STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505114	A. Building B. Wing	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aurora Valley Care	414 S University Rd Spokane, WA 99206

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review the facility failed to consistently assess fall risk, timely initiate fall care plans and implement new safety interventions for 2 of 4 sampled residents (Resident 1 and 2), reviewed for falls. Resident 1 sustained repeat falls when safety interventions were not initiated timely. This failure placed residents at risk for potentially avoidable accidents, injuries, and diminished quality of life. Findings included . Review of the facility policy titled, Fall and Injury Prevention and Management, revised 01/2023, showed residents would be assessed for fall risks on admission, quarterly, after a fall, and with a change of condition. The facility was to include the resident and/or their representative in determining a history of falls and their causative factors. A fall care plan was to be initiated at the time of admission with appropriate interventions implemented to address identified fall risk factors. The policy further showed the facility would revise the resident's care plan after a fall occurred to reduce the likelihood of another fall. <Resident 1> According to the 01/23/2024 admission assessment, Resident 1 admitted to the facility on [DATE] with diagnoses including encephalopathy (damage or disease that affects brain function causing possible confusion, loss of memory, and agitation), seizure disorder (unusual brain activity that may cause unusual behaviors, feelings, movements, and loss of awareness), and fibromyalgia (widespread chronic pain and fatigue with memory and mood issues). Resident 1 required moderate to maximal assist of staff to perform most activities of daily living. In addition, the assessment showed Resident 1 had a history of falls prior to admission with a fracture sustained related to falls in the 6 months prior to their admission. Review of the 01/12/2024 pre-admission hospital notes showed Resident 1 suffered from chronic encephalopathy ongoing from months to years and had been seen in the emergency department multiple times for falls/weakness. The notes further showed Resident 1 had near complete falls multiple times in the emergency department when trying to transfer when nobody was in the room and required fall precautions. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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NAME OF PROVIDER OR SUPPLIER: Aurora Valley Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 414 S University Rd Spokane, WA 99206	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 01/16/2024 admission fall risk assessment showed Resident 1 had a history of falls and was identified as a high risk for falls but did not require safety interventions. Review of the 01/16/2024 baseline care plan showed no documentation of the identified falls risk or fall interventions implemented. Review of the 01/16/2024 progress note written by Staff C, Advanced Registered Nurse Practitioner, showed Resident 1 had been having increased falls at home and their spouse was no longer able to care for them. Review of the comprehensive care plan showed a fall care plan initiated on 01/17/2024 with interventions that included ensuring the call light was within reach, appropriate footwear was used, frequently used items were kept within reach, and to maintain a safe environment. On 01/19/2024 interventions were added to involved Resident 1 in diversion or distraction activities and use pillows for right lateral supports related to poor trunk control. Review of Resident 1's progress notes showed they attempted to self-transfer multiple times a day and sustained falls on: - 01/20/2024 at 2:20 PM, Resident 1 had a fall out of their wheelchair while attempting to self-toilet. The call light had not been activated and Resident 1 was holding their nonskid socks in their hand. The notes further showed Resident 1's spouse informed facility staff that Resident 1 fell several times at home. - 01/21/2024 at 11:20 AM, Resident 1 had a fall out of bed. The call light was within reach but had not been activated. The notes further showed Resident 1's spouse informed facility staff that Resident 1 fell multiple times a day when at home. - 01/21/2024 at 2:25 PM, Resident 1 had very poor safety awareness and had another fall this afternoon. Resident 1 continued to attempt to self-transfer and ambulate without assistive devices or staff assistance despite the call light being within reach. Review of the 01/20/2024 2:20 PM facility fall incident report showed the root cause of the fall was identified as Resident 1 attempting to toilet self without needed assistance from staff. The care plan was reviewed and no new interventions deemed necessary. Facility fall incident reports for both falls that occurred on 01/21/2024 were requested on 02/08/2024 at 2:24 PM, 02/13/2024 at 2:34 PM, and 02/16/2024 at 11:10 AM. No documentation was provided for the fall that occurred on 01/21/2024 at 2:25 PM. Review of the 01/21/2024 11:20 AM facility fall incident report showed the root cause of the fall was identified as Resident 1 attempting to self-transfer without using their call light. According to the 01/25/2024 incident report summary note, no new fall interventions were put into place related to Resident 1 discharged on [DATE]. Further review of Resident 1's care plan showed no documentation new fall interventions were initiated after they sustained a fall on 01/20/2024 or 2 falls on 01/21/2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 1's medical record showed a 01/22/2024 fall risk assessment that continued to identify them as a high risk for falls. <Resident 2> According to the 02/01/2024 admission assessment, Resident 2 admitted to the facility on [DATE] with diagnoses including encephalopathy and transient ischemic attack (brief blockage of blood flow to brain that causes short periods of stroke like symptoms). Resident 2 required supervision to moderate assist of staff to perform most activities of daily living. In addition, the assessment showed Resident 2 had a history of falls prior to admission. Review of