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	05/09/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review the facility failed to identify verbally and physically aggressive resident to resident incidents as potential abuse, and report incidents to the State Survey Agency as required for 4 of 6 sampled residents (Resident 3, 4, 5, and 6), reviewed for abuse. In addition, the facility failed to identify a missing wallet with contents as potential misappropriation of resident property, and report the incident to the State Survey Agency as required for 1 of 6 sampled residents (Resident 2), reviewed for abuse. These failures placed residents at risk of potential abuse, unmet care needs, and diminished quality of life. Findings included . Review of the facility policy titled, Prevention and Reporting: Resident Mistreatment, Neglect, Abuse . and Misappropriation of Resident Property dated 08/2022, showed when the facility received an allegation that met the definition of abuse, neglect, exploitation, mistreatment, and misappropriation of resident property the facility would report the allegation immediately to the State Survey Agency. The policy defined verbal abuse as oral, written, or gestured language that included disparaging and derogatory terms to the resident or within their hearing distance that would demean or humiliate. The policy defined misappropriation of resident property as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. <Resident 4> Review of the quarterly assessment, dated 03/18/2024, showed Resident 4 had minimal difficulty hearing, had clear speech, was understood, and understood others. The assessment further showed Resident 4 had verbal behaviors directed towards others that occurred one to three days with the behavior status marked as the same on the previous assessment. Resident 4 was cognitively intact and able to verbalize their needs. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan revised 12/27/2023 showed Resident 4 had socially inappropriate behavior and listed Resident 4's target behaviors as being inappropriate with female staff. The care plan instructed staff to remind the resident they were there to assist them and inform the resident when their behavior was inappropriate. The depression care plan revised 12/27/2023 listed Resident 4's target behaviors as sadness, negative statements, and social isolation. The care plan instructed staff to ensure the resident needs/wishes were addressed, rule out pain/infection, and validate their feelings. The sensory/communication care plan revised 12/27/2023 showed Resident 4 had a diagnosis of hearing loss but was able to hear adequately. The care plan instructed staff to approach the resident from the front, face the resident when speaking to them, and turn the TV/radio off as needed to reduce environmental noise. A 02/28/2023 care plan intervention showed Resident 4 was able to hear staff adequately without staff adjusting the volume of their voice. Review of Resident 4's February 2024 through April 2024 nursing progress notes showed Resident 4 had TV volume issues with roommates prior to Resident 3. On 04/07/2024 at 2 AM Resident 4's roommate (Resident 3) reported Resident 4's TV was too loud at night. Resident 4 began to curse at Resident 3 and turned the TV louder. Resident 3 reported they had constantly asked Resident 4 to lower their TV volume. The Nursing Assistant (NA) asked Resident 4 if they could lower the TV volume, Resident 4 then began to curse at the NA. The NA reported the incident to the nurse. The nurse requested Resident 4 to lower the TV volume, Resident 4 started cursing at and calling Resident 3 names. The nurse attempted to explain to Resident 4 that residents were attempting to sleep, Resident 4 stated they did not give a s**t, as they did not like Resident 3. Resident 4 could not be redirected and did not calm down until 4:00 AM. Staff would continue to monitor the room and roommates. No documentation found to show the incident was identified as potential abuse and reported to the State Survey Agency as required. Review of the 03/15/2024 social service quarterly assessment showed Resident 4 had a conflict and/or was unhappy with their roommate. Resident 4 had a roommate briefly but now has their own room again. The assessment further showed Resident 4's moods were at baseline, was well adjusted, and social services had no concerns. Review of Resident 4's March 2024 through May 2024 behavior monitor showed one entry on 03/24/2024 where Resident 4 yelled and screamed. During observation and interview on 05/09/2024 at 9:41 AM, Resident 4 stated they had experienced TV volume issues with two previous roommates. Resident 4 stated TV headphones had not been attempted and the problem was ongoing while they pointed to their current roommates TV. Both TVs in the room were on with the volume on, both roommates attempted to watch and listen to the TVs mounted on the wall on their side of the room. <Resident 3> Review of the admission assessment, dated 04/08/2024, showed Resident 3 admitted to the facility on [DATE]. Resident 3 had adequate hearing and understood others. The assessment further showed Resident 3 had moderate cognitive impairment and was able to verbalize their needs. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 04/01/2024 care plan showed Resident 3 had serious mental illness related to depression with history of suicidal ideation and instructed staff to provide emotional support, provide reassurance, listen, and allow resident to express their emotions and fears. The 04/02/2024 depression care plan listed Resident 3's target behaviors as irritability and social isolation. The care plan instructed staff to not take the irritability personally, monitor for safety of other residents, do not argue or become defensive. Review of Resident 3's April 2024 nursing progress notes showed Resident 3 argued with Resident 4 on several occasions regarding the volume of Resident 4's TV. On 04/09/2024 at 5:57 AM, the NA reported Resident 4 had been verbally abusive towards Resident 3 throughout the night. Resident 4 had been calling Resident 3 a f*****g baby and telling them to get out of their room. Resident 3 turned their call light on at 3:00 AM to notify staff they were unable to sleep because of Resident 4's TV volume. Resident 4 was hard of hearing and liked to keep their TV volume high. Staff encouraged the residents to make a reasonable compromise and were informed verbal abuse was not tolerated in the facility. No documentation found to show the incident was identified as potential abuse and reported to the State Survey Agency as required. Review of the facility April 2024 incident log showed no entries for the 04/09/2024 verbal abuse resident-to-resident incident between Resident 3 and Resident 4. In an interview on 05/09/2024 at 9:28 AM, Resident 3 stated they had a roommate (Resident 4) that would yell at them and call them names which upset Resident 3, so they tried to ignore Resident 4. Resident 3 stated Resident 4 liked to keep their TV on full blast all night and always yelled. Resident 3 stated they were roommates with Resident 4 for about a week before staff moved Resident 3 per their request because they could no longer deal with the situation. In an interview on 05/09/2024 at 10:43 AM, Staff A acknowledged there was no facility action taken at the time of the incident and the incident was being reported to the State Survey Agency at that time (30 days after the incident occurred). In an interview on 05/09/2024 at 12:02 PM, Staff E, Medication Tech, stated verbally and physically aggressive resident to resident interactions would be considered potential incidents of abuse that needed to be reported to the State Survey Agency and investigated. Staff E further added that residents involved in potential incidents of abuse should be monitored for potential mental anguish following an incident. Staff E was unaware of issues between Resident 3 and Resident 4. In an interview on 05/09/2024 at 12:28 PM, Staff D, Registered Nurse, stated verbally and physically aggressive resident to resident interactions would be considered potential incidents of abuse that needed to be reported to the State Survey Agency, and residents involved monitored for potential mental anguish after an incident. Staff D was unsure of how roommate compatibility was determined but acknowledged new roommates were typically placed on alert to monitor the two and if there were issues or concerns one roommate was usually moved. Staff D was unaware of issues between Resident 3 and Resident 4. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/09/2024 at 12:46 PM, with Staff B, Resident Care Manager and Staff C, Social Service Director, stated resident behaviors were monitored through the Treatment Administration Record (TAR) and by reviewing nursing progress notes. Both Staff B and Staff C stated resident specific behaviors and interventions should be care planned, once care planned direct care staff could see the information via the Kardex. Both staff stated roommate compatibility was discussed in the morning clinical meeting, new roommates placed on alert to monitor residents, and if there were roommate concerns one was typically moved. Staff B further added they had attempted to talk to Resident 4 about lowering the TV volume after 10:00 PM but they continued to hear complaints about the TV volume. Staff B stated Resident 3 was placed in with Resident 4, but the room was too loud for Resident 3. Both Staff B and Staff C Reviewed Resident 3 and Resident 4's medical record. After reading the nursing progress notes both staff agreed the incident should have been reported to the State Survey Agency as a potential incident of abuse. In an interview on 