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	09/12/2024

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review the facility failed to repeatedly implement an effective discharge planning process, evaluate and document resident's discharge needs and discharge plan to avoid unnecessary delays in discharge, and document who determined why discharge to the community was not feasible for 3 of 3 sampled residents (Resident 4, 1, and 5), reviewed for discharge planning. This failure placed residents at risk of unsafe discharges, unmet care needs, and diminished quality of life. Findings included . Review of the facility policy titled, Discharge Management revised ,d+[DATE], showed residents were referred, transferred or discharged based on their assessed needs and by order of their attending physician. 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 policy further showed the initial discharge plan and projected discharge date would be formulated based on diagnosis, level of function, rehabilitation progress, clinical goals during the baseline care plan development and review process. The interdisciplinary team (IDT) would communicate resident goals and status on the plan of care through care conferences, 1:1 meetings, and as needed per resident request. The policy showed staff would counsel the resident and/or caregiver about community reintegration services, centers and support systems available in the community to meet their physical, mental, and psychosocial needs. Staff were to make arrangements in advance for anticipated discharges during non-business hours such as evenings or weekends. The policy instructed the IDT to prepare written discharge instruction with all pertinent information to provide a safe discharge for the resident. (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 09/12/2024
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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled, Against Medical Advice [AMA] Discharge revised ,d+[DATE], showed a discharge AMA form must be completed on all cases when a cognitively intact resident insisted on leaving the facility AMA of their attending physician or failed to return to the center by midnight on the date of the expected return without bed-hold arrangements made. Failure to return by midnight on the date of expected return would constitute a voluntary discharge from the facility AMA. The policy instructed staff to read and carefully explain the waiver on discharge AMA to the resident prior to witnessing the signature. If the resident and/or legal representative refused to sign the form, the form would be filled out, read to the resident and/or their representative, witnessed, and the statement signature refused written on the resident signature line. 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 (DNS) must be notified immediately following each AMA discharge. <Resident 4> Review of the modified admission assessment, dated [DATE], showed Resident 4 admitted to the facility on [DATE] with diagnoses including urinary tract infection (UTI) within the last 30 days, acute cystitis (inflammation of the bladder) with hematuria (blood in the urine), and urinary retention. The assessment further showed Resident 4 had an indwelling urinary catheter (flexible tube inserted into the bladder to drain urine). Review of the [DATE] hospital history and physical showed Resident 4 presented in the emergency department (ER) after being found on the floor with a distended lower abdomen and concerns for urinary retention. A urinary catheter was placed in the ER with 3.5 liters of dark urine output. Review of the [DATE] hospital case management notes showed Resident 4 could not return to their previous home because the facility did not accept or care for residents with indwelling catheters. Review of the [DATE] hospital Registered Nurse RN progress notes showed Resident 4 had the urinary catheter removed on [DATE] evening but was unable to void (urinate) and a new indwelling catheter was inserted on [DATE] for urinary retention. On [DATE] Resident 4 was tearful they had to keep the indwelling catheter in place. Review of [DATE] hospital discharge orders showed Resident 4 was to continue with the indwelling catheter until seen by a urologist (doctor that specializes in the urinary system) for urinary retention, voiding trials, and catheter discontinuation. Review of the [DATE] admission assessment showed Resident 4 admitted related to encephalopathy (brain dysfunction that could appear as confusion and memory loss) and a UTI. The assessment further showed Resident 4 had recurrent UTIs, had an indwelling catheter in place related to acute urinary retention or bladder outlet obstruction (blockage at the neck of the bladder), and estimated duration of catheter use was to be determined by a urologist. Review of the [DATE] baseline care plan showed Resident 4 was to receive catheter care and needed a urologist appointment. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the [DATE] catheter justification evaluation showed Resident 4 had an indwelling catheter placed in the hospital for acute urinary retention and a urologist appointment was being scheduled to determine the need for the catheter. Review of the [DATE] provider progress note showed Resident 4 admitted related to acute urinary retention with a UTI, a urinary catheter was placed, Resident 4 failed catheter removal voiding trial and had the catheter reinserted. Resident 4 was unable to return to their previous living setting related to catheter management issues. Review of [DATE] through [DATE] nursing progress notes showed Resident 4 was forgetful and refused catheter care occassionally. On [DATE] Resident 4 admitted to the facility with a new indwelling urinary catheter related to urinary retention and needed a follow up appointment with urology. On [DATE] staff attempted to schedule a urologist appointment. On [DATE] Resident 4's catheter drained dark urine and Resident 4 voiced their goal was to return to their previous living setting once reconditioned. Resident 4 was scheduled to discharge back to their previous living setting on [DATE]. On [DATE] at 8:29 AM Resident 4 reported feeling feverish, their face was flushed, refused breakfast, and staff would monitor for signs and/or symptoms of infection. Resident 4 discharged back to their previous living setting five hours later at 1:30 PM on [DATE]. The notes showed no documentation Resident 4's reports of feeling feverish was communicated to the discharge facility. Review of Resident 4's discharge packet included a face sheet, [DATE] and [DATE] provider progress notes, a home health referral for therapy related to Resident 4 being unable to transport self to appointments, a transfer or discharge notice that documented Resident 4's was to discharge back to their previous living setting because their health had improved sufficiently and no longer