STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505099	A. Building B. Wing	11/24/2025

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

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the consistent and required provision of Restorative Nursing Programs (RNP, a formal, planned and organized program of care which is intended to restore a lost ability or maintain a potentially deteriorating function for a particular resident), including periodic reviews of the RNP, for 4 of 4 sampled residents (Residents 49, 68, 82, and 88) reviewed for limited range of motion and mobility. These failures placed the residents at risk of development or worsening of contractures (a medical condition where muscle, tendon, or other soft tissue becomes abnormally tight and shortened, limiting the range of motion at a joint) and a diminished quality of life.Findings included.Review of a revised 08/30/2025 facility policy titled Range of Motion showed, the facility would provide range of motion (ROM, the full movement potential of a joint or series of joints) exercises to assist the resident to prevent avoidable decline including avoidable contracture development. The policy showed the facility identified residents through the comprehensive assessment as having limited ROM or at risk for decline and assessed appropriateness of formal interventions that included a referral to skilled therapy programs or a RNP. A decline in ROM and muscle atrophy (the loss or wasting of muscle tissue, resulting in decreased muscle mass and strength) was considered unavoidable if the facility adequately assessed the resident, appropriate care planning was evident, and a limb or digit was immobilized due to injury or from a surgical procedure.<Resident 49> Review of an 11/14/2025 quarterly assessment showed Resident 49 admitted to the facility on [DATE] with traumatic brain injury, dementia, and paralysis or weakness to one entire side of the body, and aphasia (a language disorder caused by damage to the brain that impairs a person's ability to communicate). The staff assessed Resident 49 had severe cognitive impairment. The assessment showed the resident had impaired Functional Limitation in Range of Motion [FLROM, limitation that interfered with daily functions or placed resident at risk of injury] to both upper and lower extremities to one side of the body and received a passive (staff perform to the resident) ROM RNP three of the seven days of the assessment reference period. An observation and interview on 11/20/25 at 11:06 AM showed Resident 49 in bed, dressed in a hospital gown. Resident 49's left hand fingers were curled inwards; no splint or brace were observed to the left hand. Their left arm was bent at the elbow, and Resident 49 used their right arm to extend open their left arm, slowly and unsuccessfully. When asked if the staff placed a splint to the left hand and how often, Resident 49 said, Not really and Not very [often]. Resident 49 said about the left-hand splint, I don't want it, I don't care.Review of Resident 49's comprehensive care plan showed an intervention that read, No splints to left hand contracture per resident preference, initiated 09/05/2025. A restorative care plan showed Resident 49 required a RNP secondary to limited physical mobility, communication problem and had contractures (date initiated 12/04/2018). Interventions dated 12/04/2018 showed a passive ROM RNP to both upper extremities, 15 minutes a day up to six days a week. Another 12/04/2018 and revised 01/03/2025 intervention showed, Assistance with splint or brace. Remove palm protector daily to monitor skin on L [left] hand and perform hand hygiene. Monitor both hands for signs of redness at pressure points and notify nurse in the morning (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and at bedtime, 15 minutes a day up to six days a week. The intervention instructed the staff to notify therapy services, if further issues arise. Review of paper RNP flow sheets showed that for the month of August 2025, Resident 49 received no RNP from 08/01/2025 to 08/10/2025. The second and third weeks of September 2025, the resident received RNP only twice each week, and only once from 09/22/2025 to 09/30/2025, a span of 9 days. In October 2025, the staff provided RNP twice on the second and third weeks of the month, and no RNP the week of 10/22/2025 to 10/28/2025. In November 2025, the staff provided RNP only twice the first week of the month, and once from 11/15/2025 to 11/20/2025. Review of the electronic medical record (EMR) showed an RNP for the palm protector. The flow sheet showed that between 10/22/2025 and 11/19/2025, Resident 40 refused the RNP 14 days (10/22/2025, 10/27/2025, 10/28/2025, 10/30/2025, 11/02/2025, 11/04/2025, 11/06/2025, 11/09/2025, 11/12/2025, 11/13/2025, 11/14/2025, 11/17/2025, 11/18/2025, and 11/19/2025).Record review showed no documentation on how the facility addressed the refusal of the RNP. Review of the medical record showed no documentation the facility periodically reviewed the effectiveness of and tolerance to the RNP. <Resident 68> Review of a 10/03/2025 quarterly assessment showed Resident 68 admitted to the facility on [DATE] with weakness, heart and lung conditions and was cognitively intact. The assessment showed Resident 68 had no FLROM and received no RNP during the assessment reference period. Review of a 03/27/2025 admission evaluation showed the staff identified Resident 68, has a contracture to the right hand that [the resident] also states does cause [them] some discomfort when touched.An observation and interview on 09/25/2025 at 1:50 PM showed Resident 68 sitting on the edge of the bed. A visible contracture was noted to the right hand, and the resident was unable to open or extend their fingers. Resident 68 said they were told, Nothing can be done for it, and received no RNP for its management. Review of a Physical Therapy Discharge summary dated [DATE] showed the therapist established and trained the staff on a Restorative Ambulation [walking] Program. Additionally, the program included, Nustep [a cross-trainer machine that provides a low-impact, total-body workout] as tolerated to improve general conditioning. Review of Resident 68's care plan and the remaining EMR showed no documentation the facility developed and implemented an RNP for the management of contractures including their worsening. The care plan showed no inclusion of the required RNP (ambulation and Nustep) developed by the therapist. Review of paper RNP flow sheets showed that for the month of August 2025, Resident 68 received no RNP from 08/01/2025 to 08/13/2025, and refused on 08/14/2025, 08/15/2025, 08/25/2025, 08/26/2025, 08/28/2025 and 08/29/2025. The resident participated in the RNP two days out of the entire month of August 2025. This flow sheet did not show which RNP were offered or refused. Review of paper RNP flow sheets showed that for the month of September 2025, Resident 68 resident received their RNP once on 09/01/2025 and refused on 09/03/2025 and 09/05/2025. There was no documentation on the flow sheet from 09/06/2025 to 09/30/2025 to show provision of the required RNP. This flow sheet did not show which RNP were offered or refused.Review of paper RNP flow sheets showed that for the month of October 2025, Resident 68 refused their RNP on 10/06/2025, 10/07/2025, 10/09/2025 and 10/16/2025. The flow sheets showed no documentation the staff provided the resident the RNP as required from 10/01/2025 to 10/05/2025, 10/10/2025 to 10/15/2025, and 10/17/2025 to 10/31/2025. This flow sheet did not show which RNP were offered or refused.Review of November 2025 paper RNP flow sheets showed no documentation the staff provided Resident 68 the RNP programs as required. Review of the medical record showed no documentation the facility periodically reviewed the effectiveness and resident tolerance to the required RNPs or how they addressed the Resident 68's refusals. <Resident 82> Review of a 09/03/2025 quarterly assessment showed Resident 82 admitted to the facility on [DATE] with the diagnosis of a stroke, one sided paralysis or weakness, and assessed to be cognitively intact. The assessment showed the resident had no FLROM and received no RNP during the assessment reference period. An observation on 11/20/2025 at 11:02 AM showed Resident 82 participating in a group activity sitting in their wheelchair. A splint was observed to their (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	right hand. Review of Resident 82's care plan showed a 09/04/2025 intervention that instructed the staff to, Provide supportive devices as recommended - [Resident] is to wear splint to [their] right hand following restorative ROM program; resident should wear for at least 3-4 hours until tolerance increases. The care plan showed the resident had a contracture of right hand. The care plan showed no mention or details of the ROM program. Review of the November 2025 Treatment Administration Record (TAR) from 11/01/2025 to 11/19/2025 showed an order for Splint to right hand r/t [related to] contracture - Restorative will don following Restorative ROM program. Leave on for at least 3-[to]4 hrs [hours] (as tolerated by resident), then remove and check skin to hand every shift for right hand contracture. The TAR showed no documentation of how long Resident 82 tolerated the splint for. Review of a Restorative Nursing Referral dated 09/04/2025 showed instructions for a passive ROM and splint RNP. The