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	06/12/2024

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review the facility failed to act timely after altercations between Resident 1 with a roommate (Resident 2) for 1 of 4 sampled residents (Resident 1), reviewed for abuse. Resident 1 experienced verbal abuse and psychosocial harm evidenced by anxiety, tearfulness, lack of sleep, and expressed fear and not feeling safe in the facility because of their roommates' behaviors. This failure placed residents at risk of verbal and mental abuse, psychosocial harm, and diminished quality of life. Findings included . Review of the facility policy titled, Prevention and Reporting: Resident Mistreatment, Neglect, Abuse . dated 08/2022, 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. Mental abuse could be verbal or non-verbal and included humiliation, harassment, and threats of punishment. Neglect was defined as disregard for resident care, comfort or safety that resulted in or could have resulted in physical harm, pain, mental anguish, or emotional distress. The policy further showed the facility would implement prevention techniques which included ongoing supervision of residents and staff, observation, and recognition of signs of resident-to-resident frustration or stress. Staff were to identify, intervene, and correct situations where abuse, neglect, and/or mistreatment were likely to occur such as resident with needs and behaviors that might lead to abuse. The policy instructed staff to provide for the immediate safety of the resident upon identification of potential abuse, neglect, or mistreatment by moving the resident to another room or unit. <Resident 1> Review of the admission assessment, dated 04/16/2024, showed Resident 1 admitted to the facility on [DATE] with diagnoses including liver cirrhosis with ascites (scarred and damaged liver that causes fluid to build up in the abdomen), and malnutrition (serious condition where the body has a nutrient deficit). Resident 1 was cognitively intact and able to make their needs known. Review of the 04/09/2024 hospital discharge summary showed Resident 1 had a complex medical history and was discharged to the facility for ongoing therapy and medical management. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 1's May 2024 nursing progress notes showed Resident 1 had a room change on 05/06/2024. On 05/07/2024 Resident 1 reported to staff they got no sleep because of their new roommate (Resident 2) yelled all night. Resident 1 was noted to be anxious on 05/09/2024, and 05/10/2024. On 05/13/2024 at 4:44 AM, Resident 1 was distressed by Resident 2 and requested staff to take them out of the room to the nurses' station so they could be in peace. Resident 1 sat at the nurses' station silently and then slept for two hours. On 05/14/2024 at 10:49 PM, Resident 1 was upset and cried because Resident 2 screamed F**k you b***h, I will kill you! You devil. Resident 1 requested a different roommate. Resident 1 was moved to a different room on 05/15/2024, the following day. No documentation for monitoring potential psychological harm was found. Review of the May 2024 facility incident log showed a resident-to-resident altercation between Resident 1 and Resident 2 occurred on 05/14/2024 at 10 PM with the action taken listed as a room move. A second entry for a resident-to-resident altercation between Resident 1 and Resident 2 that occurred on 05/15/2024 at 12:27 PM with the action taken listed as a care plan revision. In an interview on 06/07/2024 at 2:54 PM, Resident 1's spouse stated Resident 2 yelled and was belligerent. Resident 2's behavior bothered their spouse, and they had to be moved out of the room. In an interview on 06/07/2024 at 2:59 PM, Resident 1 stated they feared Resident 2 because they yelled aggressively. Resident 2 called Resident 1 the devil then told Resident 1 they were going to kill them and everyone else. Resident 1 stated Resident 2 yelled like that every night, staff was aware of the situation, but it took staff a few days to move Resident 1 out of that room. Resident 1 further stated staff did not check on them after the incident occurred, they did not feel safe in the building, and decided to discharge the facility against medical advice (AMA). Resident 1 stated the incident still bothered them, but they felt safe at home with their spouse. Review of Resident 1's June nursing progress notes showed Resident 1 planned to discharge AMA on 06/04/2024 after they attended an appointment they had that day. The notes did not specify the details of why Resident 1 chose to discharge AMA. Resident 1 discharged the facility AMA on 06/04/2024 at 12:44 PM. Review of the 06/04/2024 AMA form showed Resident 1 was informed of the medical risks versus benefits of discharge from the facility AMA. The AMA form was signed by Resident 1 and their spouse. <Resident 2> Review of the quarterly assessment, dated 04/07/2024, showed Resident 2 had diagnoses that included stroke (blocked blood flow to the brain which can lead to permanent damage and cause confusion and problems with talking or understanding language), and dementia (impaired ability to remember, think, or make decisions that interferes with everyday activities). Resident 2 had moderate cognitive impairment and exhibited no behaviors which were unchanged from the previous assessment. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 2's April 2024 and May 2024 nursing progress notes showed Resident 2 yelled, and cursed when cares were provided, which had increased in frequency. Resident 2 experienced hallucinations (false perceptions of things that were not there but seem real to the person that experienced them), delusions (abnormal thought process with false beliefs that someone holds firmly even when presented with evidence to contrary), and verbal outbursts. On 05/14/2024 at 7 PM, Resident 2 began to yell F**k you, I will kill you! You devil when staff assisted them to bed with the mechanical lift. Resident 2 did not calm down until 9:10 PM, (2 hours and 10 minutes later). On 05/15/2024 at 7:06 AM, Resident 2 had an anger outburst, yelled out, called staff demons, and yelled at staff to get away from them, when staff provided AM cares. At 12:32 PM that same day, staff heard Resident 2 yell at their roommate (Resident 1). Review of the care plan initiated 04/18/2024 showed Resident 2 had a history of demonstrating verbally abusive behaviors of cursing at staff and/or other residents related to poor impulse control, pain, and cognitive impairment. The 04/18/2024 care plan showed Resident 2 became verbally aggressive towards staff when care was provided and would become verbally aggressive towards other residents when their spouse left. Resident 2 was unable to understand the effect of their cursing or give an explanation as to why they said certain things. Interventions dated 04/18/2024, instructed staff to document Resident 2's behaviors, assess and anticipate their needs for food, thirst, toileting, comfort, body positioning, and pain. Interventions dated 04/18/2024, instructed staff to intervene before agitation escalated, guide the resident away from the source of distress, engage calmly and if Resident 2 responded aggressively staff were to walk away calmly and approach later. No new interventions were added to Resident 2's care plan after the 05/14/2024 or 05/15/2024 incidents with Resident 1. Review of the 05/14/2024 and 05/15/2024 facility incident investigation showed Resident 2 had severe cognitive impairment and had been at the facility for two and a half years. Resident 2 had behaviors that were triggered when staff provided care or when Resident 2 saw others in their room. On 05/14/2024 around 7 PM staff assisted Resident 2 to bed which caused Resident 2 to yell and curse at staff. Resident 1 was upset, afraid, cried, and slept in the hall for a couple of hours related to hearing Resident 2 yell and curse because Resident 1 thought the yelling was directed towards them. The investigation summary showed Resident 1 was moved on 05/15/2024, Resident 2's care plan was revised to include potential for verbally aggressive behaviors and interventions to help manage and de-escalate behaviors, details of interventions added were not listed. The summary further showed staff were educated on the care plan revisions. Resident 1 had no long-lasting psychosocial harm related to the incident and abuse was unsubstantiated. In an interview on 06/12/2024 at 12:40 PM, Staff C, Lead Nursing Assistant, stated Resident 2 screamed a lot and would call staff offensive, derogatory, and vulgar names when care was provided. Resident 2 could be a sweet and nice person but could also quickly flip and become very mean and aggressive without warning. Resident 2 had verbal behaviors several times per week. Staff C further stated Resident 2 had issues with roommates because the roommates felt uncomfortable and threatened by Resident 2's verbal behaviors. Staff C acknowledged Resident 1 was distressed by Resident 2's behaviors and stayed up in their wheelchair all night one night because Resident 1 did not want to go back in the room with Resident 2. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview on 06/12/2024 at 1:11 PM, Staff D, Registered Nurse, stated Resident 2 has had behaviors for some time that included waking up at night screaming, shouting for people to get out of their room, and yelling profanities. Staff D acknowledged Resident 2 sounded aggressive when they yelled because they would yell lots of profanities and things like I am going to kill you! Staff D stated Resident 2's yelling upset Resident 1, and Resident 1 was moved out. In an interview on 06/12/2024 at 1:57 PM, Staff E, Resident Care Manager, stated Resident 2 had lots of verbal behaviors, almost daily. Staff E acknowledged Resident 2 would yell at their roommates and Resident 2's roommates would be afraid of the yelling because it was very verbally aggressive. In an interview on 06/12/2024 at 2:37 PM, Staff F, Social Services Director, stated Resident 2 had been at the facility for over years and frequently experienced verbally aggressive behaviors directed towards others. Staff F stated Resident 2's behaviors were unpredictable. Staff F reviewed Resident 2's medical record. Staff F stated Resident 2 required