the Food Handler Solutions Program is currently not approved in the state of [NAME]. This program is only intended to be used for personal development and preparation for the state provided training. A review of the staffing schedules documented Staff EE had worked in the kitchen August 1st-4th 6:00AM-2:30PM, and August 7th-11th 6:00AM-2:30PM. In an interview on 8/12/2024 at 08:20AM, Staff P, Human Resources Manager, stated they ensured new hires had the appropriate credentials. They stated they verified food handler's cards by obtaining the receipt and confirmation number off the card. Staff P stated they were unaware the Food Handler Solutions Certificate was not valid in Washington State. They stated Staff EE would not be allowed to work until they obtained the appropriate food handler credential through the Washington State Department of Health. Reference: WAC 483.60(a)(3)(b)-1160

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37544 Based on observation, interview, and record review, the facility failed to provide appetizing and palatable food for 6 of 7 sampled residents (48, 59, 8, 41, 1, 43) reviewed for food. This failure placed the residents at risk for decreased nutritional intake, and a diminished quality of life. Findings included . According to [NAME] Administrative Code [PHONE NUMBER]0, Time/temperature control for safety food, hot and cold holding (FDA Food Code 3-501.16). Food must be maintained: At 135 F (57 C) or above, or at 41 F (5 C) or less. Resident Observations and Interviews <Resident 48> On 08/01/2024 at 2:41 PM, Resident 48 was observed sitting in a wheelchair in their room using their computer. When asked about the food, the resident stated the food was horrible, did not have much taste, and was not something they would eat if they had a choice. On 08/06/2024 at 8:29 AM, Resident 48 stated breakfast was good, had eggs, toast, oatmeal, and coffee, but there was no meat. Resident 48 further stated the meals often seemed incomplete, like the other night, they served mashed potatoes with gravy, and some meat, but there were no vegetables. <Resident 59> During an interview on 08/01/2024 at 12:18 PM, Resident 59 stated the food was horrible, the meat was mushy, ground garbage, and a week ago Sunday, one could not tell what it even was. In a follow-up interview on 08/06/24 between 8:45 and 9:11 AM, Resident 59 stated one of the worst foods the kitchen served was the steak teriyaki, the meat tasted and looked like little strips of cardboard. Resident 59 then stated the lasagna and pizza were made with just the sauce, there was no cheese or meat, and the stroganoff one night looked like dogfood. <Resident 8> On 08/02/2024 at 11:05 AM, Resident 8 was observed resting in bed in their room. When asked if they had any concerns, the resident stated the food was horrible, had no taste, and sometimes they didn't know what it was. <Resident 41> During an interview on 08/02/2024 at 11:47 AM, when asked about the food, Resident 41 stated the food did not taste good and was often cold. <Resident 1> (continued on next page)