referral showed that if Resident 82 refused three times in a row, they would be taken off the RNP. The referral showed ROM should be provided to the arm, elbow and wrist, as well as their hand and fingers. The referral showed no instruction on how often the RNPs should be provided to the resident. There was no acknowledgment to the referral by either a Restorative Nurse or aide. Review of the electronic medical record showed no documentation the facility provided the ROM RNP to Resident 82 as required or the periodic evaluation of the ROM and splint program to assess their effectiveness and tolerance by the resident. Review of paper RNP flow sheets showed that for the month of September 2025, Resident 82 received their RNP twice between 09/01/2025 to 09/07/2025, three times between 09/08/2025 to 09/14/2025, and once between 09/15/2025 and 09/21/2025. The flow sheet showed no documentation the staff provided the required RNP to Resident 82 between 09/20/2025 and 09/30/2025. This flow sheet did not show which RNP were offered. Review of paper RNP flow sheets showed that for the month of October 2025, Resident 82 received their RNP twice between 10/01/2025 to 10/07/2025, once from 10/08/2025 to 10/14/2025 (refused on 10/09/2025), and twice from 10/15/2025 to 10/21/2025. The flowsheet showed no documentation the staff provide the RNP to Resident 82 between 10/22/2025 to 10/29/2025. This flow sheet did not show which RNP were offered or refused.Review of November 2025 paper RNP flow sheets showed Resident 82 received their RNP once from 11/01/2025 to 11/07/2025 (refused on 11/06/2025), three times from 11/08/2025 to 11/14/2025, and once from 11/15/2025 to 11/20/2025. Review of the medical record showed no documentation the facility periodically reviewed the effectiveness and resident tolerance to the required RNPs or how they addressed the Resident 82's refusals.<Resident 88>Review of a 09/23/2025 quarterly assessment showed Resident 88 admitted to the facility on [DATE] with a stroke, had impaired FLROM to one side of their body that affected both upper and lower extremities, and was cognitively intact. The assessment showed Resident 88 received no RNP. In an interview on 09/25/2025 at 3:19 PM, Resident 88 stated they were supposed to get rehab [rehabilitation] five days a week, but there are never enough staff here to do rehab. The resident said they came to the facility to get stronger after their stroke and then hoped to discharge to an assisted living facility if possible. Review of a Restorative Nursing Referral dated 07/17/2025 showed a ROM exercise program to the upper and lower body, for conditioning and preventing contractures. The staff was to provide the RNP three to five times a week. There was no acknowledgment to the referral by either a Restorative Nurse or aide.Review of paper RNP flow sheets showed that for the month of August 2025, Resident 88 received no RNP from 08/01/2025 to 08/10/2025 and from 08/16 to 08/25/2025. The flow sheet showed the resident refused on 08/27/2025. The staff provided RNP four times out of the required minimum of 12 times in a four-week period (08/11/2025, 08/12/2025, 08/15/2025 and 08/26/2025). The staff documented Resident 88 refused their RNP on 08/27/2025. Review of paper RNP flow sheets showed that for the month of September 2025, Resident 88 resident received their RNP eight times, not meeting the minimum requirement of three times per week. There were no documented refusals. Review of paper RNP flow sheets showed that for the month of October 2025, Resident 88 received their RNP twice a week from 10/08/2025 to 10/31/2025, not meeting the minimum requirement of three times a week. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There were no documented refusals.Review of November 2025 paper RNP flow sheets showed the staff provided Resident 88 their RNP once from 11/01/2025 to 11/08/2025, twice from 11/08/2025 to 11/14/2025 and none from 11/15/2025 to 11/20/2025, not meeting the minimum requirement of three times a week. There were no documented refusals.Review of the medical record showed no documentation the facility periodically reviewed the effectiveness and resident tolerance to the required RNPs or how they addressed Resident 88's refusals.In an interview on 11/19/2025 at 12:13 PM, Staff Y, Restorative Nursing Assistant, said they were not involved in the periodic review of the residents who received RNP. Staff Y said they did not know who the Restorative Nurse was who oversaw the facility RNP adding, We haven't done that for a while [RNP reviews]. Staff Y said they were unable to complete or provide assigned RNP for the residents in the facility because the facility would pull them away from the RNP and have them escort residents to appointments or work the floor as a nursing assistant. Staff Y said when they were re-assigned from the restorative aide duties that the other nursing assistants completed the programs for their assigned residents. Staff Y said they made the facility aware a resident refused their program by documenting it in the restorative EMR or paper flow sheets. In an interview on 11/20/2025 at 11:16 AM, Staff X, acting Therapy Director/Physical Therapist, stated that they were not aware of any residents refusing their RNP.In an interview on 11/20/2025 at 10:45 AM, Staff Z, Nursing Assistant said Staff Y completed the RNP in the facility and not the Nursing Assistants. In an interview on 11/20/2025 at 11:51 AM, Staff AA, Assessment Coordinator, said they were not the Restorative Nurse and, Honestly, we do not have one. If they [facility] did it was prior to me coming here and I've been here about a year and half. Staff AA confirmed Staff Y provided the RNP to the residents in the facility. The above findings were shared in a joint interview with Staff A, Administrator, and Staff B, Director of Nursing, on 11/20/2025 at 11:55 AM. Staff B said residents on RNP were reviewed through clinical meetings and at the time of the quarterly and annual assessments, but do not have the RNP periodic reviews documented. Staff B said they expected the residents care plan to show the RNP, including the goal, frequency and duration and document it was provided in the EMR. Staff B said that if a resident refused their RNP, the staff should reapproach them and if still unsuccessful to report the refusal to the Nurse Manager. Staff B said they were only aware Resident 49 refused their RNP. Reference WAC [PHONE NUMBER] (3)(d), (j)(ix)Refer to F725 - Sufficient Nursing Staff

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview, and record review, the facility failed to ensure sufficient staff were available to meet the care needs for 3 of 6 sampled residents (Residents 4, 68, 88) reviewed for activities of daily living for dependent residents, and 4 of 4 sampled residents (Residents 49, 68, 82, and 88) reviewed for restorative nursing (interventions that promote a resident's ability to adapt and adjust to living as independently and safely as possible). Failure to ensure there was adequate nursing staff available to provide bathing and restorative services placed the residents at risk for unmet care needs, a diminished quality of life. Findings included . <Resident Council>During a Resident Council meeting on 09/30/2025 at 1:28 PM, attendees were asked if care and assistance was provided timely, without having to wait a long time. All residents in attendance (Residents 18, 20, 24, 5, 35, 41, 11, 6, 47, 75, and 91) stated they often had to wait for assistance because there wasn't enough staff. Resident 24 stated they had even used their cell phone to call the facility in an attempt to get care because their call light was not being answered, and even after the call was made, they waited another 10 to 15 minutes longer before assistance was provided. Resident 24 then stated that last weekend they were not bathed because there wasn't enough staff. All residents agreed with Resident 24 that showers were not being provided, sometimes you had to wait days to get bathed, and one resident had not been bathed in two weeks. <Resident Observations and Interviews>On 09/25/2025 at 10:32 AM Resident 32 stated there are many days were the facility was short staffed, and they have had to wait an hour for a bedpan and then 55 minutes to be assisted off of it. Resident 32 stated concern had been expressed to administration, and the response was that the facility was not understaffed, but if they are not understaffed, then they are understaffed for the care we need. On 09/25/2025 at 12:54 PM, Resident 4 stated sometimes they had to wait as long as 45 minutes to get assistance at night to the bathroom. On 09/25/2025 at 1:03 PM, Resident 99 stated it was difficult sometimes at night to be assisted to the bathroom, and they soiled the bed one night because of it. On 09/25/2025 at 1:50 PM, Resident 68 was observed sitting at the edge of their bed, their right hand was visibly contracted, with the resident being unable to open or extend their fingers. When asked if the facility a provided restorative program for their hand, Resident 68 stated no. On 09/25/2025 at 3:21 PM Resident 88 stated they wait a long time for their call light to be answered and they aren't being bathed.