05/09/2024 at 2:21 PM, Staff A, Administrator, stated verbally and physically aggressive resident to resident interactions were considered potential incident of abuse, reported to the State Survey Agency, investigated, and residents should be placed on alert to monitor for potential mental anguish. Staff A stated Resident 3 and Resident 4 had a verbal altercation on 04/09/2024 related to the volume of TV Resident 4's TV because Resident 4 liked to keep their TV up at max volume. Staff A acknowledged no interventions had been attempted yet because the incident between Resident 3 and Resident 4 was the first TV volume conflict. The surveyor read the progress notes to Staff A about previous TV volume issues with Resident 4 and informed Staff A Resident 4 stated the issue was ongoing including their current roommate. <Resident 6> Review of the quarterly assessment, dated 03/03/2024, showed Resident 6 admitted to the building on 06/13/2022 and had diagnoses including dementia (loss of cognitive function-thinking, remembering, and reasoning that interferes with activities of daily living), bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity, and concentration), and non-traumatic brain dysfunction (brain injuries caused by internal factors such as physiological problems rather than trauma). Resident 6 had severe cognitive impairment. Review of the 06/28/2022 care plan showed Resident 6 experienced hallucinations, delusions, and/or paranoia. The care plan instructed staff to listen to the resident, take them to a less stimulating environment, separate resident from others, and understand the resident cannot control these sensory perceptions. The potential for psychosocial well-being problem care plan revised 12/15/2023 showed Resident 6 had inability to problem solve and lack of impulse control. The care plan instructed staff to set realistic goals, remove resident to a calm safe environment when conflict rises, and allow the resident to vent or share their feelings. Review of the 03/01/2024 Social Service quarterly evaluation showed Resident 6 had no recurrent behaviors during the last quarter, their mood was pleasant, resident was at baseline, and social services had no concerns. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 6's March 2024 nursing progress notes showed Resident 6 had been experiencing increased behaviors prior to having a roommate placed in their room. On 03/22/2024 at 4:44 PM, Resident 6 became agitated with their new roommate (Resident 5), grabbed Resident 5's right arm angrily while being verbally aggressive. Resident 5 was moved to another room. No documentation was found to show the incident was identified as potential abuse and reported to the State Survey Agency as required. Review of the 04/22/2024 provider progress note showed Resident 6 had moderate dementia with occasional behaviors for the last several weeks. Resident was assessed, urine was tested which was positive for bacteria, and was treated for a bladder infection. In an interview on 05/06/2024 at 1:59 PM, Resident 6 denied having any issues with any peers. <Resident 5> Review of the admission assessment, dated 03/28/2024, showed Resident 5 admitted to the facility on [DATE] with diagnoses including anxiety, depression, and Post Traumatic Stress Disorder (PTSD- anxiety disorder that develops after someone experiences, witnesses, or hears about a traumatic event). Resident 5 had moderate cognitive impairment and was able to make their needs known. Review of the 03/22/2024 care plan showed Resident 5 had depression and PTSD with target behaviors listed as confusion and crying. The care plan instructed staff to provide privacy, ask the resident what might make them feel better, provide support, be patient with changes in behaviors, and report behavior to nursing staff and social services. The 03/27/2024 psychosocial care plan instructed staff to provide cares in pairs (cares with two staff) related to multiple accusatory statements. Review of Resident 5's March 2024 nursing progress notes showed: - On 03/22/2024 at 4:48 PM, Resident 5's right arm was grabbed by their roommate (Resident 6) when Resident 6 experienced an episode of agitation, both residents were separated. Resident 5 was confused regarding Resident 6's behavior. Resident 5 was moved to another room. - On 03/22/2024 at 5:22 PM, Resident 5 was moved after an incident where Resident 6 was aggressive and struck out towards Resident 5. - On 03/23/2024 at 2:14 AM, Resident 5 was moved after Resident 6 screamed at them and attempted to strike them. No documentation found to show the incident was identified as potential abuse and reported to the State Survey Agency as required. Review of the facility March 2024 incident log showed an entry for a resident-to-resident altercation between Resident 5 and Resident 6 on 03/22/2024, with notification to the hotline marked as no. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 03/22/2024 facility incident report showed Resident 5 stated Resident 6 became verbally and physically aggressive towards them. Admission within the last 72 hours, recent room change, and Resident 6 becoming confused and agitated without obvious cause were listed as predisposing factors. The incident report showed the incident was witnessed by staff, but the investigation contained no staff or resident interviews. The investigation summary did not rule out abuse or neglect. In an interview on 05/09/2024 at 8:56 AM, Resident 5 stated their previous roommate (Resident 6) yelled at them and grabbed their arm. Resident 5 stated staff was not present when the incident occurred, but a room move was made quickly. Resident 5 stated Resident 6 had dementia and did not know what they were doing. In an interview on 05/09/2024 at 12:02 PM, Staff E, Medication Tech, stated Resident 6 had behaviors of shouting at other residents or staff, accusing other residents of stealing their belongings or being in Resident 6's house. Staff E was unaware of an incident between Resident 5 and Resident 6. In an interview on 05/09/2024 at 12:28 PM, Staff D, Registered Nurse, stated Resident 6 had behaviors of yelling and being disruptive in the dining room. Staff D was unaware of an incident between Resident 5 and Resident 6. In an interview on 05/09/2024 at 12:46 PM, with Staff B, Resident Care Manager and Staff C, Social Service Director, stated Resident 6 had behaviors of wanting to leave the building to take care of their sister's baby, thinking their spouse was going to pick them up, and watching TV loudly. Staff B stated Resident 6 did not want a roommate. Both Staff B and Staff C reviewed Resident 5 and Resident 6's medical records. Both staff agreed the documentation sounded like a resident-to-resident incident, but they were unsure if it was reported to the State Survey Agency as required. In an interview on 05/09/2024 at 2:21 PM, Staff A, Administrator, stated Resident 6 had behaviors and delusions. Staff A stated that on 03/22/2024 Resident 6 became upset they were sharing their room and started yelling at their roommate (Resident 5) then Resident 6 threw their water at Resident 5. Staff A further added the incident was not witnessed by staff but Resident 5 was moved out of the room immediately. Staff A acknowledged the incident between Resident 5 and Resident 6 was not reported to the State Survey Agency because it was not considered potential abuse or neglect. <Resident 2> Review of the admission assessment, dated 02/15/2024, showed Resident 2 admitted to the facility on [DATE] with diagnoses including stroke (blood flow to the brain is interrupted or blocked that can cause brain damage, long term disability or death) with left dominant side hemiplegia (paralysis that affects one side of the body) and hemiparesis (weakness on one side of the body). Resident 2 had moderate cognitive impairment and was able to make their needs known. Review of the 02/08/2024 admission inventory sheet showed Resident 2 admitted to the facility with one brown wallet, contents of wallet were not listed. The form was signed by Resident 2 and staff member on 02/09/2024. Review of February 2024 through April 2024 nursing progress notes showed Resident 2 had a wallet in the top bedside drawer on 02/10/2024. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of 04/16/2024 e-mails correspondences between Staff A, Administrator, and a Social Worker for Home and Community Services, showed the facility was informed Resident 2 reported their wallet was missing. Review of the 04/17/2024 missing personal items report showed one brown leather wallet was missing with contents listed as one Veteran Identification Card, one Drivers License, one Social Security Card, two insurance cards, one bus pass, one Debit Card, and $77 cash. The missing item report showed the last time the brown wallet with contents was seen was on 04/15/2024 night when Resident 2 placed the wallet in their pants pocket prior to going to bed. The report showed Resident 2 routinely placed their wallet in their pants pocket nightly or on occasion placed it in the top drawer of the nightstand next to their bed. Review of the April 2024 facility grievance log showed no entries for Resident 2's report of a missing wallet. Review of the April 2024 facility incident log showed no entries for Resident 2's report of a missing wallet. In an interview on 05/09/2024 at 11:26 AM, Resident 2's spouse stated they had spoken to management at the facility and reported Resident 2 was missing their wallet with the contents of Veteran Identification Card, Driver's License, Social Security Card, Debit Card, and $77 cash. Resident 2's spouse also informed the facility Resident 2 always had their wallet in their pocket or in the top drawer of the nightstand next to their bed. In