required services provided by the facility. The recapitulation of stay included a brief summary of course of stay that documented Resident 4 admitted for therapy after hospitalization for encephalopathy, the summary did not address Resident 4's indwelling catheter status, urinary retention, voiding trials, urologist consults, or reports of Resident 4 feeling feverish the day of discharge. Resident discharge summary instructions did not address indwelling catheter status, urinary retention, voiding trials, or urologist consults. The order summary included active medication orders but no provider order for Resident 4 to discharge. Review of provider orders [DATE] through [DATE] showed no provider orders for Resident 4 to have their urinary catheter removed, urologist consult discontinued, or for Resident 4 to discharge the facility on [DATE]. In an interview on [DATE] at 10:13 AM, Staff D, Licensed Practical Nurse (LPN), stated social services assessed the resident for their discharge goals and needs. Staff D was unsure how the facility determined if the discharge destination was able to meet a resident's needs. Staff D was unsure what criteria determined if a discharge was considered AMA, but paperwork should be reviewed with the resident representative if the resident had cognitive impairment. Staff D reviewed Resident 4's medical record. Staff D stated Resident 4 admitted with urinary retention, urinary catheter in place, needed urologist follow-up, and their previous living facility could not provide indwelling catheter management. Staff D further stated Resident 4's catheter was not discontinued at the facility because they needed a urologist follow-up to determine removal and Resident 4 discharged back to their previous living setting with the catheter in place. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 11:37 AM, Staff B, Director of Nursing, reviewed Resident 4's medical record. Staff B stated Resident 4 admitted because their previous living setting was unable to manage urinary catheters but Resident 4 did not admit to the facility with a urinary catheter. Staff B acknowledged Resident 4 was not monitored for urinary retention, did not see a urologist, and Resident 4 returned back to their previous living setting on [DATE]. In a follow-up interview on [DATE] at 12:13 AM, Staff B, stated Resident 4's urology consult was cancelled by nursing staff because Resident 4 did not have a urinary catheter, the provider was notified Resident 4 did not have a catheter in place, and no new provider orders were received. Staff B was unable to locate documentation the provider was informed Resident 4 had no urinary catheter or that the urology consult had been cancelled by nursing staff. Staff B expected staff to accurately assess a resident's urinary status, follow-up and monitor urinary retention per provider orders. <Resident 1> Review of the admission assessment, dated [DATE], showed Resident 1 admitted to the facility on [DATE] with diagnoses including malnutrition, encephalopathy, and stimulant (class of drugs that speed up messages traveling between the brain and body) abuse. The assessment further showed Resident 1 had severe cognitive impairment without evidence of acute changes in mental status. Review of the [DATE] hospital discharge summary showed Resident 1's active comorbid (medical conditions in addition to primary diagnosis) conditions included substance abuse with methamphetamine (meth, a powerful and highly addictive stimulant) and fentanyl (potent synthetic narcotic drug typically used to treat pain) use identified. The summary included [DATE] urine drug screen results positive for amphetamine (synthetic stimulant) and fentanyl. Review of the [DATE] nursing to social services referral communication showed Resident 1 needed a mental health referral and had lack of access to affordable housing. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of [DATE] through [DATE] nursing progress notes showed Resident 1 admitted on [DATE] wanted a meal immediately, began to hit the nurse with their mobile phone and attempted to ram their wheelchair (WC) into staff, staff called law enforcement for assistance, Resident 1 left the building screaming and cursing. On [DATE] Resident 1 was educated on the importance of adhering to their plan of care, it was explained if they chose to leave the facility it would be considered AMA, Resident 1 signed the AMA form but then chose to return to the facility. On [DATE] Resident 1 was assessed for cognitive impairment and was identified as moderate to severe cognitive impairment. On [DATE] Resident 1 made poor health decisions such as overeating to the point of vomiting. Resident 1 was verbally and physically aggressive towards others, accusatory, refused medications and care, had moderate cognitive impairment, made numerous and frequent requests for food, had poor impulse control, wandered inside and outside the facility. On [DATE] around 7:15 PM Resident 1 was observed resting in bed watching television, at 8:05 PM staff was unable to locate Resident 1 inside the facility or on the outside patio, staff implemented their missing person process, Resident 1 was located at the local grocery store two blocks away by staff, Resident 1 was assisted back to the facility, a wanderguard (a wandering system that consist of a bracelet placed on an individual that would sound an alarm when near an exit) bracelet was not placed on the resident related to Resident 1 not showing elopement behaviors, with recent destinations in mind, and immediate return to the facility after being outdoors. Resident 1 was educated on signing out of the facility and communicating with staff when they chose to leave the facility. On [DATE] Resident 1 was assessed by therapy for operation of motorized WC inside and outside the facility, Resident 1 was educated on ensuring they had a charged battery prior to outings, signed out of the facility, notified staff if leaving the building, and Resident 1 was deemed independent with motorized WC mobility. On [DATE] Resident 1 smoked a cigarette in their room and was again educated the facility was a non-smoking campus. On [DATE] at 5:20 AM, Resident 1 was exit seeking all night and attempted to go out the front doors several times, Resident 1 left the facility at 2 PM without signing out and had not returned to the facility by 9:12 PM. On [DATE] at 4:47 AM, Resident 1 did not have any behaviors, had not slept all night, Resident 1 stated they were not tired and sat in the same position on the edge of their bed with their feet on the ground the entire shift. At 12:20 PM Resident 1 appeared off, had sporadic arm movement, and continued licking their lips from side to side. At 2:50 PM Resident 1 left the facility stating they were going downtown, returned to the facility at 9 PM, and showed awkward arm twisting. At 9:24 PM Resident 1 was drowsy and slept in the WC at their bedside. On [DATE] morning staff found 2 meth pipes and pieces of meth in Resident 1's drawer which was confiscated. At 6:08 PM Resident 1 had bouts of anger outburst throwing most of their dinner across the room, slurred incomprehensible speech, uncontrolled spastic upper body movements of the arms, neck, head, and torso while seated in their WC. At 8:16 PM Resident 1 left the facility to buy cigarettes and the administrator was called related to Resident 1 was actively coming down from suspected meth use with paraphernalia found in their room. At 9:02 PM law enforcement arrived at the facility to inform staff they were unable to locate Resident 1, drug paraphernalia and several crystal-clear glass appearing nuggets lying under a small zip lock bag was collected by law enforcement. On [DATE] Resident 1 returned to the facility after staff saw them sitting across the street at the bus depot station and assisted Resident 1 back to the facility. Resident 1 appeared to be under the influence with slurred incomprehensive speech, spastic uncontrolled upper body movements, unsteady gait and balance, Resident 1 voiced being upset staff found their crystal meth, wanted to leave facility grounds, staff attempted to educate Resident 1 on leaving AMA, at 1:30 AM Resident 1 agreed to return to the facility and was escorted back to their room by law enforcement. Staff were unable to locate Resident 1 or their motorized WC at dinner time, Resident 1 had not signed out of the facility, [DATE] at 00:52 AM staff informed the administrator Resident 1 had not returned, their status was changed to being on a leave of absence, and no further action was required at that time. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the [DATE] AMA form showed Resident 1 left the facility without notice related to drug use and had unable to sign written in the section for resident/responsible party signature. In an interview on [DATE] at 10:13 AM, Staff D, LPN, reviewed Resident 1's medical record. Staff D acknowledged Resident 1 was cognitive impairment and discharge the facility AMA after staff was unable to locate them. <Resident 5> Review of the admission assessment, dated [DATE], showed Resident 5 admitted to the facility on [DATE] with diagnoses including heart attack, ventricular tachycardia (type of irregular heartbeat that occurs when the lower chambers of the heartbeat too fast), fibromyalgia (chronic condition that causes widespread pain in the body), and ankylosing spondylitis (chronic arthritis that causes inflammation in the back bones) of the spine (back bones). Resident 5 was cognitively intact and able to verbalize their needs. The assessment further showed Resident 5 was able to perform most of their activities of daily living (ADL) independently. Review of the [DATE] hospital discharge summary showed Resident 5 admitted to the hospital after being found down pulseless and emergency cardiopulmonary resuscitation performed. Resident 5 was to discharge to the skilled nursing facility for continued rehabilitation. Review of the [DATE] admission assessment showed Resident 5 admitted after sustaining a heart attack and being revived. The assessment further showed Resident 5 was assessed as independent with all of their ADLs and a therapy referral was not needed. The assessment documented Resident 5 voice anxiousness over their upcoming surgery for their ankylosing spondylitis. Review of the [DATE] baseline care plan showed Resident 5's goal was to return to their independent home once reconditioned and needed therapy services. Review of the [DATE] provider progress note showed Resident 5 was cognitively intact and their goal was to return home with their parent. Resident 5's tachycardia was stable, and therapy was to evaluate and treat Resident 5's ankylosing spondylitis. Review of the [DATE] social services admission/discharge evaluation showed Resident 5 was identified as long-term stay, the discharge evaluation and discharge plan sections of the assessment were left blank. The assessment included documentation that Resident 5 continued to adjust to skilled nursing facility SNF placement, was pleasant and cooperative, wished to return home once reconditioned, and social services had no concerns. Review of the [DATE] resident discharge plan showed Resident 5's projected discharge date was [DATE] to an identified address with assistance at discharge location, barrier to discharge, plan to remove barriers, and alternative or back-up discharge plans listed as TBD [to be determined]. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the self-care deficit care plan revised [DATE] showed Resident 5 was able to perform their ADLs independently including bathing. A [DATE] discharge care plan showed Resident 5 wished to return home and instructed staff to ask the resident about their preferences for outside services post-discharge, assess the need for medical equipment needs, discuss discharge goals with the resident and/or family, plan family meetings, schedule follow-up appointments, and link the resident to community resources as needed to be successful in the discharge environment. Review of the [DATE] resident discharge plan showed Resident 5's projected discharge date was [DATE] to an identified address. Assistance at the discharge location and alternative or back-up discharge plan listed as TBD. The assessment documented little support in the home was a discharge barrier with the plan to remove the barrier listed as home health services after discharge. Review of the [DATE] provider progress notes showed Resident 5 continued to work with therapy and was making good progress. Review of the [DATE] provider progress notes showed Resident 5 continued to work with therapy, was making good progress, and hoped to discharge back home next week. The provider did not document any concerns related to Resident 5 discharging the following week. Review of the [DATE] cardiologist (doctor that specializes in the heart and blood vessels) progress notes showed Resident 5 denied concerns and planned to discharge home within the next week. The cardiologist did not document any concerns related to Resident 5 discharging the following week. Review of the [DATE] provider progress notes showed Resident 5 would like to discharge to their sibling's house tomorrow and would have social services speak with Resident 5. The provider did not document any concerns related to Resident 5 discharging the following day. Review of the [DATE] resident discharge plan showed Resident 5's projected discharge date was [DATE] to an identified address. The assessment showed Resident 5 would live with their sibling for a while upon discharge, barrier plan to remove barriers and alternative or back-up discharge plan were listed as TBD. Review of the [DATE] provider progress note showed Resident 5 felt they would not benefit from staying in the facility for another week of therapy and would be discharging the facility AMA that morning. Resident 5 reported they would discharge to their sibling's house for a couple of weeks prior to returning to their own home. The provider did not document any concerns related to Resident 5 discharging that day. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of [DATE] nursing progress notes showed Resident 5 was cognitive intact, able to perform their ADLs independently, was becoming bored and restless, and Resident 5 wished to return back home once reconditioned. On [DATE] therapy projected one more week of therapy for Resident 5 and social services would facilitate discharge when appropriate. On [DATE] therapy again projected one more week of therapy for Resident 5 and social services would facilitate discharge when appropriate. On [DATE] Resident 5 informed nursing staff that they had discussed discharging with social services, Resident 5's sibling would pick them up tomorrow, and requested their medication be prepared for discharge on [DATE]. On [DATE] Resident 5 walked to the front of the facility with their personal effects, sister at side, and AMA form signed. The discharge progress note did identify why the discharge was considered AMA, did not document the AMA form was read and carefully explained the waiver on discharge AMA to the resident prior to witnessing the signature, items removed from the facility, Resident 5's condition upon leaving, transportation method used, or administration notification of AMA discharge. Review of the [DATE] discharge AMA showed Resident 5's signature but the form did not include any risks and/or potential complications related to discharging the facility AMA and released the facility from liability for any adverse results caused by leaving the facility prematurely. In an interview on [DATE] at 10:13 AM, Staff D, LPN, reviewed Resident 5's medical record. Staff D acknowledged Resident 5 discharged to their sibling's home on [DATE], no discharge barriers were identified, Resident 5 was independent with cares, and the discharge was considered AMA because Resident 5 would not wait to discharge when the facility chose. In an interview on [DATE] at 11:37 AM, Staff E, Social Service Director, stated discharge planning began at admission, weekly notes were written on discharge progress, resident needs were determined by conversations with the resident, family, and/or resident representative. Staff E reviewed Resident 5's medical record. Staff E stated Resident 5 discharged on [DATE] to their sibling's house AMA. Staff E explained Resident 5's discharge was considered AMA because Resident 5 could have benefited from additional therapy because Resident 5's insurance continued to approve therapy week to week. Staff E further stated education on risks versus benefits of discharging AMA should be documented in the progress notes. In an interview on [DATE] at 12:13 PM, Staff A, Administrator, stated a discharge was considered AMA if the resident was adamant about discharging without appropriate services necessary to be safe and successful at home. Staff A further stated Resident 5's discharge was considered AMA because Resident 5 wanted to discharge as soon as possible which did not give the facility time to set up home health services, initiate a discharge appointment, or ensure there was adequate support at home. Staff A further stated Resident 5 could have benefited from an in-home care giver because Resident 5's insurance continued to approve therapy week to week. Staff A acknowledged the incorrect AMA form was reviewed and signed by Resident 5 because it did not include any risks and/or potential complications related to discharging the facility AMA. Reference WAC [DATE] This is a repeat citation from [DATE]. Refer to F690 and F689 for additional information.

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F 0689	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.
Level of Harm - Minimal harm or potential for actual harm	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328
Residents Affected - Some	Based on interview and record review the facility failed to repeatedly identify, evaluate and analyze risks, and implement safety interventions to reduce risks and hazards for 3 of 3 sampled residents (Resident 1, 2, and 3), reviewed for substance use disorder. This failure placed residents at risk of leaving the facility without staff knowledge, potentially avoidable accidents, and diminished quality of life.
	Findings included .
	Review of the facility policy titled, Substance Abuse-Residents dated 08/2022, defined substance abuse as recurrent use of alcohol and/or drugs that cause clinically and functionally significant impairment, such as health problems or disability. Signs and/or symptoms of substance abuse may include intoxication, decreased inhibition, combative behavior, belligerence, nausea/vomiting, involuntary eye movements, slurred speech, slow movements or poor coordination, tremors, falls, and dizziness. In care of an overdose staff was to notify the physician immediately and provide increased monitoring, administer opioid reversal medication with a physician's order, initiate cardiopulmonary resuscitation as needed, and contact emergency medical services. The policy instructed staff to assess residents upon admission and as needed for actual substance abuse and/or history of substance abuse using the Social Services Admission/Discharge Evaluation. A care plan would be initiated which could include interventions of offering and providing resources for counseling and support, monitoring for symptoms of relapse, provided 1:1 for safety if resident was at risk of harming self or others, assure resident had access to community substance use services, assess and develop person centered care plan related to the resident's stressors and triggers to reduce risk of relapse. The policy further showed the care plan and interventions would be re-evaluated quarterly and modified as needed.
	Review of the facility policy titled, Elopement Prevention dated 11/2022, showed the facility strived to provide an environment that was free from hazards over which the facility had control and provide supervision to each resident to prevent avoidable accidents. The policy defined elopement as when a resident who needs supervision leaves a safe area without the knowledge of the supervising staff. Adequate supervision was based on identifiable hazards according to individual resident needs. Residents would be assessed for elopement risk upon admission, quarterly, and with a change in condition. If elopement risk was identified an elopement care plan with interventions would be implemented to address the specific potential risk factors for elopement. The policy further showed identified risks and interventions would be communicated to the caregiving team including the provider. The policy instructed staff to monitor whereabouts of at-risk residents during care rounds.