<Interviews>In an interview on 11/21/2025 at 11:39 AM, Staff EE, Human Resource Director, stated there were two nursing assistants assigned to both Berryway and Morningside units and the nursing assistants on those units were responsible to provide the bathing for their residents. Staff EE stated when the concern about residents not being bathed was expressed, the decision was made to pull one of the nursing assistants to do the bathing for the residents for both units, and the three remaining nursing assistants would then provide the resident care. This was implemented on 11/05/2025 and the next day it was determined that it was not effective, and each nursing assistant was again responsible for providing the bathing for their assigned residents. Staff EE stated staff were now being written up for not completing showers, and some staff have put in their notice of resignation because of it. Staff EE stated the issue was more a lack of not enough staff to complete the bathing, rather than staff just choosing not to do the care. In an interview on 11/21/2025 at 7:00 AM, Staff P, Licensed Practical Nurse, stated there was not enough nursing assistants to complete showers consistently. In an interview on 11/24/2025 at 11:18 AM, Staff FF, Staffing Coordinator, stated staffing was based on resident census and currently for day and evening shifts, eight nursing assistants were scheduled for each unit, and five nursing assistants were scheduled for the entire building at night. Staff FF stated each resident care manager had a radio and staff were able to call for assistance if needed. At 11:52 AM during the continued interview related to staffing, Staff FF stated Staff Y, restorative aide, would also be pulled to work the floor if needed. When informed there were concerns also with restorative services not being provided, Staff FF stated they were not (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	aware. In an interview on 11/24/2025 from 12:07 PM to 12:25 PM with Staff A, Administrator and Staff B, Director of Nursing, concerns were expressed with the facility not having adequate staff to complete bathing and restorative services. Staff A stated staffing needs were based on resident census and the facility always referred to the State minimum requirements. Both Staff A and Staff B acknowledged there had been issues with residents not being bathed, but believed that there was adequate nursing staff to complete and it was a matter of disciplinary action. When informed that restorative services were not being completed due to the restorative aide being pulled to work the floor, neither Staff A nor Staff B stated they were aware. Please see F677 ADL care for Dependent Residents and F688 Increase/Prevent Decrease in ROM/Mobility for additional information.Reference (WAC): 388-97-1080(1)

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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. Based on observation, interview, and record review, the facility failed to consistently provide bathing/showers for 3 of 6 sampled residents (4, 68, 88) reviewed for activities of daily living (ADLS). This failure placed the residents at risk for a diminished quality of life and unmet care needs. Findings included .<Resident 4>The 09/19/2025 quarterly assessment documented Resident 4 was cognitively intact to make decisions regarding their care and required assistance from nursing staff to complete activities of daily living (ADLS) such as bathing. On 09/29/2025 at 8:48 AM, Resident 4 was observed in their room. During conversation with the resident, they stated it had been a couple of weeks since they were last bathed, and they did not know why they were not getting bathed. Review of the ADL care plan documented Resident 4 needed assistance to bathe from one nursing staff. Interventions implemented on 03/19/2024 instructed nursing staff to bathe the resident twice a week and as needed, and to provide a bed bath when the resident refused or was unable to tolerate being bathed. Review of the Documentation Summary Reports from 09/01/2025 through 11/18/2025 documented the following: - Resident 4 was bathed on 09/03/2025, and was not bathed until a week later on 09/10/2025. Bathing occurred again on 09/13/2025 and 09/17/2025, but the next bath was not provided until 10 days later on 09/27/2025. - Resident 4 was next bathed 28 days later on 10/25/2025. The only other documented bath occurred on 10/29/2025. Documentation showed the resident had been bathed twice for the month of October.- Resident 4 was bathed 11/05/2025, a period of seven days from their last bath on 10/29/2025. Review of the progress notes from the same time period found no documentation that Resident 4 had refused to bathe, nor was there documentation that stated the resident was not being bathed or reasons provided for the lack of bathing. <Resident 68>The 10/03/2025 quarterly assessment documented Resident 68 was cognitively intact to make decisions regarding their care and required assistance from nursing staff to complete activities of daily living (ADLS) such as bathing. In addition, the assessment documented Resident 68 was not bathed during the seven-day time frame of the assessment. On 09/25/2025 at 1:30 PM, Resident 68 was observed sitting at the edge of their bed. When asked if they had any concerns about their care, Resident 68 stated they were supposed to be bathed twice a week, and it wasn't happening because there wasn't enough staff. A review on 11/18/2025 of the ADL care plan documented interventions were implemented on 03/27/2025 which informed nursing staff Resident 68 needed assistance from one nursing staff to bathe, was to be bathed on Wednesdays and Saturdays, and when the resident refused or was unable to tolerate being bathed, a bed bath was to be provided. A review of the Documentation Summary Reports from 09/01/2025 through 11/18/2025 documented the following: - Resident 68 was bathed on 09/08/2025 and 09/11/2025, and was not bathed again until 09/25/2025, a period of 14 days. For the month of September 2025, Resident 68 was bathed a total of four times. - Resident 68 was bathed on 10/25/2025, a period of 30 days from the last documented shower on 09/25/2025 and had refused to be bathed on 10/29/2025. No other documentation was found that showed Resident 68 had been offered a bed bath after refusing to be bathed as instructed in the care plan. - Resident 68 was bathed on 11/05/2025, 10 days from the last shower on 10/25/2025. Documentation showed the resident refused to be bathed on 11/08/2025, however, no documentation was found that showed Resident 68 had been offered a bed bath. <Resident 88>The 09/23/2025 quarterly assessment documented Resident 88 was cognitively intact to make decisions regarding their care, and needed assistance from one nursing staff for bathing. In addition, the assessment documented the resident had not been bathed during the seven days of the assessment period. During a resident interview on 09/25/2025 at 3:17 PM, Resident 88 stated he wanted to stay clean, was scheduled to be bathed on Tuesdays and Fridays, but was not getting showered regularly. Resident 88 further stated they were bathed Friday (09/19/2025), and the last shower prior to that had been three weeks ago. Review of the ADL care plan documented interventions related to bathing were implemented on 03/17/2025 and informed nursing staff that (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 88 preferred to be bathed twice a week, needed assistance from one nursing staff, and a bed bath was to be provided if bathing was refused or Resident 88 was unable to tolerate being bathed.Review of the Documentation Summary Report from 09/01/2025 through 11/18/2025 documented the following:- Resident 88 was bathed on 09/02/2025, and was not bathed again until 09/16/2025, 14 days later. Bathing occurred on 09/19/2025 and 09/23/2025, but the next bath did not occur until a week later on 09/30/2025.- No documentation was found that showed Resident 88 had been bathed in October 2025.- Resident 88 was bathed 11/04/2025, a period of 34 days after last being bathed, and at the time of the review, the last documented bath occurred on 11/11/2025, seven days ago. <Interviews>In an interview on 09/30/2025 at 9:57 AM, Staff P, Licensed Practical Nurse, stated all documentation for bathing/showers was done in the resident's electronic records, there was not a shower log or paper documentation. In a follow-up interview on 11/21/2025 at 7:00 AM, After discussion of bathing documentation, Staff P confirmed residents were not being bathed consistently. See F725 - Sufficient staffing for additional information

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	505099	A. Building B. Wing	11/24/2025