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/01/2024 at 10:15 AM, Resident 1 was observed lying in their bed in their room talking with their representative. When asked if the food tasted good, Resident 1 gave a thumbs down gesture with their left hand. The representative stated the food was disgusting, did not taste good, and sometimes resembled glue. In response to the comment, Resident 1 then made a thumbs up gesture and shook his head up and down. <Resident 43> In an interview on 08/06/2024 at 3:17 PM, Resident 43 stated the food was terrible, and did not taste good at all. The resident further stated that they had been excited to get fried chicken at lunch, but the meat was so fused to the bones on the piece of the back that they were served that they couldn't eat it. Interviews In an interview on 08/12/2024 at 12:32 PM, when informed of the food concerns expressed by the above residents, Staff II, Dietary Manager, stated they were not aware of any food complaints. With regards to the food not having much taste/flavor, Staff II stated there was a new cook and they may be afraid of using the spices and seasonings that were available. 47728 <Test tray> During an observation and sampling of the lunch meal on 08/09/2024 at 12:15 PM the food was not colorful and did not appear appetizing. The meal consisted of brown meatloaf with a dark red sauce, white mashed potatoes, white cauliflower, off-white banana cream pie and a dark purple fruit flavored drink. The temperatures of the food items were outside of the acceptable parameters and were as follows: Meatloaf 115 F, Mashed Potatoes 110 F, Cauliflower 80 F, Banana cream pie 60 F, and Grape flavored drink 58 F. The flavor of the food was bland with the meatloaf having only a slight taste of onion, the mashed potatoes tasted only of salt, the banana cream pie tasted only of sugar, and the drink tasted like a grape drink mix for children. In an interview on 08/09/2024 at 2:23 PM, when asked what seasonings are used when preparing the food for the residents, Staff II stated onion, garlic, sage, all sorts of seasonings, and stated they tasted the food as it was prepared. Reference: WAC 483.60(d)(1)(2)-1100 (1), (2)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47728 Based on observation and interview the facility failed to ensure hand hygiene was completed when indicated during 1 of 4 meals observed during dining. This failure resulted in potential risk of food borne illness and a decreased quality of life for all residents. Findings included . On 08/01/2024 at 11:59 AM, Staff JJ, Nursing Assistant was observed pushing a resident in a wheelchair into the Dayspring dining room. Staff JJ then proceeded, without performing hand hygiene, to deliver a meal tray to a second resident, cut the resident's sandwich, and refill the coffee cup. Staff JJ continued, without performing hand hygiene, to take a meal tray for a third resident and unwrap the food items, pour water into a cup, place the eating utensils on the tray, and deliver the meal tray to the resident in the dining room. Then again, without performing hand hygiene, Staff JJ prepared a meal tray for a fourth resident by cutting up the food, opening items, opening straws and putting them in the drinks, then delivered the meal to the resident in the dining room. During an observation on 08/01/2024 at 12:11 PM, Staff JJ delivered a meal tray to a resident in their room, assisted the resident to sit up in bed, then exited the room and without performing hand hygiene, took a meal tray to a different resident in a different room. On 08/01/2024 at 12:17 PM Staff JJ was observed pushing a resident in a wheelchair into the Dayspring dining room then, without performing hand hygiene, Staff JJ began assisting a different resident with eating by spooning the food into the resident's mouth. In an interview on 08/01/2024 at 12:35 PM, when asked, Staff JJ stated hand hygiene should be performed between passing each meal tray. They stated they had gotten busy and forgot. In an interview on 08/06/2024 at 10:23 AM, Staff C, infection preventionist stated hand hygiene should be performed when entering/exiting a resident room and in between meal trays. Reference: WAC 483.60(i)(1)(2)-1100

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 37544

Based on observation, interview and record review, the facility failed to ensure enhanced barrier precautions (EBP, an infection control intervention to reduce transmission of multi-drug resistant organisms) were implemented when indicated for 4 of 4 sampled residents (69, 7, 73, 1) reviewed, and that hand hygiene was completed when indicated during 1 medication pass observed and 2 wound treatments observed. Additionally, the water management plan was not developed and implemented as required, Infection Prevention Program policies and procedures were not reviewed annually, and appropriate follow-up measures were not completed timely when one resident screened for Tuberculosis exposure (TB, a bacterical infection that mainly affected the lungs) had a positive skin test. These failures placed residents at risk for cross contamination of infectious material, and possible exposure or illness from debilitating bacterial and viral illnesses.

The article, Implementation of Personal Protective Equipment (PPE) use in Nursing Homes to present the spread of multi-drug resistant organisms (MDROs), published by the Center of Disease Control (CDC) on 07/12/2022 stated because nursing home residents with wounds and indwelling medical devices were at especially high risk of acquisition and/or colonization of an MDRO, the use of enhanced-barrier precautions which included the use of a gown and gloves during high contact resident care activities such as: dressing, bathing, transferring, providing hygiene, changing linens, providing assistance with toileting or incontinence care, wound care, and device care was indicated.

Findings included .

46033

<Enhanced Barrier Precautions>

<Resident 69>

A quarterly assessment dated [DATE] documented Resident 69 had diagnoses including state 4 pressure ulcer, and a history of multi-drug resistant organisms (MDROs) in a leg wound. Resident 69 was moderately cognitively impaired, required moderate staff assistance with most Activities of daily living (ADLs), and required use of an indwelling urinary catheter (a catheter inserted in the bladder that allowed urine to drain into a collection bag.)

The 05/07/2024 care plan documented Resident 69 required enhanced barrier precautions (EBP) related to their wound treatments and their indwelling catheter. Staff were instructed to use a gown and gloves for high contact resident care including dressing, bathing, transferring, toileting care, changing linens, or device or wound care. Staff were to monitor and report any signs or symptoms of infection to the provider. The resident was able to leave their room.