	(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 policy titled, Against Medical Advice [AMA] Discharge revised 05/2023, showed a discharge AMA form must be completed on all cases when a cognitively intact resident insisted on leaving the facility AMA of their attending physician or failed to return to the center by midnight on the date of the expected return without bed-hold arrangements made. Failure to return by midnight on the date of expected return would constitute a voluntary discharge from the facility AMA. The policy instructed staff to read and carefully explain the waiver on discharge AMA to the resident prior to witnessing the signature. If the resident and/or legal representative refused to sign the form, the form would be filled out, read to the resident and/or their representative, witnessed, and the statement signature refused written on the resident signature line. 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 (DNS) must be notified immediately following each AMA discharge. The website nih.gov - in which nih refers to national institute of health - with regard to Brief Interview for Mental Status (BIMS) showed - the BIMS performance-based screener includes five items in total: three questions measure temporal orientation and two questions assess recall. The response option allow for differential scoring for answers to temporal orientation questions that are 'close' to correct and partial credit when a resident can recall an item after being prompted or cued. The scores from each item are summed to create a total BIMS score ranging from 15 (all items correct) to 0 (no items correct). The BIMS has displayed high levels of sensitivity and specificity in identifying cognitive impairment and has been categorized into 3 levels: 13-15 intact/borderline cognition, 8-12 moderate cognitive impairment, 0-7 severe cognitive impairment. <Resident 1> Review of the admission assessment, dated 07/26/2024, showed Resident 1 admitted to the facility on [DATE] with diagnoses including malnutrition, encephalopathy (brain dysfunction that could appear as confusion and memory loss), and stimulant (class of drugs that speed up messages traveling between the brain and body) abuse. The assessment further showed Resident 1 had severe cognitive impairment without evidence of acute changes in mental status. Review of the 07/19/2024 hospital discharge summary showed Resident 1's active comorbid (medical conditions in addition to primary diagnosis) conditions included substance abuse with methamphetamine (meth, a powerful and highly addictive stimulant) and fentanyl (potent synthetic narcotic drug typically used to treat pain) use identified. The summary included 06/18/2024 urine drug screen results positive for amphetamine (synthetic stimulant) and fentanyl. Review of the 07/19/2024 admission assessment showed Resident 1 expressed desire to leave the facility, had a history of wandering, demonstrated exit seeking behavior, attempted to elope the facility four times on day of admission, had impaired cognition, was independent in wheelchair, had a history of alcohol or drug abuse, stated desire to return home upon arrival, yelled, was impulsive, aggressive, irritable, restless, and angry. Resident 1 was identified at risk for elopement and the assessment instructed staff to implement plan of care for unsafe wandering and exit seeking behavior. The assessment included staff rationale may leave AMA to apartment. (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 07/19/2024 baseline care plan did not address Resident 1's risk for leaving the facility without staff notification, elopement risk, substance use disorder, or risk for substance use while in the facility. Review of the 07/21/2024 nursing to social services referral communication showed Resident 1 needed a mental health referral and had lack of access to affordable housing. Review of the 07/22/2024 provider progress note showed Resident 1 had a recent hospitalization with a history of methamphetamine and fentanyl use, had agitated and combative behaviors that required physical restraints while hospitalized , consult was requested for assistance with finding a medical decision maker with recommendation to purse guardianship related to Resident 1's cognitive impairment, being estranged from their siblings and an identified friend did not have the ability to act as a trusted decision maker. Review of the 07/23/2024 social service admission/discharge evaluation showed Resident 1 was considered long term care and was only oriented to self. The assessment further showed most of the assessment was left blank including sections for memory, mood and behavior, drug/alcohol abuse, psychiatric conditions, discharge evaluation, and discharge plan. The assessment included documentation that Resident 1 continued to adjust to skilled nursing facility (SNF) placement, was combative, wished to return to their previous home environment, and social services had no concerns. The assessment did not address Resident 1's risk for leaving the facility without staff notification, elopement risk, substance use disorder, or risk for substance use while in the facility. Review of Resident 1's risk for elopement care plan that was both initiated and resolved on 07/22/2024, identified Resident 1 as a risk for elopement/wandering related to a history of attempts to leave the facility unattended, impaired decision-making skills, impaired safety awareness, and feeling their dog needed to be checked on. Elopement care planned interventions instructed staff to assess for fall risk and pain, document wandering behaviors and attempted diversional interventions, reassure Resident 1 their dog was well cared for by their neighbor, and identify a pattern of wandering were also initiated and resolved on 07/22/2024. A risk for elopement care plan implemented on 07/23/2024 and resolved on 08/05/2024 showed Resident 1 was at risk for elopement related to desire to return to their apartment to see their pet and instructed staff to allow for safe wandering, offer conversation, redirect, reassure and remind the resident they were at the right place, and distract from wandering by offering pleasant diversions, structures activities, food, television or book. A 08/05/2024 impaired cognitive function care plan showed Resident 1 had impaired decision making and instructed staff to ask yes or no question, monitor and report changes in cognitive function, orient the resident to time, place, and person. A 08/05/2024 history of substance abuse care plan instructed staff to establish resident goals, refer the resident to drug and/or alcohol counselling as resident would allow, use a calm and empathetic approach, educate the resident on potential interactions between ordered medications and substance abuse, and notify the provider if the resident appeared impaired. (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 July 2024 through August 2024 nursing progress notes showed Resident 1 admitted on [DATE] wanted a meal immediately, began to hit the nurse with their mobile phone and attempted to ram their wheelchair (WC) into staff, staff called law enforcement for assistance, Resident 1 left the building screaming and cursing. On 07/20/2024 Resident 1 was educated on the importance