frequent redirection but was unable to state what behavioral interventions Resident 2 had in place. Staff F reviewed Resident 1's medical record. Staff F acknowledged Resident 1 was distressed on 05/13/2024 because their roommate (Resident 2) yelled out F**k you, I will kill you! Resident 1 requested to be taken to the nurses' station and slept in their wheelchair for two hours. Resident 1 was moved rooms on 05/15/2024. Staff F further stated Resident 1 discharged home AMA shortly after the incident with Resident 2. In an interview on 06/12/2024 at 3:19 PM, Staff H, Resident Care Manager, reviewed Resident 2's medical record. Staff H acknowledged Resident 2 liked to yell out and curse at others, almost daily. Resident 2 yelled out and said things like get the f**k out of my room and I am going to kill you! Staff H reviewed Resident 1's medical record. Staff F acknowledged Resident 2 yelled I am going to kill you! one night and Resident 1 was worried Resident 2 (their roommate) was talking to them and would do something to them. In a phone interview on 06/12/2024 at 4:14 PM, with Staff A, Administrator and Staff B, Director of Nursing, they acknowledged Resident 2 had verbal behaviors directed towards others for at least six months that were triggered when care was provided. Staff A stated interventions included guiding Resident 2 away from the source of agitation and try to figure out if they had any unmet needs such as thirst, pain, or hunger. Staff A stated Resident 2 had a history of issues with roommates because they did not understand the room was a shared space. Both Staff A and Staff B acknowledged Resident 1 was distressed by Resident 2 because Resident 2 yelled out and Resident 1 could not get sleep which ultimately resulted in Resident 1 being moved out of the shared room. Reference WAC: 388-97-0640 (1) See F744 for additional information.

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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 implement interventions to reduce fall hazards, monitor for intervention effectiveness, and modify interventions when necessary for 1 of 3 sampled residents (Resident 4), reviewed for falls. This failure resulted in Resident 4 sustaining repeat falls and placed residents at risk for avoidable accidents, significant injury, and diminished quality of life. Findings included . Review of the facility policy titled, Fall and Injury Prevention and Management Care Plan revised 01/2023, showed the facility would revise a resident's care plan and/or center practices to attempt to determine casual factors that may have led to a fall, to prevent future occurrences and reduce the likelihood of another fall. The facility was to assess risk factors and hazards to identify potential interventions to implement. Review of the facility policy titled, Fall Injury Management- Post Fall or Injury revised 01/2023, showed proper action following a fall included: assessing for injury, determining potential cause, or contributing factors, addressing potential contributing factors, revising the care plan and/or center practices to reduce the likelihood of another fall, and communicating a fall to the physician and the resident representative in a timely manner. The policy instructed staff to initiate and complete a fall incident report, complete a fall risk assessment, determine potential causes to the fall, review and revise fall interventions, and communicate changes and/or interventions to staff. Review of the quarterly assessment, dated 05/03/2024, showed Resident 4 admitted to the facility on [DATE] with diagnoses including non-traumatic brain dysfunction (complex medical condition that occurs when internal factors damage the brain), transient ischemic attach (TIA- temporary stoke like symptoms), and reversible encephalopathy (condition that affects the brain with mental changes, confusion, vision problems that may resolve when the underlying cause is fixed). The assessment showed Resident 4 sustained two or more non injury falls, and one injury fall since their admission to the facility. Resident 4 had severe cognitive impairment which was a change in mental status from their baseline cognition. Review of the 04/24/2024 fall risk assessment showed Resident 4 was at high risk for falls because they had a history of falling and overestimated/forgot their limitations. Review of April 2024 through June 2024 nursing progress notes showed Resident 4 sustained 13 falls in 44 days between 04/23/2024 through 06/06/2024. Resident 4 had falls on: 04/23/2024 at 10:48 AM, 05/01/2024 at 11:45 PM, 05/07/2024 at 2:54 PM, 05/10/2024 at 3:29 PM, 05/17/2024 at 2 AM, 05/23/2024 at 8:20 AM, 05/24/2024 at 3:15 AM, 05/28/2024 at 9:50 PM, 05/30/2024 at 10:14 AM and 7:50 PM, 06/02/2024 at 10:13 PM, 06/05/2024 at 8:16 PM, and 06/06/2024 at 9:24 PM. All 13 fall incident reports for Resident 4 were requested from Staff A, Administrator on 06/07/2024 at 8:18 AM, only 8 out of 13 fall incident reports were provided. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The remaining 5 fall incident reports were requested on 06/11/2024 at 1:49 PM from both Staff A and Staff B, Director of Nursing. No documentation was provided for the fall that occurred on 06/02/2024 at 10:13 PM. Review of the facility incident report for the fall that occurred on 05/07/2024 at 1:05 PM showed Resident 4 was found on the floor next to their bed. The incident report summary dated 05/11/2024 showed Resident 4's care plan was reviewed but no new interventions were added. A medication review was requested from the physician and pharmacist. Review of a pharmacy interim medication regimen review form showed the pharmacist completed a review of Resident 4's record on 05/13/2024, six days after they sustained the fall. The physician did not review the pharmacy recommendations until 06/07/2024, 31 days after Resident 4 sustained their fall. Review of the facility incident report for the fall that occurred on 05/28/2024 at 9:50 PM showed the incident report had numerous question marks, missing information, and was mostly left blank. Review of the facility incident report for the fall that occurred on 05/30/2024 at 10:14 AM showed Resident 4 was found on the floor in the dining room. The incident report summary dated 06/04/2024 showed Resident 4's care plan was reviewed, and Resident 4 was placed on 1:1 monitoring (one staff to one resident supervision) to prevent continued falls. Resident 4 sustained another fall the same day, at 7:50 PM. Review of the facility incident report for the fall that occurred on 05/30/2024 at 7:50 PM showed Resident 4 had an unwitnessed fall in their room. The incident report showed there were no witnesses to the fall and no documentation was found to indicate if Resident 4 had 1:1 monitoring in place, which had been implemented earlier that day. The incident report summary dated 06/03/2024 showed Resident 4's care plan was reviewed and updated to keep Resident 4 in areas of high visibility when they were out of bed. Review of the care plan showed no documentation this intervention was added. Review of risk for fall care plan initiated 01/29/2024 showed Resident 4 was at risk for falls related to being unaware of safety needs and cognitive impairment. The care plan included 01/29/2024 interventions to ensure the call light was within reach, ensure frequently needed items such as water were kept within reach and provide a safe environment without spills and/or clutter. Care plan interventions dated 01/30/2024 instructed staff to involve Resident 4 in activities that provide diversion and distraction, complete neurologic checks per facility protocol and monitor for signs and symptoms of latent injuries for 72 hours a fall. Care plan intervention dated 04/23/2024 instructed staff to offer toileting before and after meals, and before and after lying down. Care plan intervention dated 05/02/2024 involved hanging visual cues to remind Resident 4 to use their call light and wait for staff assist. A care plan intervention dated 05/10/2024 involved hanging a sign on the bathroom door reminding Resident 4 to call for assistance. Care planned interventions dated 05/28/2024 instructed staff to wake Resident 4 up between midnight and 2 AM and offer toileting, and not to leave Resident 4's wheelchair at the bedside. A 05/29/2024 intervention added a fall mat next to the bed while Resident 4 was in bed. A 05/31/2024 intervention showed Resident 4 should have a pancake shaped call light at the bedside. On 06/04/2024 a care plan intervention for 1:1 supervision to be provided when staffing allowed, if staffing did not allow for 1:1 supervision then visual check should be conducted every 15 minutes. (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 the facility incident report for the fall that occurred on 06/05/2024 at 8:15 PM showed Resident 4 was found on the floor in their room alone and unattended. The incident report showed there were no witnesses to the fall and no documentation found indicating Resident 4 had 1:1 monitoring in place that had been implemented on 05/30/2024. The incident report summary dated 06/10/2024 showed Resident 4 was placed on 24 hour 1:1 monitoring, bowel medications were reduced, medications for insomnia were discontinued, was moved closer to the nurses' station, walker was removed from the room, blood and urine testing was being done. Review of the facility incident report for the fall that occurred on 06/06/2024 at 7 PM showed Resident 4 was again found on the floor in their room alone and unattended. The incident report showed there were no witnesses to the fall and no documentation found indicating Resident 4 had 1:1 monitoring in place that had been implemented on 05/30/2024. The incident report summary dated 06/10/2024 showed the same note with the same interventions added as the fall that occurred the previous day, 06/05/2024. Resident 4's physician orders were reviewed on 06/07/2024. Three different active orders dated 01/25/2024 for bowel medications and two different active orders dated 01/25/2024 for medications to help with insomnia were found. No changes in medication dose or frequency were found as documented on the 06/05/2024 and 06/06/2024 fall incident report summaries. In an interview on 06/12/2024 at 12:40 PM, Staff C, Lead Nursing Assistant, stated any