an interview on 05/09/2024 at 12:02 PM, Staff E, Medication Tech, stated Resident 2 always had their wallet with them but they were unaware of the wallet contents. In an interview on 05/09/2024 at 12:28, Staff D, Registered Nurse, stated a missing wallet would typically be reported to management so an investigation could be done. Staff D was unaware of Resident 2's missing wallet. In an interview on 05/09/2024 at 12:46 PM, Staff B, Resident Care Manager, stated they were aware Resident 2 reported their wallet was missing, a missing item report had been filled out, and turned into management. Staff B was unsure of the contents of the wallet. Staff B acknowledged Resident 2's spouse did not sign the discharge inventory sheet when Resident 2 discharged the facility. In an interview on 05/09/2024 at 2:21 PM, Staff A, Administrator, stated a resident inventory sheet was completed on admission that should be updated as new items were brought into the facility. Staff A acknowledged they received a missing item report on 04/17/2024 for Resident 2 that included a wallet, and contents were listed as one Veteran Identification Card, one Driver's License, one Social Security Card, two insurance cards, one bus pass, one Debit Card, and $77 cash. Staff A stated family visited one evening, family saw Resident 2 had the wallet in the pocket of the pants they were wearing but could not find the wallet the following day. Staff A acknowledged the missing wallet had not been reported to the State Survey Agency as potential misappropriation because the Resident 2's spouse did not state or indicate the wallet had been stolen or give specific staff names. Reference WAC 388-97-0640 (5)(a)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review the facility failed to ensure facility-initiated discharges had a valid basis for discharge, and the discharge documentation included the required components 2 of 3 sampled residents (Resident 1 and 2), reviewed for facility-initiated discharge. These failures placed residents at risk of discontinuation of medical services, untreated conditions, unsafe living conditions, and diminished quality of life. Findings included . Review of the facility policy titled, Discharge Management revised 05/2023, showed discharges would be based on the resident's clinical condition and would occur as soon as reasonably possible following the physician's discharge order. The interdisciplinary team (IDT) would assist in planning and coordination of needed outside services and prepare written discharge instructions with pertinent information to provide a safe discharge. Review of the facility policy titled, Against Medical Advice discharge date d 08/2022, showed a discharge against medical advice (AMA) form must be read and carefully explained to the resident prior to it being signed when a resident insisted on leaving the facility against medical advice of their attending physician or failed to return to the facility by midnight without bed hold arrangements made. The completed AMA form was to be placed in the resident's medical record. The policy instructed staff to complete a detailed progress note including reason for discharging AMA given by the resident and/or their representative, resident condition upon leaving, transportation method used, persons accompanying the resident, and items removed from the facility. The policy further showed the attending physician, Executive Director, and Director of Nursing must be notified immediately following each AMA discharge. Review of the pharmacy policy and procedure manual titled, Infusion Therapy dated 08/2021, showed an intravenous catheter would be removed when ordered by the provider when the infusion therapy was completed, when clinically indicated or when deemed no longer necessary for the plan of care. The manual instructed licensed staff to verify the provider discontinuation order for removal of the catheter. <Resident 1> Review of the admission assessment, dated 08/04/2023, showed Resident 1 admitted to the facility on [DATE]. Resident 1 had diagnoses of osteomyelitis (a serious bone infection that can spread via the blood stream) and diabetes (one's body does not make enough or cannot use insulin properly leading to decreased sensation in extremities and decreased wound healing). Resident 1 received intravenous (IV) medications prior to being at the facility and while a resident at the facility. The assessment further showed Resident 1 had diabetic foot ulcers and surgical wounds with application of dressings to their feet. Resident 1 was cognitively intact and able to make their needs known. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 07/28/2023 hospital discharge summary showed Resident 1 had diabetic foot ulcers on both feet and underwent a partial left forefoot amputation on 07/24/2023 related to osteomyelitis. Resident 1 was recently diagnosed with diabetes, was on insulin (injectable hormone that lowers blood glucose) that would be continued upon hospital discharge with recommendations to transition to oral diabetic medications. Resident 1 had a peripherally inserted central catheter (PICC) for administration of IV antibiotics. Resident 1 was discharged to the facility for wound care, and completion of six weeks of both IV and oral antibiotics for osteomyelitis. Review of provider orders showed 07/28/2023 orders indicating Resident 1 could go out of the facility for individual activities and take a leave of absence with medications. Provider orders dated, 08/01/2023 showed Resident 1 was to be administered IV antibiotic three times daily for 34 days until 09/04/2023 for osteomyelitis, and oral antibiotics three times daily for 38 days until 09/08/2023 for osteomyelitis. Review of the 08/01/2023 provider progress note showed Resident 1 was admitted to the facility to complete six weeks of IV antibiotics for osteomyelitis after undergoing a partial left foot amputation as a result of osteomyelitis. The note showed Resident 1 was informed they were diabetic at the hospital and had decreased sensation to their feet with diabetic wounds. Review of the 08/10/2023 care plan showed Resident 1 had diabetic wounds, a partial foot amputation related to uncontrolled diabetes, and osteomyelitis with IV antibiotics until September 2023. The care plan instructed staff to provide IV care per provider orders or pharmacy protocol, monitor for adverse side effects from antibiotics, and notify the provider of signs or symptoms of a new or worsening infection. Review of Resident 1's July 2023 through September 2023 nursing progress notes showed Resident 1 often left the facility for personal outings and the following documentation: -On 08/16/2023 at 9:42 AM, Resident 1 was informed if they did not return to the facility before 10 PM from their personal outing they would be discharged from the facility without help of a safe discharge. -On 08/30/2023 at 10:45 PM, Resident 1 was out of the facility with family until almost 10 PM. - On 09/02/2023 at 1:58 PM, Resident 1's PICC line was discontinued, and Resident 1 was discharged AMA for not complying with the facility rules of returning to the facility timely and safely for proper medical treatment. Further review of Resident 1's medical record showed no documentation a discharge AMA form had been read to the resident, carefully explained, or completed. The discharge progress note did not document the resident's condition upon leaving the facility, transportation method used, persons accompanying the resident, items removed from the facility or notifications to the physician, Executive Director, or Director of Nursing as per facility policy. No provider order was found to discontinue the PICC line. When Resident 1 was discharged from the facility on 09/02/2023, they were to be administered 20 units of insulin at bedtime daily for diabetes, had not completed the ordered course of IV or oral antibiotics with seven doses of IV antibiotics and 19 doses of oral antibiotics left to be administered. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/09/2024 at 10:13 AM, the resident facility sign out sheets for 07/2023 through 09/2023 were requested from Staff A, Administrator. No documentation was provided. In an interview on 05/09/2024 at 10:43 AM, Staff A, stated residents could leave the facility and staff encouraged them to sign out of the building each time but staff did not monitor the resident sign out book to ensure residents signed out consistently. In an interview on 05/09/2024 at 12:02 PM, Staff E, Medication Tech, stated facility residents had the right to leave the facility for personal outings but they were encouraged to notify staff, sign out of the building, and return before 11 PM because the front doors locked. Staff E stated if a resident chose to discharge AMA, staff would attempt to discourage it by educating them, complete the AMA paperwork and place it in their medical record. In an interview on 05/09/2024 at 12:28 PM, Staff D, Registered Nurse, stated facility residents could leave the facility for personal outings but were encouraged to sign out of the building, and notify staff ahead of time to ensure they were ready, and medications sent with them if needed. Staff D stated they had not had to deal with AMA discharges, so they were unsure of the facility process. Staff D acknowledged a provider order was required to discontinue IV or PICC access. In an interview on 05/09/2024 at 12:46 PM, with Staff B, Resident Care Manager and Staff C, Social Service Director, they acknowledged residents could go out of the facility on personal outings but had to return before midnight because certain insurances had stipulations for leave days and medication administration had to be considered. They stated residents were encouraged to