On 08/02/2024 at 2:37 PM, the door to Resident 69's room had signage on the door indicating contact precautions were to be in use when the resident's room was entered. A cart containing personal protective equipment (PPE, disposable gowns and gloves used to prevent contact with harmful bacteria and body fluids) was located next to the door at the entrance.

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

On 08/06/2024 at 9:15 AM, the door to Resident 69's room was open, and the resident was observed from the hall. There was no longer a PPE cart at the entrance or contact precautions signage on the door. At 9:19 AM, a student Nursing Assistant (NAC) was observed wearing gloves and no gown and pushing a mechanical lift out of the room. The student parked the lift in the hall next to the door, re-entered the room, disposed of their gloves and washed their hands. The lift was not cleaned after it's use. A staff member later identified as Staff HH, NAC, was observed straightening the linens on Resident 69's bed. They were not wearing a gown or gloves. Resident 69 was now seated in their wheelchair in the room.

During an interview on 08/06/2024 at 9:27 AM, Staff HH stated Resident 69 was not on any type of care precautions; the roommate had been on antibiotics, so gloves were required when providing care to Resident 69's roommate. Staff HH stated they had been educated on EBP and the Infection Control Nurse told the staff who required precautions. Staff HH stated residents with urinary catheters did not require enhanced barrier precautions.

On 08/07/2024 at 9:58 AM, Resident 69 was out of their room. There was no signage on the door indicating EBP was required. There was a PPE cart at the entrance again.

On 08/08/2024 at 10:00 AM, Staff HH and an unidentified male staff entered Resident 69's room pushing a mechanical lift into the room. Neither staff wore a gown or gloves into the room. There was no signage on the door indicating EBP was in use.

During an interview on 08/13/2024 at 2:10 PM, Staff C, Infection Control Registered Nurse, stated EBP was an ongoing battle. Staff C stated they placed a red stop sign on a resident's door and an additional sign underneath that notified staff of the reason the resident required EBP. Staff C stated they made rounds on the units to ensure signage was in place when indicated. Staff C stated they expected staff to put on the appropriate PPE when residents were on EBP. They stated it protected residents from cross contamination and decreased the change that infections were spread to other residents.

<Resident 1>

The 07/08/2024 annual assessment documented Resident 1 had diagnoses which included neurogenic bladder, a condition caused from injury to the spinal cord, brain or nerves that resulted in the loss of bladder control, was dependent on nursing staff to complete ADLS and utilized a urinary catheter.

The 11/16/2023 care plan documented enhanced barrier precautions were implemented for Resident 1 due to the use of an indwelling catheter, and nursing staff were instructed that gown and gloves were required when performing high-contact resident care (dressing, bathing, transferring, incontinence or toileting care, dressing, changing linens, or device/wound care).

On 08/01/2024 at 9:34 AM, Resident 1 was observed lying in their bed talking with their representative. A sign on the door informed visitors and staff that enhanced barrier precautions were in place due to device care/use and asked them to speak to the nurse before entering the room. The sign included information on what PPE were to be used and a cart containing PPE supplies was in the hall next to the entrance to the resident's room.