unintended change in elevation was considered a fall that required a fall incident report to be completed. Staff C stated a new fall intervention should be implemented right away because if it was not then the resident could fall again. Staff C further stated Resident 4 had significant cognitive impairment and had sustained repeat falls. Staff C acknowledged Resident 4 had 1:1 monitoring in place for some time for safety because they kept falling. In an interview on 06/12/2024 at 1:11 PM, Staff D, Registered Nurse, stated an unintended change in elevation was considered a fall. Staff D stated a new fall intervention should be implemented after a fall occurred because a resident could have more potential falls or get injured if interventions were not implemented timely. Staff D acknowledged Resident 4 had significant cognitive impairment and sustained numerous falls. Staff D further stated Resident 4 had numerous fall interventions in place including 1:1 staff monitoring. In an interview on 06/12/2024 at 1:57 PM, Staff E, Resident Care Manager, stated a new fall intervention needed to be implemented each time a fall occurred because the resident could sustain repeat falls if a new intervention was not implemented. Staff E further stated Resident 4 had severe cognitive impairment and sustained numerous falls. Staff E acknowledged Resident 4 was placed on 1:1 monitoring the week prior. In an interview on 06/12/2024 at 3:19 PM, Staff H, Resident Care Manager, stated a new fall intervention should be implemented as soon as a fall occurred because a resident could sustain another fall or get injured if not. Staff H further stated Resident 4 had severe cognitive impairment and sustained frequent falls, sometimes every other day or multiple times in a day. Staff H acknowledged Resident 4 had visual cues placed in their room to remind them to call for assistance but Resident 4 was not cognitive enough to read the signs. Staff H stated Resident 4 was currently on 1:1 monitoring to try to prevent falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a phone interview on 06/12/2024 at 4:14 PM, with Staff A and Staff B, they stated a fall was an unplanned change in elevation that required the resident to be assessed, assisted up, fall incident report completed, provider and family notifications made, and resident placed on alert for monitoring. Staff B stated a new fall intervention should be added within the first 48 hours after a fall had occurred, sooner if possible. Staff B stated another fall could occur if an intervention was not implemented immediately, but sometimes it took time to find appropriate interventions. Both Staff A and Staff B acknowledged Resident 4 had severe cognitive impairment and started falling more frequently at the end of April 2024. Staff A stated Resident 4 had a fall intervention implemented every time they fell and had various fall interventions in place including current 1:1 monitoring. Reference WAC: 388-97-1060 (3)(g) This is a repeat citation from 02/16/2024 and 10/12/2023.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on observation, interview, and record review the facility failed to provide trauma informed care by ensuring trauma survivors were appropriately assessed, implement trauma care plans with potential triggers identified to prevent potential re-traumatization, and limit a resident's exposure to potential trauma triggers for 1 of 1 sampled residents (Resident 3), reviewed for trauma informed care. This failure placed residents at risk of becoming retraumatized, unmet care needs, and diminished quality of life. Findings included . Review of the facility policy titled, Trauma-Informed Care and Screening revised 04/2023, showed a resident's experiences were accounted for in the development of a plan to eliminate or mitigate triggers that may cause re-traumatization. The policy listed examples of potential trauma which included experiencing or witnessing physical abuse or domestic violence. The policy showed all residents would be universally screened for trauma to determine if additional evaluations were indicated, if so a referral for additional evaluations by a mental health provider and additional care planning was implemented. Review of the admission assessment, dated 03/28/2024, showed Resident 3 admitted on [DATE] with diagnoses that included anxiety, depression, and Post Traumatic Stress Disorder (PTSD- mental health disorder that can develop after a person experience traumatic events). Resident 3 had moderate cognitive impairment and could verbalize their needs. Review of 03/20/2024 hospital care management notes showed Resident 3 previously lived with their spouse but Resident 3 did not want to return to an emotionally abusive and unkept environment. The notes further showed a recent report was made to an outside agency related to domestic violence concerns. Review of 03/21/2024 hospital discharge summary showed Resident 3 had a history of verbal abuse from their spouse and may require alternative living arrangements upon discharge. Review of the 03/22/2024 social service admission and discharge evaluation showed most of the assessment was left