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to fully assess and implement orders and interventions, monitored a change in condition for 4 of 9 sampled residents (Residents 7, 24, 6 and 51) whose records were reviewed for quality of care. This failure placed residents at risk of medical complications, discomfort and a decreased quality of life. Findings included . <Resident 51> Review of Resident 51's medical record showed the resident had a bowel movement (BM) on [DATE], and not again until [DATE], a span of six days with no BM. Review of Resident 51's medical record showed the resident had a BM on [DATE] and not again until [DATE], a span of five days with no BM. Review of Resident 51's medical record showed the resident had a BM on [DATE] and not again until [DATE], a span of six days with no BM. Review of a [DATE] progress note showed Resident 51, is complaining of constipation, looked over B&B (bowel and bladder record) and [they have] not had a BM documented since 9-9 2025 [a span of 11 days]. The note showed the nurse asked the aide to take the resident to their room to administer an enema. Review of the [DATE] Medication Administration Record showed no documentation the staff administered the enema on [DATE]. Review of a [DATE] progress note showed Resident 51 experienced a fall on their way to the bathroom. The note showed Resident 51 was found sitting in front of their bathroom and Resident was concern [sic] of being constipated. The note showed the nurse gave the resident MOM (Milk of Magnesia, a laxative) and encouraged fluids. Review of the [DATE] MAR showed the MOM administration was ineffective. Review of a [DATE] Secure Conversations progress note showed the doctor gave an order for the staff to administer, dulcolax [a stool softener] rectally daily as needed for constipation. The progress note showed the staff addressed the provider's order on [DATE], two days later, and informed the provider that Resident 51 was transferred to the hospital on [DATE] (after two falls) and Does not appear these orders were processed prior to resident going OOF [out of facility]. Review of the [DATE] MAR showed no documentation the provider's [DATE] order to administer the Dulcolax suppository was implemented. Review of the [DATE] MAR showed various medications available for administration to relieve constipation or facilitate a BM: - Polyethylene Glycol by mouth if no BM in 24 hours: The MAR showed it was only administered as given on [DATE] and was ineffective. - Milk of Magnesia Suspension orally as needed for no BM for two days. If no results within 24 hours, see Dulcolax Suppository order: The MAR showed no documentation it was administered for the month of [DATE] until [DATE] and it was ineffective. - Dulcolax Suppository rectally as needed if no results from MOM. If no results in 24 hours, see Fleets Enema order: The MAR showed no documentation it was administered for the review period of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] to [DATE]. - Fleet Enema as needed if no results from MOM and subsequent Dulcolax suppository. Complete bowel assessment and notify the doctor if no results: The MAR showed no documentation it was administered for the review period of [DATE] to [DATE]. The above findings were shared with Staff B, Director of Nursing, on [DATE] at 9:22 AM. Staff B acknowledged the staff did not but should have documented the administration of the enema on [DATE] and implemented available as needed orders to address bouts of no documented BM as required. Staff B acknowledged the staff did not implement the provider order to administer the Dulcolax suppository when ordered on [DATE]. When asked why the facility took two days to recognize the [DATE] provider order, Staff B stated, Normally, the nurse managers process the orders. They're not here on the weekends. According to the American Red Cross (a nonprofit humanitarian organization that offers services like domestic disaster relief, blood services, and health/safety training like CPR [Cardiopulmonary Resuscitation, an emergency lifesaving procedure performed when the heart stops beating] and First Aid), a level of less than 85 percent (%) oxygen saturation is considered severe hypoxia. Severe hypoxia is a condition where the body's tissues do not receive enough oxygen and can lead to organ damage and confusion. It is a life-threatening medical emergency that requires immediate attention. Review of a [DATE] at 12:41 PM progress note showed Resident 51 vomited in the dining room at lunch time. The staff obtained vital signs and assessed an oxygen saturation level of 80%. A subsequent note at 2:18 PM showed the nurse called the provider who instructed the nurse to put oxygen on resident to bring up oxygen stats [sic]. Another note showed the resident fell at 2:35 PM and the nurse obtained an oxygen saturation level of 96%. The resident was transferred to the hospital after a second fall on [DATE] at 12:53 AM. Review of an Oxygen Saturation Summary and the remaining medical record showed no documentation the nurse obtained, documented, or monitored Resident 51's oxygen saturation level or their respiratory rate and heart rate on [DATE] from 12:41 PM until 2:35 PM (when the resident fell). Review of the [DATE] MAR showed no orders for the delivery of oxygen as documented in the [DATE] note to put oxygen on resident. Review of the remaining medical record showed no documentation the nurse administered oxygen to Resident 51, how much oxygen was given, and method of delivery. The above findings were shared with Staff B on [DATE] at 9:22 AM. Staff B acknowledged the medical record did not show the nurse frequently monitored Resident 51's oxygen saturation level after identifying it was at a dangerously low level. Staff B stated, Our standing [doctor's] order is to place oxygen with a saturation level below 88%. Staff B acknowledged the medical record showed no documentation the nurse implemented the provider's order to administer oxygen when directed. <Resident 7> According to a comprehensive assessment dated [DATE], Resident 7 had diagnoses of lung disease, pneumonia, and respiratory failure. They were alert and able to make their needs known. Resident 7 was totally dependent on staff for repositioning, toileting, and was always incontinent of their bowels. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the bowel task record from [DATE] through [DATE], showed that the resident had a bowel movement (BM) on [DATE]. There were no BM's documented until [DATE], 12 days later. Review of the [DATE] MAR showed the resident had three medications scheduled daily for their bowels. Additionally, the resident had the following medications that could be given PRN (as needed) for constipation: 1) An [DATE] order for Milk of Magnesia (MOM, a liquid laxative), give 1 dose by mouth as needed for No BM for 72 hours. If no results within 24 hours, see Dulcolax suppository order. 2) An [DATE] order for Dulcolax Suppository (a laxative given rectally), insert 1 suppository rectally as needed for bowel care, if no results from MOM. If no results in 24 hours, see Fleets Enema order. 3) An [DATE] order for Fleets Enema (a liquid laxative given rectally) insert 1 unit rectally as needed for bowel care if no results from MOM and subsequent Dulcolax suppository after 24 hours. Complete bowel assessment and notify MD if no results. Per the [DATE] MAR, a dose of MOM was given on [DATE] at 6:42 PM. The follow-up code documented results as unknown. No other doses of any PRN medications were given. Review of progress notes from [DATE] through [DATE] showed no documentation related to Resident 7 lack of BM's, nor any offers or refusals of prn bowel medications. In an interview on [DATE] at 10:14 AM, Staff C, Nursing Assistant (NA) stated that the NA's documented in the computer which residents had BM's. The nurse had a list of residents who did not have a BM to track. In an interview on [DATE] at 10:24 AM, Staff D, Licensed Practical Nurse, stated that the nurse managers run a report every morning that showed who was due for a BM, and gave that list to the floor nurse. In interviews with Staff E, NA on [DATE] at 9:10 AM and Staff F, NA on [DATE] at 9:19 AM, both stated that Resident 7 did not verbalize or indicate any signs of abdominal discomfort when they took care of them recently. In an interview on [DATE] at 12:29 PM, Staff B, Director of Nursing was informed of the documentation of no BM's from [DATE] until [DATE], PRN medications not given and lack of documentation about it. They stated that it was a long span of time and that should have been caught and followed up on. <Failure to Follow a Doctor's Order> <Resident 24> Review of a [DATE] quarterly assessment showed Resident 24 re-admitted to the facility on [DATE] with medically complex conditions, including diabetes. The assessment showed Resident 24 was cognitively intact and received insulin and an anticoagulant (blood thinner). Review of a [DATE] Medication Administration Record (MAR) showed an [DATE] physician order (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that instructed the nurses to check Resident 24's blood sugars at mealtimes and administer insulin based on the blood sugar reading. The orders showed that if the blood sugar reading was between 350 and 399, the nurses must give five units of Novolog (a type of insulin) and call the provider. Review of the MAR showed blood sugar measurements of 394 on [DATE] at 8:00 AM and 355 on [DATE] at 12:00 PM. Review of the medical record showed no documentation the nurse notified the provider of the elevated blood sugars as ordered. Review of a [DATE] MAR showed an [DATE] physician order that instructed the nurses to check Resident 24's blood sugars at mealtimes and administer insulin based on blood sugar reading. The provider orders showed that if the blood sugar reading was between 350 and 399, the nurses must give five units of Novolog and call the provider. Review of the MAR showed blood sugar measurements of 388 on [DATE] at 5:00 PM. Review of the medical record showed no documentation the nurse notified the provider of the elevated blood sugar as ordered. The above findings were shared with Staff B, Director of Nursing, on [DATE] at 10:25 AM. Staff B acknowledged the medical record showed no documentation the nurses notified the provider of Resident 24's elevated blood sugars as ordered. <Resident 6> Review