of adhering to their plan of care, it was explained if they chose to leave the facility it would be considered AMA, Resident 1 signed the AMA form but then chose to return to the facility. On 07/22/2024 Resident 1 was assessed for cognitive impairment and was identified as moderate to severe cognitive impairment. On 07/29/2024 Resident 1 made poor health decisions such as overeating to the point of vomiting. Resident 1 was verbally and physically aggressive towards others, accusatory, refused medications and care, had moderate cognitive impairment, made numerous and frequent requests for food, had poor impulse control, wandered inside and outside the facility. On 08/12/2024 around 7:15 PM Resident 1 was observed resting in bed watching television, at 8:05 PM staff was unable to locate Resident 1 inside the facility or on the outside patio, staff implemented their missing person process, Resident 1 was located at the local grocery store two blocks away by staff, Resident 1 was assisted back to the facility, a wanderguard (a wandering system that consist of a bracelet placed on an individual that would sound an alarm when near an exit) bracelet was not placed on the resident related to Resident 1 not showing elopement behaviors, with recent destinations in mind, and immediate return to the facility after being outdoors. Resident 1 was educated on signing out of the facility and communicating with staff when they chose to leave the facility. On 08/13/2024 Resident 1 was assessed by therapy for operation of motorized WC inside and outside the facility, Resident 1 was educated on ensuring they had a charged battery prior to outings, signed out of the facility, notified staff if leaving the building, and Resident 1 was deemed independent with motorized WC mobility. On 08/14/2024 Resident 1 smoked a cigarette in their room and was again educated the facility was a non-smoking campus. On 08/15/2024 at 5:20 AM, Resident 1 was exit seeking all night and attempted to go out the front doors several times, Resident 1 left the facility at 2 PM without signing out and had not returned to the facility by 9:12 PM. On 08/16/2024 at 4:47 AM, Resident 1 did not have any behaviors, had not slept all night, Resident 1 stated they were not tired and sat in the same position on the edge of their bed with their feet on the ground the entire shift. At 12:20 PM Resident 1 appeared off, had sporadic arm movement, and continued licking their lips from side to side. At 2:50 PM Resident 1 left the facility stating they were going downtown, returned to the facility at 9 PM, and showed awkward arm twisting. At 9:24 PM Resident 1 was drowsy and slept in the WC at their bedside. On 08/17/2024 morning staff found 2 meth pipes and pieces of meth in Resident 1's drawer which was confiscated. At 6:08 PM Resident 1 had bouts of anger outburst throwing most of their dinner across the room, slurred incomprehensible speech, uncontrolled spastic upper body movements of the arms, neck, head, and torso while seated in their WC. At 8:16 PM Resident 1 left the facility to buy cigarettes and the administrator was called related to Resident 1 was actively coming down from suspected meth use with paraphernalia found in their room. At 9:02 PM law enforcement arrived at the facility to inform staff they were unable to locate Resident 1, drug paraphernalia and several crystal-clear glass appearing nuggets lying under a small zip lock bag was collected by law enforcement. On 08/18/2024 Resident 1 returned to the facility after staff saw them sitting across the street at the bus depot station and assisted Resident 1 back to the facility. Resident 1 appeared to be under the influence with slurred incomprehensive speech, spastic uncontrolled upper body movements, unsteady gait and balance, Resident 1 voiced being upset staff found their crystal meth, wanted to leave facility grounds, staff attempted to educate Resident 1 on leaving AMA, at 1:30 AM Resident 1 agreed to return to the facility and was escorted back to their room by law enforcement. Staff were unable to locate Resident 1 or their motorized WC at dinner time, Resident 1 had not signed out of the facility, 08/19/2024 at 00:52 AM staff informed the administrator Resident 1 had not returned, their status was changed to being on a leave of absence, and no further action was required at that time. (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 08/20/2024 AMA form showed Resident 1 left the facility without notice related to drug use and had unable to sign written in the section for resident/responsible party signature. In an interview on 09/12/2024 at 9:49 AM, Staff C, Nursing Assistant, stated there were numerous potential signs and/or symptoms of substance use. Staff C was unsure of the facility process for dealing with potential emergencies related to substance use, which facility staff were trained to recognize signs and/or symptoms of substance use, how safety was maintained or how to monitor a resident with a substance use disorder to ensure they do not use substance during their stay. Staff C stated direct care staff was not always informed when residents had a history of substance abuse. Staff C acknowledged staff found meth and drug paraphernalia in Resident 1's nightstand. Staff C further stated two days prior, Resident 1 experienced slurred speech, abnormal arm movements, and refused meals when they previously had a good appetite. In an interview on 09/12/2024 at 10:13 AM, Staff D, Licensed Practical Nurse, was able to state potential signs and/or symptoms of substance abuse but was unsure which facility staff were trained to recognize potential signs and/or symptoms of substance use or if the facility completed an assessment for substance use disorders. Staff D stated if a resident had specific interventions for substance use, they would be listed in their care plan, but a history of substance abuse was not always communicated to direct care staff unless the history directly affected the residents' care. Staff D further stated the facility cared for numerous residents with histories of substance use and some received medications to help treat detoxing (the process where addictive toxins leave the body) and/or withdrawals (the process of cutting back on or stopping an addictive substance). Staff D reviewed Resident 1's medical record. Staff D acknowledged Resident 1 admitted for encephalopathy with current history of stimulant drug abuse, had a positive hospital urine drug screen for amphetamine and fentanyl, and had severe cognitive impairment. Staff D stated Resident 1 had a changed in behaviors, was going out of the facility on personal outing more frequently, experienced abnormal arm movements, then staff found paraphernalia in Resident 1's room. Staff D further stated Resident 1 did not want to be at the facility, attempted to leave the facility on different occasions, and ended up discharging AMA. Staff D acknowledged Resident 1 was at risk for elopement but did not use a wanderguard bracelet and according to Resident 1's 08/05/2024 substance use care plan interventions included education, goal establishment, and a referral to counseling. In an interview on 09/12/2024 at 11:37 AM, Staff E Social Service Director, stated they did not receive training on how to