blank. The assessment showed Resident 3 had PTSD but had not experienced or witnessed any traumatic events. Resident 3 was married but separated. Review of the 03/22/2024 care plan showed Resident 3 used medications to treat PTSD. Care planned interventions included monitoring for common medication side effects, medication related cognitive impairment, and to complete a medication information sheet. When behaviors occurred the care plan instructed staff to document the number of occurrences, provided privacy, ask the resident what might make them feel better, and report observations to nursing and social service staff. The 03/27/2024 care plan showed Resident 3 had a psychosocial well-being problem related to numerous diagnoses and instructed staff to remove Resident 3 to a calm safe environment when conflict arose, allow Resident 3 to vent and share their feelings, and provide cares in pairs related to multiple accusatory statements. The care plan did not specify Resident 3 had a history of domestic violence or identify potential triggers for staff to avoid to prevent or mitigate re-traumatization. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 3's March 2024 through April 2024 nursing progress notes showed on 03/22/2024 at 4:30 PM (the day after Resident 3 admitted to the facility) Resident 3 was aggressively grabbed by the arm by their roommate when the roommate experienced an episode of agitation. Resident 3's roommate was aggressive, screamed, and struck out. Resident 3 was confused by the roommate's aggressive behaviors and was moved out of the room. On 04/02/2024 a care conference meeting was held to discuss Resident 3's progress and goals, Resident 3's spouse was listed as one of the meeting member attendees. In an interview on 06/06/2024 at 9:41 AM, Resident 3's child stated Resident 3 had experienced verbal, physical, mental, and financial abuse from their spouse for years. Resident 3's child notified the facility of the domestic violence history the week after Resident 3 admitted to the facility, the last week of March 2024. During observation and interview on 06/12/2024 at 12:25 PM, Staff I, Receptionist, had a sign with Resident 3's spouses picture posted at the receptionist desk. The sign stated Resident 3's spouse was not to have contact with Resident 3 and instructed staff to contact law enforcement if they were seen on the premises. Staff I stated Resident 3 admitted to the facility 03/21/2024, but administration posted the sign in May 2024. Staff I was unsure if the issues between Resident 3 and their spouse existed when Resident 3 admitted to the facility. In an interview on 06/12/2024 at 12:40 PM, Staff C, Lead Nursing Assistant, stated potentially traumatic events could be different for every resident but a potential trigger could include to hear yelling if a resident had PTSD. Staff C stated trauma and potential triggers to avoid should be listed in a resident's care plan so direct care staff were aware of what triggers to avoid and what interventions to implement. Staff C acknowledged Resident 3 had a history of domestic violence and staff were to call law enforcement if Resident 3's spouse was on the premises. In an interview on 06/12/2024 at 1:11 PM, Staff D, Registered Nurse, acknowledged Resident 3's child informed them of the domestic violence history between Resident 3 and their spouse, at the end of March 2024 but stated the hospital relayed information regarding Resident 3's history of domestic violence to the facility prior to Resident 3's admission to the facility. Staff D was unsure how the facility determined if a resident had a history of trauma or how potential triggers were identified but those things should be found in the care plan. Staff D acknowledged when Resident 3 admitted to the facility they were placed in with a roommate who was known to have verbally aggressive behaviors; Resident 3 was in that room for a few weeks prior to being moved out because the roommates' verbally aggressive behaviors bothered Resident 3. In an interview on 06/12/2024 at 2:37 PM with Staff F, Social Service Director and Staff G, Social Service Assistant, stated the facility determined if a resident had previously experienced trauma by reading the previous settings progress notes, reviewing the medical history, and speaking to the resident and/or their family to obtain additional information. Staff G further stated in order to provide a safe environment and prevent re-traumatization it would depend on what the experienced trauma was in order to identify potential triggers. Both Staff F and Staff G acknowledged Resident 3 had a history of experiencing domestic violence which included verbal and physical abuse. Staff F reviewed Resident 3's medical record. Staff F acknowledged Resident 3 had no trauma interventions or potential triggers listed on their care plan. Staff F further stated upon admission, Resident 3 was originally placed with a roommate that was known to yell out verbally aggressive statements which could have affected Resident 3 because of their history of verbal abuse. (continued on next page)

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	505114	A. Building B. Wing	06/12/2024