of a [DATE] quarterly assessment showed Resident 6 admitted to the facility on [DATE] with medically complex conditions, including high blood pressure and diabetes. The assessment showed Resident 6 was cognitively intact and received insulin. Review of a [DATE] MAR showed an order that instructed the staff to check Resident 6's blood sugar before meals and at bedtime since [DATE]. The MAR showed the staff obtained the blood sugars at bedtime only. The above findings were shared with Staff O, Resident Care Manager, on [DATE] at 12:32 PM. Staff O acknowledged the staff should have but did not obtain Resident 6's blood sugars as ordered by the provider. Review of a [DATE] MAR showed an order that instructed the nurses to give Resident 6 Lisinopril (a medication for high blood pressure) 2.5 milligrams (a measurement) in the morning. The MAR showed the nurse did not give the Lisinopril on [DATE] due to Vitals out of parameter and documented a blood pressure of 98/58. Review of the medical record showed no provider orders that directed the nurse when to hold the Lisinopril or that the nurse notified the provider of their action and obtained an order to hold the medication. The above findings were shared with Staff O on [DATE] at 12:29 PM. Staff O stated the nurse should have notified the provider of the low blood pressure and obtained an order to hold the Lisinopril or clarify the order to show hold parameters. <Resident 24> Review of the [DATE] American Diabetes Association (ADA, an organization that funds research, advocates policy changes and access to care, and provides education and resources for patients, families, and healthcare professionals) article The Injection Technique Factor: What You Don't Know or Teach Can Make a Difference showed, insulin injections should be rotated to avoid repeat tissue (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trauma and prevent lipohypertrophy (a condition where fatty tissue develops hard lumps or pits, which impairs insulin absorption and leads to unpredictable blood sugar levels). Rotating sites allowed the fatty tissue to recover, ensured consistent insulin uptake and action, helped maintain stable glucose (sugar) control, and prevented injection site complications like scarring and pain. Review of a [DATE] progress note showed the provider saw Resident 24 for a routinely scheduled visit. The notes showed the provider documented the resident, has been having some bruising to [their] abdomen that is nonpainful, the resident was somewhat concerned about it, and was happening where the resident primarily receives [their] insulin injections. The notes showed the provider Discussed with nursing staff about using an alternative site and they state that they can use [the resident's] arm. Review of the [DATE] MAR showed scheduled insulin orders four times a day at 8:00 AM, 12:00 PM, 5:00 PM and bedtime. The MAR showed the nurses documented they administered the insulin injections to Resident 24's abdomen from [DATE] to [DATE]. Review of the medical record showed no documentation Resident 24 refused to have the insulin administered to other alternative sites. Review of the [DATE] MAR from [DATE] to [DATE] showed scheduled insulin orders four times a day at 8:00 AM, 12:00 PM, 5:00 PM and bedtime. The MAR showed the nurses documented they administered the insulin injections to the Resident 24's abdomen except once (on [DATE] to the right arm). Review of the medical record showed no documentation Resident 24 refused to have the insulin administered to other alternative sites. The above findings were shared with Staff B on [DATE] at 10:39 AM. Staff B acknowledged the medical record showed the nurses continued to use the abdomen as the site for insulin injections despite previous discussion with the provider to rotate or use alternative injection sites to prevent trauma to the abdomen. <Resident 24> Review of a [DATE] progress note showed the nurse trimmed Resident 24's right foot toenails. Review of the physician orders showed an order dated [DATE] that instructed the staff to provide nail and foot care every Saturday. Review of a [DATE] Skin Inspection Note showed, skin assessment head to toe completed upon admission. No skin issues noted. Review of a [DATE], [DATE], and [DATE] Skin Inspection notes showed, no new skin issues. Review of a [DATE] progress note showed Resident 24, has been complaining about rt [right] big toenail . for 6 weeks. It's in the drs [doctor's] book x3 [three times]. The note showed the nurse assessed, redness is going up from the toenail approx 14 cm [centimeters, a measurement] and blister has developed on front of toe. The note showed the nurse then called the provider who prescribed a topical antibiotic for the diagnosis of paronychia, a nail inflammation that may result from trauma, irritation or infection. Review of the medical record showed no documentation the staff monitored Resident 24's right big toenail, including an initial assessment, preceding the [DATE] progress note. The medical record showed no documentation the staff escalated the persistent concern of the right big toenail when it (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not addressed the first time in the provider communication book. The above findings were shared with Staff B on [DATE] at 10:45 AM. Staff B stated, I will find information, when asked if the medical record showed the staff monitored and promptly addressed Resident 24's change in condition preceding [DATE]. No further information was provided. <Failure To Clarify a Physician's Order> A [DATE] facility policy titled Intravenous (IV, by vein) Therapy showed, any IV order was accurately transcribed to the appropriate forms and documented in the resident's medical record. According to a quarterly assessment dated [DATE], Resident 7 had diagnoses of lung disease, diabetes, and hypotension (low blood pressure). They were alert and able to make their needs known. In an interview on [DATE] at 11:34 AM, Resident 7 was observed in their room. They had an IV saline lock (A tube inserted into a vein that does not have fluid running through it. Nurses periodically flushed with saline solution to prevent blockage) in their right wrist. Resident 7 stated that it was placed about a week ago to get IV fluids because they were dehydrated. They further clarified that they only needed fluids one time, and it had not been used since. A review of Resident 7's orders included a [DATE] order to insert an IV catheter to administer fluids, for one time only. This order was signed as completed at [DATE] at 11:03 PM on the [DATE] Treatment Administration Record (TAR). Another [DATE] order instructed the nurses to follow facility IV policy for flushing and site maintenance. This order was not found on the September TAR or MAR. During an interview on [DATE] at 10:24 AM, Staff D, Licensed Practical Nurse, stated that routine care of an IV catheter included flushing it every shift to make sure it did not get clogged. The saline flushes were documented on the MAR. During an interview on [DATE] at 11:31 AM, Staff G, Assistant Director of Nursing, stated that an IV should be flushed every shift if not in use, or the IV line could clog and not be usable. When Staff G reviewed Resident 7's September MAR, they acknowledged there was no order that instructed the staff to document saline flushes every shift and there should have been, and the facility did not follow their policy and the provider order for flushing the IV catheter. Reference WAC 388-97-1060(1)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review the facility failed to assess a resident's smoking abilities, appropriately care plan, and implement safety interventions as needed for 1 of 5 sampled residents (Resident 81), reviewed for accidents. This failure placed residents at risk of potentially avoidable accidents, unmet care needs, and diminished quality of life. Findings included.According to the 09/15/2025 admission assessment, Resident 81 had diagnoses of metastatic cancer (cancer that had spread to other parts of the body). Resident 81 was alert and oriented, made their needs known and used a wheelchair for mobility.During observation and interview on 09/25/2025 at 3:38 PM, Resident 81 was in their room with a red lighter in their hand. Resident 81 stated they smoked, but only 4 cigarettes a day and went out to the other side of the road to smoke. When asked what they were informed about smoking at this facility, Resident 81 replied there were no rules about cigarettes.Review of Resident 81's admission documents showed a Smoke Free Campus Acknowledgement. The document included that the facility prohibited the use of any tobacco or tobacco products by residents while on company premises. The document also included the statement I am requesting to proceed with the admission, understanding that I will not be able to smoke at the facility or on the premises. The form was initialed by the resident on 09/11/2025 and signed by facility staff as witnessed.Review of September 2025 nursing progress notes showed the following: -09/10/2025 at 11:13 PM an admission summary documented that when Resident 81 arrived, they immediately wanted to go out to smoke and were very upset the facility was a non-smoking facility.