(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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/01/2024 from 9:57 AM, Staff S, Nursing Assistant, was observed doing ADL care for Resident 1. Staff S performed hand hygiene and donned gloves, but no gown, then used cleansing wipes to clean the resident's groin area and buttocks. After placing an incontinence brief on Resident 1, Staff S then doffed the gloves, performed hand hygiene and donned new gloves, but no gown, and began to assist the resident to put on a shirt. When Staff S was asked what type of PPE should be used for Resident 1 when doing cares, Staff S stated they were told only gloves were needed. After getting the shirt on Resident 1, Staff S doffed the gloves, performed hand hygiene, donned new gloves and then emptied the urinary catheter bag before putting pants on the resident. Once the resident was dressed, Staff S doffed the gloves, did hand hygiene and left the room. On 08/01/2024 at 10:11 AM, Staff S returned to the room with a Hoyer lift, a mechanical lift used to transfer residents, and Staff OO, Licensed Practical Nurse, to get Resident 1 up in their wheelchair. Both Staff S and Staff OO performed hand hygiene, donned gloves, but no gown, and then used the Hoyer to transfer Resident 1 into their wheelchair. In an interview on 08/13/24 02:02 PM, Staff B, Director of Nursing, was informed of the above observations of enhanced barrier precautions/PPE not being implemented. Staff B stated it was the expectation that staff would implement EBP as instructed. <Resident 7> According to the 06/25/2024 Assessment, Resident 7 was severely cognitively impaired, unable to direct their own care, required assistance for Activities of Daily Living (ADLs) such as positioning in bed, and personal hygiene. Resident 7 had a feeding tube (a flexible plastic tube placed into the stomach or bowel to supply nutrients and fluids), and had diagnoses which included malnutrition and catatonic disorder (a brain disorder which often results in a lack of movement and communication). A sign by the door outside of the resident's room indicated Enhanced Barrier Precautions (EBP) were to be implemented for this resident and instructed staff to wear gloves and a protective gown when performing personal care for the resident as well as transferring, and device care and use including a feeding tube. During an observation on 08/26/2024 at 9:44 AM, Staff LL, Registered Nurse (RN) provided medication and fluid administration to Resident 7 through the feeding tube. Upon entering Resident 7's room, Staff LL did not put on gloves or a gown. Staff LL with the assistance of Staff MM, Resident Care Manager, who was wearing gloves but no gown, positioned the resident in bed, adjusted the over bed table, used the bed controls to adjust the bed height, and removed a surgical mask from the resident's face. Staff LL then performed hand hygiene and put on gloves but still no gown and proceeded to use a syringe to administer water and medications through Resident 7's feeding tube, then used a gloved hand and cleaned out the resident's mouth with a moistened foam swab, and applied lip balm to Resident 7's lips. In an interview on 08/06/2024 at 10:07 AM when asked what EBP meant, Staff LL stated they were not doing that and that they wore gloves when doing device care. In an interview on 08/06/2024 at 10:23 AM, Staff C, Infection Preventionist stated EBP included gloves and gown being worn when providing any personal care to a resident, including transfers, rolling, and positioning in bed. (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

<Resident 73>

According to a provider note date 07/29/2024, Resident 73 was cognitively intact, able to direct their own care and had diagnoses including fracture of the right lower leg with a subsequent infection. They had a Peripherally Inserted Central Catheter (PICC- a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near the heart) through which they received an antibiotic (a medication that can kill or stop the growth of bacteria).

A sign by the door outside of the resident's room indicated Enhanced Barrier Precautions (EBP) were to be implemented for this resident and instructed staff to wear gloves and a protective gown when performing personal care for the resident, as well as when performing device care and use of a central line (a long flexible tube inserted into a large vein that leads to the heart).

During an observation on 08/12/2024 at 8:48 AM, Staff E, Licensed Practical Nurse (LPN) entered the resident's room and put on gloves but did not put on a gown. Staff E then proceeded to administer medication through the PICC line.

In an interview on 08/12/2024 at 9:01 AM when asked why the resident was on EBP, Staff E stated the resident was no longer on those precautions. When Staff E was shown the EBP sign on resident's door and the central line instruction were pointed out, Staff E stated the resident didn't have a central line. When Staff E was informed that a PICC line is a central line they stated they should have gowned and gloved when performing PICC line care and medication administration because it was important to prevent the spread of infection.

<Infection Prevention Policies>

A review of the Infection Prevention Program policies and procedures showed the following:

-The facility Infection Prevention and Control Program policy was released 10/31/2017 and revised 10/15/2022.

-The facility Influenza Program policy was released 10/31/2017 and revised 08/01/2023.

-The facility Infection Control Sub-Committee policy was released 11/28/2017 and revised 09/10/2020.

-The facility Pneumococcal Program policy was released 10/31/2017 and revised 05/31/2023.

-The facility Infection Engineering Controls policy was released 10/01/2017.

-The facility Infection Exposure Control Plan policy was released 10/31/2017.

-The facility Antibiotic Stewardship policy was released 10/01/2017 and revised 10/15/2022.

None of the listed policies had dates listed on them that indicated the policies had been reviewed (or revised when indicated) within the previous year.

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Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During an interview on 08/13/2024 at 2:10 PM, Staff C stated they were not aware the infection prevention policies were required to be reviewed annually. Staff C stated they were not sure who was responsible for reviewing the policies, if it was them, or if this was done at the corporate level.

<Water Management Plan>

On 08/12/2024 at 7:28 AM, documents detailing the facility water management plan were requested and provided by Staff KK, Maintenance Director. At that time, two binders and a water test kit were provided.

The Water Test Kit was observed and listed 17 elements the kit identified if present in a water sample. The 17 elements the kit tested for did not include Legionella (a water-born bacteria that if inhaled caused pneumonia.)