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview on 06/12/2024 at 4:14 PM, Staff A, Administrator, stated trauma fell into two categories; acute trauma which Staff A defined as trauma that occurred once like a natural disaster and complex trauma which Staff A defined as trauma that reoccurred such as a history of abuse or emotional distress. Staff A stated the facility would review a resident's medical history to see if they had experienced any previous trauma. If trauma was experienced, then it should be care planned with interventions customized to the trauma experienced to prevent re-traumatization. Staff A acknowledged Resident 1 had a history of experiencing physical and emotional abuse from their spouse. Staff A was unsure if Resident 1 had any triggers identified. No associated WAC

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review the facility failed to develop and implement person-centered care plans with individualized interventions to address behaviors for 1 of 2 sampled residents (Resident 2), reviewed for dementia care. This failure placed residents at risk of increased behaviors, unmet needs, and diminished quality of life. Findings included . Review of the facility policy titled, Dementia Care: Addressing Behaviors and Preventing Unnecessary Antipsychotic Use revised 06/2023, showed residents with dementia may exhibit behaviors as a way to communicate underlying and unresolved medical, physical, emotional, psychiatric, or environmental issues. The facility was to develop an individualized care plan focused on non-pharmacological approaches. The goal was to use person-centered approaches to reduce potentially distressing or harmful behaviors and promote quality of life. The policy instructed staff to assess new or worsening behaviors for possible underlying causes and gave a list of potential causes to consider. After medical issues were ruled out, staff was to develop a person-centered plan with non-pharmacological interventions. The policy instructed staff to document the effectiveness of non-drug interventions, review and revise interventions based on their effectiveness and/or adverse consequences. The policy further showed that after investigating potential causes of behavior, and non-drug interventions fail, and medical work-up does not reveal another cause, and behaviors pose a risk or danger to the resident or others, or the resident experienced inconsolable or persistent distress or substantial difficulty receiving care, and the benefits outweigh the risk of potential adverse effects, the interdisciplinary team would evaluate and may consider use of psychoactive drug therapy targeted at behaviors. Review of the quarterly assessment, dated 04/07/2024, showed Resident 2 admitted to the facility on [DATE] and had diagnoses that included stroke (blocked blood flow to the brain which can lead to permanent damage and cause confusion and problems with talking or understanding language), and dementia (impaired ability to remember, think, or make decisions that interferes with everyday activities). The assessment further showed Resident 2 had moderate cognitive impairment and exhibited no behaviors which was unchanged from the previous assessment. Review of the 01/17/2024 social service quarterly evaluation showed Resident 2's care plan was not reviewed or updated and did not have psychiatric services involved in care. Resident 2 did not use antianxiety medication. The assessment showed Resident 2's behaviors for November 2023 through January 2024 were reviewed and Resident 2 had increased agitation and combativeness. The assessment further showed Resident 2 did not experience a change in their mood from the previous assessment. The assessment section for effective interventions was left blank and the section for behavioral symptoms was marked to indicate no behaviors were experienced. The assessment included a summary which stated Resident 2 continued to adjust to facility placement and experienced a fluctuating mood that varied from quiet and pleasant to agitated but social services had no concerns. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 04/08/2024 social service quarterly evaluation showed Resident 2's care plan was not reviewed or updated, did not have psychiatric services involved in care, and used antianxiety medication. Resident 2 had a room change without adjustment issues identified. The assessment showed Resident 2's behaviors for January 2024 through March 2024 were reviewed and Resident 2 had increased agitation and combativeness. The assessment further showed Resident 2 did not experience a change in their mood from the previous assessment. The assessment section for effective interventions was marked as not applicable and the section for behavioral symptoms was marked to indicate no behaviors were experienced. The assessment included a summary which stated Resident 2 continued to adjust to facility placement and experienced a fluctuating mood that varied from quiet and pleasant to agitated but social services had no concerns. Review of March 2024 through June 2024 nursing progress notes showed Resident 2 frequently