-09/12/2025 at 5:42 PM Resident 81 had a pack of cigarettes and was observed smoking them in the parking lot the day before. A facility staff member re-educated the resident on the no-smoking policy. No documentation was found to show Resident 81 was assessed and determined to be able to safely smoke a cigarette independently. Review of the 09/12/2025 smoking care plan showed Resident 81 wished to smoke cigarettes and had been determined to be [Specify: Independent, Dependent] with the process. An intervention instructed staff to complete the smoking/nicotine use evaluation on admission, quarterly and with changes of functional ability that may affect the ability to manage smoking materials. Additional review of Resident 81's record showed no documentation a smoking/safety evaluation was completed.During an interview on 11/20/2025 at 11:53 AM, Staff G, Assistant Director of Nursing, stated if a resident admitted , who was a current smoker, they were educated the facility was non-smoking and offered smoking cessation aids, such as the patch or gum. If a resident insisted on smoking, they were asked not to smoke on facility grounds. When asked how they ensured resident safety with smoking, Staff G replied, that was a good question. Staff G further stated since the facility was non-smoking, they did not have a good smoking evaluation to complete. Staff G reviewed Resident 81's medical record. Staff G stated they initiated the smoking care plan, and meant to ask Staff B, Director of Nursing, about the smoking evaluation referenced, but did not follow up on it. Staff G acknowledged they should have assessed and evaluated Resident 81's ability to safely smoke independently. Reference WAC 388-97-1060 (3)(g)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure consistent, ongoing communication and collaboration with the dialysis (a treatment that removes waste products and excess fluid from the blood when the kidneys are unable to do so) center regarding dialysis care and services for 1 of 1 sampled resident (Resident 24) reviewed for dialysis. Failure to ensure accurate and complete communication to and from the dialysis center, address dietitian communication, and ensure administration and disposition of medications on dialysis days, placed the resident at risk for unmet care needs and dialysis complications.Findings included.Review of an 08/03/2025 quarterly assessment showed Resident 24 re-admitted to the facility on [DATE] with medically complex conditions, including diabetes. The assessment showed Resident 24 was cognitively intact, staff administered insulin, and they received dialysis services.<Communication Before and After Dialysis>Review of an 11/07/2024 care plan in Resident 24's medical record showed the resident had an AV fistula (a surgical procedure that creates a direct connection between an artery and a vein, allowing blood to flow directly from one to the other. This is done to provide adequate blood flow for dialysis) to the left upper arm. Blood flow through the fistula was checked by feeling for a thrill (vibration) and listening for a bruit (whooshing sound). Checking the blood flow was crucial for effective dialysis. The care plan also showed the staff was to, Collaborate with dialysis center regarding medications, diet, nutritional counseling, weight, and lab results and to Communicate and send Dialysis Communication record to every dialysis appointment. Validate report is returned with the resident. Process any changes in progress note.Review of a Dialysis Communication Record showed required written communication between the facility and the Dialysis Center (DC). The form showed the facility would list the medications given within the last six hours prior to sending the resident for the dialysis treatment, the type of access site with choices of an AV fistula, an AV graft (a synthetic tube is implanted between an artery and a vein, creating an artificial channel for blood flow), and a Central Venous Catheter (CVC, a thin, flexible tube inserted into a large vein in the chest or neck for the purpose of administering hemodialysis), if there were signs of infection, if the dressing was dry and intact, if no bleeding was present after last dialysis treatment, the time of the resident's last meal, the resident's most recent weight, and if there were any changes or information to the resident's condition, to include compliance with fluid and diet restrictions. The DC was responsible for communicating to the facility what medications were given during and after the dialysis treatment, the residents before and after treatment weight and vital signs, what foods and how much the individual ate or drank, and any special instructions, comments or changes in the resident's condition during the dialysis treatment, including lab results drawn and the resident's tolerance to the dialysis procedure.Review of Resident 24's Dialysis Binder showed instructions for the nurses titled LN [Licensed Nurse] tasks to complete Pre [before] and Post [after] dialysis. Before dialysis the nurse was instructed to open and fill out the dialysis communication evaluation form in PCC [electronic medical record], print out and place in the dialysis binder. Send binder with the resident to dialysis. Ensure resident has sack lunch or snack to take with them to dialysis. Administer any medications per MAR [Medication Administration Record] and note on the communication evaluation. The instructions showed that after dialysis, the nurse was to receive the dialysis binder back from the resident, Review dialysis communication form received back from dialysis. Enter pertinent information from the form into the evaluation in PCC, then sign and lock the evaluation in PCC. Chart the post-dialysis weight only in weights [section] in PCC. Review evaluation for any medications administered by dialysis then proceed with medications due here at facility assuming there's no overlap or contradictions.Review of Dialysis Communication Records from 08/01/2025 to 10/06/2025 showed incomplete or inaccurate information or missing records:- 08/4/2025 showed no indication of who the facility staff was that assessed the resident before going to dialysis.- 08/6/2025 showed no (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indication of time of last meal or assessment of bleeding after last dialysis treatment- 08/13/2025 showed no indication of the access site assessment, time of last meal, or what the resident's weight was after dialysis.- 08/15/2025 showed no indication of the access site assessment or time of last meal. Additionally, the dialysis center wrote the name of two medications in the weight section. - 08/18/2025 showed the staff assessed Resident 24 had a CVC for their access site.- 08/20/2025 showed no assessment of the access site or time of last meal. - 08/22/2025 showed the record was electronically dated as 08/22/2025, but on the top of the page it was handwritten 08/29/2025. The record showed no assessment of the access site or time of last meal. Dialysis staff also hand-dated the form with their signature 8/29/2025.- 08/29/2025 showed the staff did not assess the resident status prior to going to dialysis, dialysis staff also did not assess the resident status during dialysis, and no post dialysis weight or vital signs were documented. - 09/01/2025 showed no documentation of access site assessment or time of last meal; only one of the two pages were scanned into the EMR which did not include post-dialysis communication. Additionally, the dialysis staff documented the medications they gave during the dialysis treatment in the section that asked the facility staff to list the medications given within the last six hours prior to sending the resident to dialysis. - 09/03/2025 showed no documentation of access site assessment and time of last meal.- 09/05/2025 showed no documentation when the nurse obtained the vital signs and did not include a temperature. - 09/08/2025 showed no indication of the access site assessment or time of last meal. - 09/10/2025 showed no documentation of the access site assessment or time of last meal.- 10/01/2025 showed no documentation of a pre-dialysis weight.- 10/03/2025 showed no assessment of the access site or time of last meal and undated by the dialysis staff. Additionally, review of the medical record showed no Dialysis Communication Records for 08/01/2025, 08/08/2025, 08/25/2025, 09/12/2025, 09/15/2025. 09/17/2025, 09/19/2025, 09/22/2025, 09/24/2025, 09/26/2025, and 09/29/2025.The above findings were shared in a joint interview on 10/09/2025 at 10:46 AM with Staff B, Director of Nursing, and Staff N, Resident Care Manager (RCM). Both Staff B and N acknowledged and confirmed the staff did not ensure consistent, complete and accurate communication with the DC.<Failure to Address Dietitian Communication>Review of Resident 24's medical record showed an order summary for a Renal diet [designed for individuals with kidney disease], regular texture, thin liquid consistency, Phosphorus < (less than) 1200, K+ [potassium] 3 gram, dated 07/30/2025. The summary included a 07/31/2025 order for Boost [liquid nutrition supplement] once a day.Review of an Order Summary Report showed orders for Sevelamer 800 MG (milligrams) Give 3 tablet by mouth three times a day and To be taken with meals; Ok [okay] for resident to keep this medication at bedside in lockbox and self-administer since 08/05/2025 and Velphoro Oral Tablet Chewable 500 MG, Give 1 tablet by mouth three times a day with meals. Sevelamer and Velphoro are phosphate binders, prescribed to people on dialysis to help remove excess phosphate from the body, preventing progression of chronic kidney disease and fractures.Review of a 09/12/2025 Monthly Nutrition Communication Form sent from the dialysis Registered Dietitian [RD] showed the RD informed the facility that Resident 24's potassium and phosphorus levels were elevated. The dialysis RD asked the facility to encourage the resident to increase protein intake, continue/recommend adding protein powder to appropriate foods, continue/recommend adding a protein bar for additional protein and calories, decrease potassium and phosphorus rich foods, and ensure phosphate binder was given with meals and snacks. This communication was noted by the facility staff on 09/12/2025 and FAXED to [facility] RD.Review of a 09/12/2025 progress note showed the facility provided education to Resident 24 regarding phosphorous and potassium levels and eating a diet of low phosphorus and potassium foods, Resident verbalized understanding. Education material provided. Review of the medical record showed no documentation the facility RD responded to the FAX or of what efforts the facility made to follow-up with their RD after the FAX was sent and address the low phosphorus, potassium and protein levels. The diet orders remained unchanged.The above findings were shared in a joint interview with Staff B and Staff N on 10/09/2025 at 10:12 AM. Staff B said they expected the (continued on next page)