The Water Test results were logged in one of the binders under the heading titled Monthly Legionella Testing. Results were documented as negative.

A further review of the water management binders included a title page that documented the plan had been reviewed in 04/2024 and showed policies and procedures as references that were from the facility's previous owner's group. Water system descriptions, ways of monitoring facility water sources, and interventions were specific to a facility located at a different site.

During an interview on 08/13/2024 at 8:10 AM, Staff KK stated they had quickly reviewed the Water Management binders with their corporate resource staff member. At that time, they had done the risk assessment, but Staff KK stated they had not read through all of the documents in the plan thoroughly and did not realize they referred to a different facility. Staff KK stated a previous version of the water test kits they had used tested for Legionella and when new ones arrived, they had not noticed that the new kits no longer included Legionella. Staff KK stated they would review the plan more closely and make it specific to their facility.

46115

<Hand Hygiene>

<Resident 75>

According to the 07/01/2024 admission assessment, Resident 75 had a wound to their buttock and was cognitively intact.

On 08/07/2024 at 10:46 AM, an observation was made of the wound care and dressing change to Resident 75's left buttock with Staff E, Licensed Practical Nurse. Staff E donned gloves and removed the dressing from the resident's left buttock, removed their gloves, and without performing hand hygiene, placed a new pair of gloves on and applied the treatment and dressing. Staff E did not perform hand hygiene during glove changes when indicated.