experienced behaviors which included, crying out, panic attacks, anxiety, waking up in fear from potential dreams, decreased sleep, visual and auditory hallucinations (false perceptions of things that were not there but seem real to the person that experienced them), delusions (abnormal thought process with false beliefs that someone holds firmly even when presented with evidence to contrary), and verbal outburst. The notes showed Resident 2's verbal outbursts consisted of Resident 2 screaming obscenities and statements like get away from me!, F**k you! I will kill you! You devil!, Don't kill me!, Die b***h!, get the f***k out!, Go to hell you sons of b***h**, and you are dead to me! The notes show on numerous occasions Resident 2's behaviors were triggered when care was provided or there was a peer in Resident 2's room. The notes showed Resident 2 was inconsolable and screamed out for two and a half hours on 05/14/2024, one hour on 05/17/2024 and on 05/18/2024. The notes further showed that when Resident 2 yelled for excessive amounts of time, staff would close the door to muffle the noise, and eventually Resident 2 would fall asleep. Review of the care plan initiated 04/18/2024 showed Resident 2 had a history of demonstrating verbally abusive behaviors of cursing at staff and/or other residents related to poor impulse control, pain, and cognitive impairment. The 04/18/2024 care plan showed Resident 2 became verbally aggressive towards staff when care was provided and would become verbally aggressive towards other residents when their spouse left. Resident 2 was unable to understand the effect of their cursing or give an explanation as to why they said certain things. Interventions dated 04/18/2024, instructed staff to document Resident 2's behaviors, assess and anticipate their needs for food, thirst, toileting, comfort, body positioning, and pain. Interventions dated 04/18/2024, instructed staff to intervene before agitation escalated, guide the resident away from the source of distress, engage calmly and if Resident 2 responded aggressively staff were to walk away calmly and approach at a later time. The care plan did not include individualized non-pharmacological approaches to care. In an interview on 06/12/2024 at 12:40 PM, Staff C, Lead Nursing Assistant, stated Resident 2 screamed a lot and would call staff offensive, derogatory, and vulgar names when care was provided. Resident 2 could be a sweet and nice person but could also quickly flip and become very mean and aggressive without warning. Staff C acknowledged Resident 2 experienced verbal behaviors since their admission, but they had increased in frequency to now occurring several times per week, but staff had no known behavioral interventions to attempt. Staff C stated Resident 2 potentially showed signs and/or symptoms of pain but was unable to verbalize it. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/12/2024 at 1:11 PM, Staff D, Registered Nurse, stated Resident 2 experienced behaviors since their admission which included waking up screaming from potential nightmares, yelling out offensive profanities, and sometimes worried about caring for a baby. Staff D further stated Resident 2's behaviors would decrease when they informed Resident 2 they would care for the baby. In an interview on 06/12/2024 at 1:57 PM, Staff E, Resident Care Manager, stated Resident 2 had advanced dementia with lots of daily behaviors that included yelling out and cursing. Staff E stated they observed Resident 2's behaviors increased when they could not see out of their room because the privacy curtain blocked their view but Resident 2's behaviors stopped when the curtain was opened up. In an interview on 06/12/2024 at 2:37 PM, Staff F, Director of Social Services, stated Resident 2 experienced frequent verbal behaviors which included yelling out and cursing since their admission. Staff F stated Resident 2's behaviors could be signs and/or symptoms of potential pain. Staff F reviewed Resident 2's medical record. Staff F acknowledged Resident 2 required frequent redirection but was unable to find resident specific behavioral interventions. In an interview on 06/12/2024 at 3:19 PM, Staff H, Resident Care Manager, stated Resident 2 experienced verbal behaviors during cares first thing in the morning, at night during their bedtime routine, during showers, and when staff provided cares because Resident 2 was in pain. Staff H reviewed Resident 2's medical record. Staff H acknowledged Resident 2's pain interventions including medications had not been adjusted and alternative bathing options had not been attempted. In a phone interview on 06/12/2024 at 4:14 PM, Staff A, Administrator, stated Resident 2 had verbal behaviors directed towards others for the last six months. Staff A reviewed Resident 2's medical record. Staff A stated care planned interventions included to take Resident 2 away from the source of agitation and try to figure out if they had any unmet care needs such as hunger, thirst, or pain. Staff A acknowledged Resident 2's behaviors were triggered when staff provided care. Reference WAC 388-97-1040 (1)(a-c) See F600 for additional information.