the 01/24/2024 pre-admission rehabilitation center notes showed Resident 2 had falls on 12/22/2023 and 01/02/2024. Resident 2 required minimum to moderate staff assist for bed mobility, transfers, and walking depending on their level of alertness, cognition, and behaviors which could be highly variable day to day and hour to hour. The notes showed Resident 2 had difficulty with following direction, reasoning, remembering, orientation, and agitation. Review of the 01/25/2024 admission fall risk assessment showed Resident 2 had a history of falls, was identified as a high risk for falls and required safety interventions. Review of the 01/26/2024 baseline care plan showed no documentation of the identified falls risk or fall interventions implemented. Review of Resident 2 progress notes showed they were very confused, had difficulty sleeping, wandered, experienced hallucinations, and required redirection multiple times. Resident 2 sustained a fall on 01/26/2024, the day after they admitted . Review of the comprehensive care plan showed a fall care plan initiated on 01/29/2024 (4 days after admission and 3 days after they sustained a fall) with interventions that included ensuring the call light was within reach, appropriate footwear was used, frequently used items were kept within reach, and to maintain a safe environment. On 01/30/2024 interventions were added to involved Resident 2 in diversion or distraction activities and monitoring for injuries after a fall occurs. Review of the 01/26/2024 facility fall incident report showed Resident 2 fell when they did not utilize their call light and self-transferred. According to the 01/30/2024 incident report summary note, the care plan was reviewed, and interventions were being followed at the time the fall occurred (the fall care plan was not initiated until 3 days after the fall occurred). Review of Resident 2's medical record showed a 01/29/2024 fall risk assessment that continued to identify them as a high risk for falls. In an interview on 02/16/2024 at 12:47 PM, Staff D, Nursing Assistant, stated staff should find a resident's required level of assist and any safety interventions in their care plan but that information was typically missing for new admissions. Staff D stated a fall was when any body part other than the feet touched the floor unless a resident was cognitively intact, independent with mobility and intentionally put themselves on the floor. Staff D acknowledged Resident 2 had falls upon admission because of their behaviors. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/16/2024 at 1:45 PM, Staff E, Resident Care Manger, stated staff could find a resident's required level of assistance or any safety interventions in the care plan and staff should go to the nurse or therapy if the information was missing. Staff E stated a new fall incident report should be filled out each time there was a new fall because the mechanism of action could be different each time. Staff E acknowledged a new safety intervention should be initiated immediately each time a new incident occurred because a resident could have repeat falls if safety interventions were not initiated timely. Staff E stated they were unsure how often residents should be assessed for fall risk. Staff E reviewed Resident 2's pre-admission progress notes, baseline, and comprehensive care plans. Staff E acknowledged Resident 2 was at high risk for falls, but the baseline care plan did not address falls and safety interventions were not initiated on the comprehensive care plan until 01/29/2024 (4 days after admission and 3 days after they sustained a fall). Staff E reviewed Resident 1's pre-admission progress notes, baseline, and comprehensive care plans. Staff E stated Resident 1 admitted related to frequent falls at home and their spouse was no longer able to care for them. Staff E acknowledged Resident 1's baseline care plan did not address falls and new safety interventions were not initiated after Resident 1 sustained a fall on 01/20/2024 or 2 falls on 01/21/2024. In an interview on 02/16/2024 at 2:31 PM, Staff B, Director of Nursing, stated residents were assessed for fall risk upon admission, quarterly, when a fall occurred, and when there was a change of condition. Staff could find a resident's required level of assist and safety interventions in the care plan. Staff B stated the facility goal was to initiate a fall intervention within 72 hours of an incident, but safety interventions were not always needed. Staff B reviewed Resident 2's medical records. Staff B acknowledged Resident 2's fall care plan was not initiated timely and should have been initiated within 48 hours of admission. Staff B reviewed Resident 1's medical record. Staff B acknowledged the progress notes showed Resident 1 had 2 falls on 01/21/2024 but they could only locate one incident report for that day, and Resident 1 discharged prior to additional safety interventions being initiated. Staff B stated they expected an incident reported to be filled each time there was a fall. In an interview on 02/16/2024 at 3:00 PM, Staff A, Administrator, stated a fall was an unintended change in plane. Staff A stated that ideally floor staff would immediately initiate a new fall safety intervention each time a new incident occurred which was then reviewed by the nurse manager and the interdisciplinary team to verify it was appropriate. Staff A further stated that residents should be assessed for fall risk upon admission, quarterly, when there is a fall, or a change of condition and the fall care plan should be initiated upon admission based on the risk factors identified in the assessment. Staff A reviewed Resident 2's medical records. Staff A acknowledged Resident 2 had a fall upon admission and the fall care plan was not initiated until 3 days after their admission but should have been initiated upon admission. Staff A reviewed Resident 1's medical record. Staff A acknowledged Resident 1 had 2 falls on 01/21/2024 but they could only locate one incident report for that day. Staff A expected staff to complete an incident report and initiate a new safety intervention each time a new fall occurred. Reference WAC: 388-97-1060 (3)(g) This is a repeat citation from complaint investigations dated 10/12/2023.