<Resident 283>

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 07/15/2024 admission assessment, Resident 283 had vascular wounds to their left lower extremity and was cognitively intact. On 08/07/2024 at 1:10 PM, an observation was made of the wound care and dressing change to Resident 283's left heel and lateral side of ankle with Staff E. Staff E donned gloves, removed the bandages, cleaned the wounds and removed their gloves, and without performing hand hygiene, placed a new pair of gloves on and applied the treatment and dressing. Staff E did not perform hand hygiene during glove changes when indicated. During an interview on 08/07/2024 at 1:34 PM, Staff E stated hand hygiene needed to be completed before and after the dressing change and was unsure if it needed to be completed after their gloves were removed. In an interview on 08/13/2024 at 10:03 AM, Staff C, Infection Prevention Registered Nurse, stated gloves needed to be changed when going from a clean area to a dirty area and hand hygiene was not needed after gloves were removed unless you touched something unclean. During an interview on 08/13/2024 at 10:12 AM, Staff B, Director of Nursing, stated hand hygiene needed to be completed after gloves were removed during dressing changes and this was important to prevent the spread of bacteria. During an observation on 08/26/2024 at 9:44 AM, Staff LL, Registered Nurse (RN) provided medication and fluid administration to Resident 7 through a feeding tube. Upon entering the resident's room, Staff LL washed their hands at the sink in the room and put on gloves. After they used a syringe to administer fluids and medications through the feeding tube, Staff LL rinsed the syringe at the sink in the resident's room and turned off the water using their gloved hand, then without performing hand hygiene or changing gloves, placed the syringe in a plastic bag, cleaned the resident's mouth, and applied lip balm to the resident's lips. Staff LL then removed their gloves and rinsed their hands with water at the sink, they did not wash with soap or use alcohol-based hand sanitizer to clean their hands. Staff LL then proceeded to prepare medications and administer them to another resident. In an interview on 08/06/2024 at 10:07 AM, when asked why they only rinsed with water after removing their gloves, Staff LL stated they never washed with soap after removing gloves. They said they only washed their hands with soap and water before putting on gloves. During an observation on 08/12/2024 at 8:48 AM Staff E, Licensed Practical Nurse prepared and administered medication to Resident 3 through the resident's PICC line. Upon entering the resident's room, Staff E washed their hands with soap and water, scrubbing their hands with the soap for five seconds, turned off the water faucet with their bare hand, and proceeded to put on gloves and administer the medication. After removing their gloves, Staff E washed their hands with soap and water, scrubbing their hands with the soap for three seconds, then turned off the water faucet with their bare hand. In an interview on 08/12/2024 at 09:01 AM, when asked how handwashing should be performed, Staff E stated, turn on the water, apply soap to hands, scrub hands with soap for 10-15 seconds, use a paper towel to dry hands, then use another paper towel and turn off the water. Staff E stated this was important to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/06/2024 at 10:23 AM Staff C, Infection Preventionist stated nursing staff were expected to wash their hands when entering or exiting a resident room, before putting on gloves, and after removing gloves. 47728 <Tuberculosis Surveillance> In a review of Resident 48's record there was documentation of a positive reaction to a tuberculosis (TB) skin test. (TB- a contagious bacterial infection that affects the lungs and can spread through the air), (TB skin test- a simple and low-cost method to detect TB infection by injecting a solution under the skin). Staff NN, Licensed Practical Nurse documented on 5/18/2024 that resident 48's TB skin test resulted in a one centimeter touchable, raised, hardened area, at the TB test site. No further documentation of testing related to the TB skin test result was found in Resident 48's record. In an interview on 08/13/2024 at 11:19 AM, Staff C, Infection Preventionist stated they monitored the residents records to ensure documentation on TB testing was completed. Staff C stated a positive TB skin test result consisted of any induration, a raised, hard, reddened area, present at the test site. When asked what would happen if a resident had a positive TB skin test result, Staff C stated, they would investigate further by having the resident get a chest X-ray and/or a more conclusive TB test, and the results would have been documented in the resident record. Staff C stated they were unaware of Resident 48's positive TB skin test and no further action had been taken. An interview with Staff NN was unable to be conducted because they were no longer employed by the facility and did not return a phone call requesting an interview. Reference: WAC 388-97-1320(1)(c)(2)(a)(b)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46033 Based on record review and interview, the facility failed to ensure residents were provided education regarding the risks and benefits of influenza and pneumococcal immunizations, and received the immunizations or did not receive them due to contraindications or refusals for 4 of 5 sampled residents (36, 48, 66, 69) reviewed. This failure put residents at risk of being unable to participate in aspects of their care, and at risk of acquiring viral and bacterial diseases. Findings included . The 03/04/2022 revised Influenza Program facility policy documented residents and family members received education regarding the benefits of the influenza immunization. Residents were offered and given the vaccine unless it was contraindicated, they had already received it during the current flu season, or the resident refused it. The 05/31/2023 revised Pneumococcal Program facility policy documented residents and family members received education regarding the benefits of pneumococcal immunization. Residents were offered and given the vaccine unless contraindicated, they had already received it, or they refused it. A review of resident records on 08/12/2024 documented the following: <Resident 36> Resident 36 was admitted on [DATE] and had diagnoses including chronic obstructive pulmonary disease (COPD, a group of conditions in the lungs that cause inflammation and difficult breathing) and diabetes. Review of the Immunizations section of the electronic medical record (EMR) had no historical documentation that the resident had received a dose of the seasonal influenza vaccine or pneumococcal vaccines. There was no documentation that Resident 36 had been offered education regarding the vaccines or that they had consented to receive them or refused. The 04/24/2024 admission assessment documented Resident 36 did not receive the influenza vaccine as they were not in the facility during this year's influenza vaccination season, and they also did not receive the pneumococcal vaccine because they were