notify staff and sign out of the building when leaving the building. Staff B acknowledged a provider order was required for discontinuation of IV access. Both Staff B and Staff C stated if a resident chose to discharge AMA, they would try to educate them on the risks vs benefits and if they continue to choose to discharge AMA then there was AMA paperwork that needed to be filled out. Staff B and Staff C reviewed Resident 1's medical record. Staff B acknowledged there was no provider order to discontinue Resident 1's PICC and there should have been. Staff B stated Resident 1 was diabetic but medications were not sent with Resident 1 when they were discharge from the facility. Staff B further acknowledged Resident 1 still had over two days of IV antibiotics and over six days of oral antibiotics left to be administered for osteomyelitis when Resident 1 was discharged from the facility. Staff B stated potential complications from untreated osteomyelitis could include the spread of infection resulting in further amputations. Both Staff B and Staff C were unable to locate the discharge AMA paperwork for Resident 1. Both staff acknowledged the facility was able to meet Resident 1's needs and provided similar care to other residents in the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024

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

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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 0622

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

In a follow up interview on 05/09/2024 at 2:21 PM, Staff A, Administrator, stated residents were allowed to go out of the facility for personal outings but were encouraged to return before midnight because certain insurances required the facility to take additional steps if residents were out after midnight. Staff A stated a discharge would be considered AMA if there was a lack of support at home, if they required home health but live in a rural area where it was not available, or they were not willing to wait for services to be set up. Staff A stated if a discharge was considered AMA, then the facility would inform the resident they would not receive facility help with the discharge process. Staff A reviewed Resident 1's medical record. Staff A acknowledged Resident 1 admitted to the facility to complete six weeks of IV antibiotics to treat osteomyelitis. Staff A stated Resident 1 discharged on [DATE] because they were not willing to cooperate with IV antibiotic administration times and was found to be out of the facility. Staff A acknowledged residents had the right to refuse medical treatment. Staff A stated a provider order was needed to discontinue IV access but was unable to locate one for Resident 1. Staff A further stated Resident 1 had at least 2 days of IV antibiotics left to be administered when they were discharged from the facility, but no medications were sent with them. Staff A further stated potential complications of untreated osteomyelitis could include loss of an extremity, sepsis (life threatening medical emergency that occurs when the body has an extreme response to an infection), or death. Staff A acknowledged the facility was able to meet Resident 1's needs and provided similar care to other residents in the facility.

<Resident 2>

Review of the admission assessment, dated 02/15/2024, showed Resident 2 had diagnoses including stroke (blood flow to the brain is interrupted or blocked that can cause brain damage, long term disability or death) with left dominant side hemiplegia (paralysis that affects one side of the body) and hemiparesis (weakness on one side of the body), anxiety, depression, and intentional self-harm by salicylates (Aspirin- over the counter medication that reduces pain, fever, inflammation, and blood clotting) poisoning. Resident 2 had moderate cognitive impairment and was able to make their needs known.

Review of the 01/23/2024 hospital history and physical summary notes showed Resident 2 was hospitalized on [DATE] for an intentional salicylate overdose after they ingested about 50 tablets of Aspirin secondary to being dissatisfied/upset with their current living arrangements and their quality of life. Review of the 02/08/2024 hospital discharge summary showed Resident 2 was evaluated by psychiatry and started on an antipsychotic three times daily to be continued upon hospital discharge.

Review of the 02/15/2024 care plan showed Resident 2 used mood stabilizing medications and antidepressants with resident specific target behaviors listed as irritability and fatigue. The care plan instructed staff to report signs of worsening depression and/or suicidal behavior or thinking.

Review of the 02/18/2024 recapitulation of stay evaluation showed Resident 2 was planned to discharge home on 02/23/2024 at 10 AM with a home health referral to be sent to the specified home health company.