recognize potential signs and/or symptoms of substance use and was unsure which facility staff were trained. Staff E acknowledged they did not assess residents for risk of substance use while in the facility, safety was maintained by potentially offering drug counseling meetings if not already attending, and any substance use interventions implemented would be on the care plan. Staff E reviewed Resident 1's medical record. Staff E acknowledged Resident 1 had a known history of substance use upon admission, had moderate cognitive impairment, was assessed and cleared by therapy to be ok to leave the facility without supervision. <Resident 2> (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 modified quarterly assessment, dated 08/05/2024, showed Resident 2 admitted to the facility on [DATE] with diagnoses including psychoactive (substances that affect the brain) substance abuse, seizure disorder (abnormal electrical activity in the brain that temporarily affects a person's consciousness, muscle control and behavior), stroke (blood flow to the brain is stopped or there is bleeding in the brain), hydrocephalus (when too much fluid builds up in the brain and spinal cord, causing the brain to push against the skull), and cerebral (brain) cryptococcosis (potentially fatal fungal infection). Resident 2 was cognitively intact and able to perform most activities of daily living (ADL) independently. Review of 04/24/2024 hospital progress notes showed Resident 2 had a polysubstance abuse disorder, presented to the ER after experiencing 4-5 seizures over the last week, Resident 2 had used fentanyl 40 minutes prior to hospital arrival, had witnessed seizure like activity, acute toxic encephalopathy and bradycardia (low heart rate) in the waiting room. Resident 2 was found to have hydrocephalus possibly related to drug use. The notes further showed Resident 2's hospital urine drug screen was positive for methamphetamine and fentanyl. Review of the 04/28/2024 elopement risk assessment identified Resident 2 as not at risk for elopement related to being confined to bed. Review of the 04/29/2024 admission assessment showed Resident 2 admitted related to fentanyl substance abuse and hydrocephalus. Resident 2 was unresponsive and dependent on staff for ADLs. Review of the 04/29/2024 baseline care plan showed Resident 2 received nutrition via a feeding tube (flexible plastic tube that delivers nutrition and fluids directly into the stomach or small intestines when a person is unable to eat or drink safely by mouth) and was to have nothing by mouth, the rest of the assessment was left blank. The baseline care plan did not address Resident 2's risk for leaving the facility without staff notification, elopement risk, substance use disorder, or risk for substance use while in the facility. Review of the 04/29/2024 social service admission/discharge evaluation showed Resident 2 was considered long term care. The assessment further showed most of the assessment was left blank including sections for memory, mood and behavior, drug/alcohol abuse, psychiatric conditions, discharge evaluation, and discharge plan. The assessment did not address Resident 2's risk for leaving the facility without staff notification, elopement risk, substance use disorder, or risk for substance use while in the facility. Review of the 04/28/2024 ADL deficit care plan showed Resident 2 was able to perform most of their ADLs independently. The 04/30/2024 care plan showed Resident 2 had a history methamphetamine and fentanyl substance abuse and instructed staff to refer Resident 2 to social services for emotional support, notify the provider if Resident 2 appeared impaired, use a calm and empathetic approach for communication. The care plan did not address Resident 2's risk for leaving the facility without staff notification, elopement risk, or risk for substance use while in the facility. Review of the 08/02/2024 social services quarterly evaluation showed Resident 2 did not have a change in cognitive status since the last review, made themselves understood, understood others, and was scheduled to discharge on 08/15/2024. The assessment did not address risk for leaving the facility without staff notification, elopement risk, substance use disorder, or risk for substance use while in the facility. (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 08/08/2024 quarterly nursing evaluation showed Resident 2 was independent with all ADLS, had their feeding tube removed, no skin issues identified. The assessment further showed most of the assessment was left blank including sections for elopement risk, mobility and safety. <Resident 3> Review of the quarterly assessment, date 05/22/2024, showed Resident 3 admitted to the facility on [DATE] with diagnoses including non-traumatic brain dysfunction (brain damage caused by internal factors rather than an external force to the head), malnutrition, alcohol abuse with alcohol-induced disorder, and Wernicke's encephalopathy (neurological condition characterized by loss of muscle coordination or control, confusion, and paralysis or weakness in eye muscles). Resident 3 had moderate cognitive impairment and was able to do perform their ADLs independently. Review of the 01/24/2024 hospital history and physical showed Resident 3 was a poor historian, experienced alcoholism but it was unclear when Resident 3 had their last drink and was considered at moderately high risk for alcohol withdrawals. The notes included 01/24/2024 magnetic resonance imaging (MRI, non-invasive imaging that uses radio waves and a powerful magnet to create detailed images of the inside of the body) results highly suspicious for acute Wernicke's encephalopathy. Review of the 02/13/2024 admission assessment showed Resident 3 admitted to the facility related to alcohol induced encephalopathy. Resident 3 was extremely confused only oriented to self, wandered around, and a wanderguard bracelet was placed to discourage elopement. Review of the 02/13/2024 baseline care plan showed Resident 3 required medication management, assist with ADLs, and therapy for strengthening. The baseline care plan did not address Resident 3's risk for leaving the facility without staff notification, elopement risk, substance use disorder, or risk for substance use while in the facility. Review of the 02/14/2024 elopement risk evaluation showed Resident 3 expressed desire to leave, was independent with WC mobility, was identified as a risk for elopement, and a wanderguard bracelet was placed to Resident 3's left ankle. Review of the 02/16/2024 social service admission/discharge evaluation showed Resident 3 was considered long term care, alert and oriented x 3, understood others, and was understood. The assessment further showed most of the assessment was left blank including sections for memory, mood and behavior, drug/alcohol abuse, discharge evaluation, and discharge plan. The assessment included documentation that Resident 3 continued to adjust to SNF placement, was pleasant and cooperative without behaviors, wished to return home, and social services had no concerns. The evaluation did not address Resident 3's risk for leaving the facility without staff notification, elopement risk, substance use disorder, or risk for substance use while in the