not offered it. <Resident 48> Resident 48 was admitted on [DATE] and had diagnoses including morbid obesity, and diabetes. Review of the Immunizations section of the EMR had no historical documentation that the resident had received any doses of the seasonal influenza vaccine or pneumococcal vaccines they had received, if any. The 05/13/2024 admission assessment documented Resident 48 did not receive the influenza vaccine as they were not in the facility during this year's influenza vaccination season, and they did not receive the pneumococcal vaccine because they were not eligible. There was no documentation why the resident was determined to be ineligible. <Resident 66> (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 66 was admitted on [DATE] and had diagnoses including malnutrition and diabetes. Review of the Immunizations section of the EMR had no historical documentation that the resident had received any doses of the seasonal influenza vaccine, or pneumococcal vaccines. There was no documentation that Resident 66 had received education regarding the vaccines, or that they had consented or refused to receive the vaccines. The 12/15/2023 admission assessment documented the resident did not receive the seasonal influenza vaccine or pneumococcal vaccine because they were not offered. <Resident 69> Resident 69 was admitted on [DATE] and had diagnoses including diabetes and pressure ulcers. Review of the Immunizations section of the EMR had no historical documentation that the resident had received any doses of the seasonal influenza vaccine or any pneumococcal vaccines. There was no documentation that Resident 69 had been offered education, had given consent or had refused to receive the vaccines. The 05/08/2024 admission assessment documented Resident 69 had not received the seasonal influenza vaccine or pneumococcal vaccine because they were not offered. On 08/13/2024 at 8:20 AM, immunization records, education regarding influenza and pneumococcal vaccine risk/benefits, and consents or refusals were requested for Residents 36, 48, 66, and 69, and none was provided. Staff B, Director of Nursing stated they had been unable to locate the documentation. During an interview on 08/13/2024 at 2:10 PM, Staff C, Registered Nurse, Infection Prevention, stated the facility had been working on the immunization process. They were planning to obtain a resident's immunization status when admitted and complete the process at that time. Staff C stated they had not been doing any record audits to ensure the resident vaccines were offered or education had been received. Staff C stated they had been doing both Infection Prevention and Resident Care Manager duties initially, so had been unable to follow up on the vaccines. Reference: WAC 388-97-1340(1)(2)(3)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46033 Based on record review and interview, the facility failed to ensure resident records included evidence of the resident's vaccination status for COVID-19 (a viral illness that caused difficulty breathing, fever, or other severe symptoms that included possible death), that the residents had been offered education regarding the risks or potential side effects of the vaccine, had been offered the vaccine if available, refusals, contraindications, or administrations if given, for 4 of 5 sampled residents (36, 48, 66, 69) reviewed. This failure placed residents at risk of not being informed of their choices to receive immunizations, and at risk for acquiring serious viral illnesses. Findings included . The 07/03/2024 Centers for Disease Control (CDC) Staying Up to Date with COVID-19 Vaccines retrieved 08/14/2024 from cdc.gov/covid/vaccines/stay-up-to-date.html documented everyone aged 5 years and older should get 1 dose of an updated COVID-19 vaccine to protect against serious illness. People who are up to date with the COVID-19 vaccination have lowered risk of severe illness, hospitalization and death from COVID-19 than people who are unvaccinated or who have not completed the doses recommended for them by the CDC. A review of resident records on 08/12/2024 showed the following: <Resident 36> Resident 36 was admitted on [DATE] and had diagnoses including chronic obstructive pulmonary disease (COPD, a group of conditions in the lungs that cause inflammation and difficult breathing) and diabetes. Review of the Immunizations section of the electronic medical record (EMR) had no documentation that the resident had received any doses of a COVID-19 vaccination or booster in the past. A further review of the record failed to locate Resident 36's complete immunization history, documentation of education regarding the risks/benefits of receiving the COVID-19 vaccine, or documentation of refusal or administration of the vaccine. <Resident 48> Resident 48 was admitted on [DATE] and had diagnoses including morbid obesity, and diabetes. Review of the Immunizations section of the EMR had no documentation that the resident had received any doses of a COVID-19 vaccination or booster in the past. A further review of the record failed to locate Resident 48's complete immunization history, documentation of education regarding the risks/benefits of receiving the COVID-19 vaccine, or documentation of refusal or administration of the vaccine. <Resident 66> (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 66 was admitted on [DATE] and had diagnoses including malnutrition and diabetes. Review of the Immunizations section of the EMR had no documentation that the resident had received any doses of a COVID-19 vaccination or booster in the past. A further review of the record failed to locate Resident 66's complete immunization history, documentation of education regarding the risks/benefits of receiving the COVID-19 vaccine, or documentation of refusal or administration of the vaccine. <Resident 69> Resident 69 was admitted on [DATE] and had diagnoses including diabetes and pressure ulcers. Review of the Immunizations section of the EMR had no documentation that the resident had received any doses of a COVID-19 vaccination or booster in the past. A further review of the record failed to locate Resident 69's complete immunization history, documentation of education regarding the risks/benefits of receiving the COVID-19 vaccine, or documentation of refusal or administration of the vaccine. On 08/13/2024 at 8:20 AM, immunization records, education regarding COVID-19 vaccine risk/benefits, and consents or refusals were requested for Residents 36, 48, 66, and 69, and none was provided. Staff B, Director of Nursing, stated they had been unable to locate the documentation. During an interview on 08/13/2024 at 2:10 PM, Staff C, Registered Nurse, Infection Prevention, stated the facility had been working on the immunization process. They were planning to obtain a resident's immunization status when admitted and complete the process at that time. Staff C stated they had not been doing any record audits to ensure the resident vaccines were offered or education had been received. Staff C stated they had been doing both Infection Prevention and Resident Care Manager duties initially, so had been unable to follow up on the vaccines. Reference: WAC 388-97-1320