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	505099	A. Building B. Wing	11/24/2025

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

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility RD to respond to the FAX by the next Nutrition Meeting, on or around 09/17/2025. Staff B said there were no changes made to Resident 24's diet and acknowledged the dialysis RD recommendations remained unaddressed. <Medication Administration on Dialysis Days>Review of a 06/27/2025 Secure Conversations Messages showed the facility sought clarification about medications on dialysis days and asked the provider, Can we send resident with am [morning] medications on dialysis days or administer prior to leaving facility for dialysis around 0600 [6:00 AM]? Or are meds [medications] just supposed to be held/not administered on those AM's [mornings]? The provider answered, Any AM meds can be given before dialysis. It looks like most are administered [at] noon or hs [bedtime].Review of a 07/18/2025 Secure Conversations Messages showed Resident 24 desired to keep the medication Sevelamer at bedside in lockbox for self-administration. The provider agreed to the request. Review of the August 2025 MAR showed the staff did not administer Resident 24 the following medications on dialysis days even though the provider instructed them that, Any AM meds can be given before dialysis:- - Carvedilol (used treat several heart and blood vessel conditions), Amlodipine (used to treat high blood pressure and certain types of chest pain), and Isosorbide (to prevent and manage chest pain (angina) in people with coronary artery disease), Eliquis (a blood thinner), furosemide (a water pill), escitalopram (an antidepressant), Renavite (used to treat nutritional deficiencies in patients with kidney disease or those on dialysis) and rosuvastatin (for cholesterol) scheduled at AM or unspecified morning time - 08/01/2025, 08/04/2025, 08/06/2025, 08/11/2025, 08/13/2025, 08/27/2025, and 08/29/2025.- - Loperamide (for loose stools) at AM or unspecified time in the morning - 08/01/2025, 08/04/2025, 08/06/2025, 08/13/2025, 08/27/2025, and 08/29/2025.- - Aspart (an insulin) scheduled at 8:00 AM - 08/06/2025, 08/11/2025, 08/13/2025, 08/15/2025, 08/18/2025, 08/20/2025, 08/22/2025, 08/27/2025, and 08/29/2025.- - Sevelamer and Velphoro - 08/01/2025, 08/04/2025, 08/06/2025, 08/13/2025, 08/15/2025, 08/20/2025, 08/22/2025. Record review showed no documentation of what efforts the facility made to ensure Resident 24 received the Sevelamer, Velphoro, and insulin with a meal prior to dialysis. Record review showed no documentation the facility communicated to the provider and dialysis center staff, including the dialysis Registered Dietitian (RD), the resident was not administered their insulin, the phosphate binders and other medications on dialysis days.Review of an Order Summary Report showed a 09/11/2025 instruction to the nurses that it was, OK [Okay] to give am [morning] meds [medications] after dialysis every Monday, Wednesday and Friday. Review of the September 2025 MAR showed Resident 24 missed the following medications on dialysis days: - - Amlodipine, Furosemide, Carvedilol, Aspirin, Escitalopram, Isosorbide, Loperamide, Renavite, Rosuvastatin and Eliquis at AM or unspecified time in the morning - 09/17/2025.- - Aspart insulin with meals at 8:00 AM - 09/01/2025, 09/03/2025, 09/05/2025, 09/08/2025, 09/10/2025, 09/12/2025, 09/15/2025, 09/17/2025, 09/19/2025, 09/22/2025, 09/24/2025, 09/26/2025, and 09/29/2025.- - Sevelamer scheduled at 8:00 AM and Velphoro scheduled at 7:30 AM with meals- 09/01/2025, 09/03/2025, 09/05/2025, 09/08/2025, 09/10/2025, 09/12/2025, 09/15/2025, 09/17/2025, 09/19/2025, 09/22/2025, 09/24/2025, 09/26/2025, and 09/29/2025.Record review showed no documentation of what efforts the facility made to ensure Resident 24 received the phosphate binders, Sevelamer and Velphoro, and insulin with a meal prior to dialysis. Record review showed no documentation the facility communicated to the provider and dialysis center staff, including the dialysis RD, the resident was not administered their insulin and phosphate binders on dialysis days.Review of the October 2025 MAR showed Resident 24 missed the following medications on dialysis days:- - Aspart insulin with meals scheduled at 8:00 AM on 10/01/2025, 10/03/2025, 10/06/2025 and 10/08/2025.- - Sevelamer scheduled at 8:00 AM and Velphoro scheduled at 7:30 AM with meals - 10/03/2025, 10/06/2025 and 10/08/2025.On 10/02/2025 at 12:52 PM (a Thursday, the day after Resident 24's dialysis treatment), the Surveyor opened Resident 24's dialysis binder in the presence of Staff O, RCM. A small transparent envelope was observed inside the inner pocket of the front cover of the binder. The envelope had three white tablets marked S6 and a round brown tablet (continued on next page)

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	505099	A. Building B. Wing	11/24/2025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	marked PA 500. Staff O identified these as Sevelamer (white tablets) and Velphoro (brown tablet). In the binder was a Dialysis Communication/Referral form that showed communication between the facility and the DC for the 10/01/2025 treatment. The form showed no documentation the facility communicated to the DC that the phosphate binders were sent with Resident 24 or that the resident took them while at the DC. Staff O stated that if a resident was sent with medications to dialysis, they would ensure the disposition of the medication by asking the resident if they took the medication and documented it in the MAR if the resident took the medication or not.On 10/02/2025 at 12:57 PM, Staff P, Licensed Practical Nurse, and Resident 4's primary nurse on day shift identified the medications in the dialysis binder as Sevelamer and Velphoro and stated, Oh my God, that's [the] meds [the resident] takes before dialysis. I will get rid of them right now.On 10/09/2025 at 9:08 AM, Resident 24 was observed sitting in their wheelchair in their room. Resident 24 said that on dialysis days, I go without it [the insulin]. I always thought it was weird that I don't get the insulin before I go there. They have not offered me an early breakfast, and I leave at 5:30 [AM]. Resident 24 stated that they asked the staff to give them the Sevelamer and Velphoro to take with them to dialysis where, I take them with the food I am sent with on that day.Review of Dialysis Communication Records from 08/01/2025 to 10/06/2025 showed no documentation the staff administered Velphoro, Sevelamer, or insulin to Resident 24 with a meal prior to going to dialysis or that any medication was sent with the resident to the DC with instructions to take with a meal. On 10/08/2025 at 1:51 PM, a DC Collateral Contact (CC) stated the residents needed to take their medications at the nursing home prior to arriving at the dialysis center because they gave no assistance to the resident except maybe a glass of water. When another DC CC was asked whose responsibility was it to ensure insulin was given if scheduled during dialysis hours they stated, They [the nursing home staff] have to give it before [dialysis].The above findings were shared in a joint interview with Staff B and N on 10/09/2025 at 10:46 AM. Staff N said the staff either send the phosphate binders along with the resident to dialysis or the resident, can pack it up and take with [them] as well. Staff N said the staff should document they sent the medication with the resident on the Dialysis Communication Record form sent with the resident on dialysis days and, we would be able to take [the resident's] word that [they] took the medications unless dialysis wrote it down [in the form]. Staff B acknowledged the staff did not ensure Resident 24 received their phosphate binders and insulin on dialysis days. No further information was provided to show what efforts the facility made to coordinate with the dialysis center and the provider the effective and consistent administration of the phosphate binders and insulin on dialysis days.Reference WAC 388-97-1900 (1), (6)(a-c).