Review of Resident 2's February 2024 through April 2024 nursing progress notes showed:

- On 02/13/2024 at 4:23 PM, Resident 2 wished to return home with services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Aurora Valley Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 02/19/2024 at 3:04 PM, Resident 2 attended a care conference. Facility staff informed Resident 2 the hospital documentation showed they took a bunch of Aspirin and asked Resident 2 if their situation had changed. Resident 2 informed facility staff they were unaware of what could occur if they took too much Aspirin but were now aware and had a hold of their emotions. Facility staff recommended counseling or therapy through an outside provider. - On 04/04/2024 at 1:28 PM, discharge planned for next week per nursing. - On 04/09/2024 at 11:56 AM, Resident 2 refused wound care related to I will be leaving soon [referring to discharging], won't make a difference. - On 04/18/2024 at 10:49 AM, Resident 2 was out of the facility with their spouse and Resident 2 would return to the facility in a couple of hours only in anticipation of discharge today. - On 04/18/2024 at 1:24 PM, facility spoke to Resident 2's spouse via phone Resident 2 had chosen not to come back to the facility from their personal outing. Social services explained AMA to Resident 2's spouse. Review of 04/15/2024 through 04/16/2024 e-mails correspondences from Staff A, Administrator, and an outside provider social worker, showed if Resident 2 discharged home on 04/17/2024 as scheduled it would be without home caregiver support, facility staff were to inform Resident 2. Facility staff chose to move the discharge to the following week. Further Review of Resident 2's medical record showed no documentation Resident 2 was informed their scheduled 04/18/2024 discharged was postponed until the following week or details of why the 04/18/2024 discharge would be considered AMA. Resident 2's medical record showed no documentation a discharge AMA form had been read to the resident and/or their representative, carefully explained, or completed. The discharge progress note did not document the resident's condition upon leaving the facility, transportation method used, persons accompanying the resident, items removed from the facility or notifications to the physician, Executive Director, or Director of Nursing as per facility policy. In an interview on 05/09/2024 at 11:26 AM, with Resident 2's spouse, stated they had gone out for a personal outing with Resident 2 back in April 2024 but Resident 2 refused to return to the facility. The spouse informed the facility, requested Resident 2's medications but was told it was AMA and the facility refused to give them any medications including the antipsychotic medication Resident 2 had been started on when recently hospitalized . In an interview on 05/09/2024 at 12:02 PM, Staff E, Medication Tech, stated Resident 2's discharge was planned and went home with their spouse. (continued on next page)

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	05/09/2024

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

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/09/2024 at 12:46 PM with Staff B, Resident Care Manager and Staff C, Social Service Director, stated Resident 2 previously lived alone and admitted to the facility after a hospitalization for an attempted overdose. Both Staff B and Staff C were unsure of where Resident 2 discharged to. Staff B acknowledged medications were not sent with Resident 2 because they had initially gone out of the facility on a day outing with their spouse and intended to return to the facility that day. Staff B and Staff C reviewed Resident 2's medical record. Both Staff B and Staff C acknowledged there was no discharge AMA paperwork completed for Resident 2, the facility was able to meet Resident 2's needs and provided similar care to other residents in the facility. In an interview on 05/09/2024 at 2:21 PM, Staff A, Administrator, stated Resident 2 admitted to the facility after an attempted overdose. Resident 2 was originally scheduled to discharge in February 2024 but that was postponed because there were no caregivers in the home. Staff A further stated the discharge was then changed to 04/17/2024 because that is when they would have met their mobility therapy goals, but that discharge was also postponed because Resident 2 still had no home caregivers. Staff A stated Resident 2 discharged AMA because they did not want to wait for care givers to be set up. Medications were not sent with Resident 2 because they originally went on an outing and then did not want to return. Staff A acknowledged there was no documentation in Resident 2's medical record of reasons for postponing their planned discharges, details of why the discharge was considered AMA, or that Resident 2 had been kept informed. Staff A was unable to locate discharge summary paperwork or AMA paperwork for Resident 2. Staff A acknowledged the facility was able to meet Resident 2's needs and provided similar care to other residents in the facility. Reference WAC 388-97-0120 (1)