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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. Based on observation, interview, and record review, the facility failed to ensure expired medications were disposed of timely, in accordance with currently accepted professional standards, in 2 of 4 medication storage rooms and 2 of 4 medication carts were not maintained in a sanitary manner. This failure placed residents at risk for receiving compromised or ineffective medication. Findings included .During an observation of the Berry Way medication room on 09/26/2025 at 10:15 AM, with Staff B, Director of Nursing, there were three bags of Zosyn, an intravenous (IV) antibiotic medication for Resident 78 that had expired on 08/27/2025, Gabapentin liquid, a medication used to treat seizures or pain, for Resident 57 that had expired on 08/28/2025. In an interview on 09/26/2025 at 10:35 AM, Staff B stated the nurse managers and themselves checked the medications monthly to ensure they were not expired. Staff B stated it was important to discard the expired medications to ensure the residents did not receive medication that might not be effective. In an observation on 09/26/2025 at 10:44 AM of the Mountain View medication room, there were 10 packs of Juven (a nutritional powder) that had expired on 09/01/2025. In an observation on 09/26/2025 at 10:56 AM of the refrigerator in Staff B's office that contained the vaccines, there was a bottle of Tubersol (medication used to check for tuberculosis) that had been opened and dated 08/20/2025. Tubersol needed to be discarded 30 days after it was opened. In an interview on 09/26/2025 at 11:04 AM, Staff B stated they checked the vaccines monthly to ensure they were not expired, and it was important to discard the Tubersol after 30 days because the results of the test might be inaccurate. In an observation on 09/26/2025 at 1:39 PM of the Mountain View medication cart with Staff W, Licensed Practical Nurse, there was an Aspart insulin pen (medication used to treat diabetes) that had been used without a date of when it had been opened. Staff W stated the insulin was good for 30 days and it was important to date the insulin pens because if it was used past the date, it might change the efficacy of the medication. The medication cart was unclean with remnants of pills and small pieces of torn paper. Staff W stated they had bought a miniature vacuum to clean it out because they did not like the way it looked. In an observation on 09/26/2025 at 2:44 PM of the Morning Side medication cart with Staff L, Licensed Practical Nurse, the cart was unclean with spilled pills, dust from the pills and pieces of torn paper. There were insulin pens for Resident 78 and 47 that had been used with no open dates. In an interview on 09/26/2025 at 3:03 PM, Staff L stated the insulin needed to be dated so you knew when to discard it so it did not go bad, and it was important to keep the medication carts clean for infection control. Reference: WAC 388-97-1300 (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident records were complete and accurate for 2 of 3 sampled residents (Resident 6 and 17) reviewed for advance directives (a legal document that outlined a resident's wishes for medical treatment if they could not make decisions for themselves) and 2 of 6 sampled residents (Resident 2 and 3) reviewed for admission. This failure placed the residents at risk of delay in care, inaccurate medical records, and decreased quality of life. Findings included. Review of facility policy titled, Resident Medical Record revised October 2022, showed each resident medical record was to be maintained complete, accurately documented, readily accessible, and systematically organized.<Resident 6> Review of a 08/20/2025 Care Conference Review showed Resident 6 had an advanced directive and a copy of the healthcare Power of Attorney (POA, a document that appointed a person to make medical decisions on the resident's behalf) was on file. Review of the medical record showed no presence of the POA paperwork. The above findings were shared with Staff Q, Social Services Director (SSD), on 11/19/2025 at 11:54 AM. Staff Q said the reference to the POA paperwork documented in the 08/20/2025 Care Conference Review, might have been a typo [mistake made while typing or printing]. Staff Q said that sometimes resident representatives dropped off advance directives paperwork at the front desk with the receptionist and, I won't see it. No further information was provided. <Resident 17> According to the 10/13/2025 quarterly assessment, Resident 17 admitted to the facility on [DATE]. Resident 17 was cognitively intact. Review of the 01/08/2025 care conference summary showed Resident 17 had a POA. A summary showed POA paperwork was provided during the care conference. Additional record review showed no documentation of Resident 17's POA paperwork on file. In an interview on 11/18/2025 at 1:05 PM, Staff Q, SSD, stated they asked residents if they had advanced directives during the initial care conference, obtained paperwork, and gave it to medical records to upload into the record or uploaded it themselves. POA paperwork for Resident 17 was requested from Staff Q on 11/18/2025 at 1:13 PM and on 11/19/2025 at 2:38 PM. No documentation was provided. <Resident 2> According to the 11/03/2025 quarterly assessment, Resident 2 admitted to the facility on [DATE] with diagnoses including non-traumatic brain dysfunction (brain impairment not caused by physical trauma), dementia, and encephalopathy (brain disorder that caused confusion, memory loss, and trouble thinking). Resident 2 had severe cognitive impairment with inattention. Additional review of the medical record showed no documentation of admission paperwork on file. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 05/03/2023 durable power of attorney (POA, legal document that allows an individual to appoint a representative to make medical decisions when a person was unable to do so) showed Resident 2 had a designated POA. The agreement further showed Resident 2's representative had no power to agree to pre-dispute binding arbitration. Review of the voluntary agreement for arbitration showed it was electronically signed by the severely cognitively impaired Resident 2, on 12/26/2024. Review of the 05/05/2025 care plan showed Resident 2 had impaired communication related to cognitive decline and instructed staff to ask simple and direct questions. In an interview on 11/19/2025 at 1:01 PM, Resident 2 was asked to explain binding arbitration. Resident 2 replied, well, oh boy, lets see, I can't think, no one explained things, I just can't think. In an interview on 11/19/2025 at 3:19 PM, Resident 2's POA stated staff reviewed paperwork with them upon Resident 2's admission but binding arbitration was not ringing a bell and did not recall staff reviewing that with them. The POA further stated Resident 2 would not know what an arbitration agreement is. In an interview on 11/19/2025 at 1:31 PM, Staff J, Admissions Coordinator, stated they reviewed the binding arbitration agreements with new admissions. Staff J explained they printed out the agreement, offered to read it out loud and answered any questions. Staff J further stated they were not sure if a resident who has cognitive impairment should sign, it's not up to me to decide if someone is too cognitively impaired to sign the paperwork. In an interview on 11/19/2025 at 2:22 PM, Staff A, Administrator, stated binding arbitration agreements were reviewed upon admission. Staff A acknowledged if a resident had severe cognitive impairment or a POA, the arbitration agreement should be reviewed with the appointed resident representative. <Resident 3> According to the 10/27/2025 quarterly assessment, Resident 3 admitted to the facility on [DATE] with diagnoses including dementia without behaviors. Resident 3 had severe cognitive impairment with disorganized thinking. Additional review of the medical record showed no documentation of admission paperwork on file. In an interview on 11/20/2025 at 2:58 PM, Staff A, Administrator, stated they expected resident records to be complete and accurate. Reference WAC 388-97-1720 (1)(a)(i-iv)(b)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to perform hand hygiene when indicated during 2 of 3 medication administration observations. This failure placed residents at risk for potential unintended health consequences and diminished quality of life.Findings included .In an observation on 09/29/2025 at 7:26 AM, Staff P, Licensed Practical Nurse, sanitized their hands and put on gloves. At 7:27 AM, Staff P walked down the hall wearing their gloves, opened a resident's door, and moved their curtains. Wearing the same gloves, Staff P lifted Resident 38's gown, wiped their abdomen with an alcohol swab, and gave them their insulin injection. In an interview on 09/29/2025 at 11:33 AM, Staff P stated they should have removed their gloves and performed hand hygiene after they touched those things, prior to administering the medications, and it was important to do so for infection control. In an observation on 09/29/2025 at 8:53 AM, Staff D, Licensed Practical Nurse, was wearing gloves and opened the door to Resident 22's room. Wearing the same gloves, Staff D, moved the resident's tray table and administered their medications though a gastrostomy tube (a feeding tube inserted through a small opening in the abdomen directly into the stomach used to deliver nutrition, fluids and medications) without hand hygiene being performed or gloves changed.In an interview on 09/29/2025 at 9:00 AM, Staff D stated they should have removed their gloves and performed hand hygiene after they opened the door and moved the tray table, prior to administering Resident 22's medication to prevent cross contamination. In an interview on 09/29/2025 AT 3:53 PM, Staff G, Infection Preventionist, stated hand hygiene and glove changes needed to be performed after touching items, prior to administering medications. Staff G stated it was important to prevent the spread of bacteria. Reference: WAC 388-97-1320