facility. (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 care plan implemented on 02/14/2024 showed Resident 3 was at risk for elopement related to impaired cognitive function and instructed staff to allow for safe wandering, complete the elopement assessment when indicated, offer reassurance and redirection, and distract Resident 3 from wandering by offering pleasant diversion and structured activities. A 02/21/2024 care plan showed Resident 3 had impaired cognitive function related to Wernicke's encephalopathy and instructed staff to ask yes or no questions, call Resident 3 by their preferred name, orient as needed, break tasks into one step at a time, monitor and report changes in cognitive function. The 05/20/2024 ADL deficit care plan showed Resident 3 was able to perform their ADLs independently. The care plan did not address Resident 3's substance use disorder or risk for substance use while in the facility. In an interview on 09/12/2024 at 12:13 PM, with Staff A, Administrator, and Staff B, Director of Nursing, Staff B stated a substance use disorder was when a person abused drugs, alcohol, or mind-altering substances and signs and/or symptoms varied depending on the substance consumed. Both staff stated the facility dealt with potential emergencies related to substance use by notifying the provider and holding medications that could cause issues when combined with substance abuse. Staff A stated nursing staff was trained to recognize signs and/or symptoms of substance use. Both staff stated the facility reviewed a residents' medical history to determine if there was a history of substance abuse, but the facility did not complete a formal assessment to determine a residents' risk for using substances while in the facility and ensured safety of a resident with a substance use disorder by monitoring them similarly to other residents, and any interventions implemented would be documented in their care plan. Staff A acknowledged a resident with a substance use disorder was at higher risk of obtaining and using substances compared to an individual without a history of substance use because of their addiction. Reference WAC 388-97-1060 (3)(g) This is a repeat citation from 06/12/2024, 02/16/2024, and 10/12/2023. Refer to F660 for additional information.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review the facility failed to accurately assess urinary status, follow provider orders, provide appropriate care and services to restore or improve normal bladder function, and provide indwelling urinary catheter (flexible tube inserted into the bladder to drain urine) care according to standards of practice for 1 of 3 sampled residents (Resident 4), reviewed for urinary catheter management. These failures placed residents at risk of medical complications, unmet care needs, and diminished quality of life. Findings included . Review of the facility policy titled, Indwelling Catheters revised 07/2023, showed all residents with indwelling catheters required a medical justification for initiation and continued use. A comprehensive assessment that included underlying factors supporting medical justification, determination of which factors could be reversed and development of a plan for appropriate indications for continued use of an indwelling catheter would be completed. The policy identified urinary retention that could not be treated or corrected medically or surgically, for which alternative therapy is not feasible, and characterized by: documented post void residual (PVR- scans of the bladder showing the amount of urine retained in the bladder after voluntary urination) volumes of over 200 milliliters (mls), inability to manage the retention with intermittent catheterization, and persistent overflow incontinence, symptomatic infections, and/or renal (kidney) dysfunction as potential factors supporting medical justification. A catheter care plan was to be initiated upon admission and updated quarterly, and for changes of condition. The use of a Bladder Data Collection Evaluation and/or the Catheter Justification Evaluation was required for all residents with an indwelling catheter, findings reviewed, appropriateness of catheter removal discussed with the provider and the interdisciplinary team. Staff were to evaluate the appropriateness of catheter removal placed for untreatable blockages, history of being unable to void after catheter removal in the past, and inability to manage retention with intermittent catheterization. A provider order was to be obtained for catheter discontinuation. The website nih.gov - in which nih refers to national institute of health - with regard to the urinary tract showed the urinary tract is the body's drainage system for removing urine, which is made up of wastes and extra fluid. For normal urination to occur, all body parts in the urinary tract need to work together, and in the correct order. The urinary tract includes two kidneys, two ureters, a bladder, and a urethra. Kidney: two bean- shaped organs, each about the size of a fist. They are located just below your rib cage, one on each side of your spine [back bones] Ureters: thin tubes of muscle that connect your kidneys to your bladder and carry urine to the bladder Bladder: a hollow, muscular, balloon-shaped organ that expands as it filles with urine. The bladder sits in your pelvis [area in lower abdomen] between your hip bones. A normal bladder acts like a reservoir. It can hold 1.5 to 2 cups [360mls - 480mls] of urine . Urethra: a tube located at the bottom of the bladder that allows urine to exit the body during urination (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the modified admission assessment, dated 07/26/2024, showed Resident 4 admitted to the facility on [DATE] with diagnoses including urinary tract infection (UTI) within the last 30 days, acute cystitis (inflammation of the bladder) with hematuria (blood in the urine), and urinary retention. The assessment further showed Resident 4 had an indwelling urinary catheter and a urinary toileting program was not attempted. Resident 4 was able to perform most of their activities of daily living independently including toileting hygiene. Review of the 07/14/2024 hospital history and physical showed Resident 4 presented in the emergency department (ER) after being found on the floor with a distended lower abdomen and concerns for urinary retention. A urinary catheter was placed in the ER with 3.5 liters (3,500 mls) of dark urine output. Review of the 07/16/2024 hospital case management notes showed Resident 4 could not return to their previous home because the facility did not accept or care for residents with indwelling catheters. Review of the 07/17/2024 hospital Registered Nurse (RN) progress notes showed Resident 4 had the urinary catheter removed on 07/14/2024 evening but was unable to void (urinate) and a new indwelling catheter was inserted on 07/16/2024 for urinary retention. On 07/17/2024 Resident 4 was tearful they had to keep the indwelling catheter in place. Review of 07/19/2024 hospital discharge orders showed Resident 4 was to continue with the indwelling catheter until seen by a urologist (doctor that specializes in the urinary system) for urinary retention, voiding trials, and catheter discontinuation. Review of the 07/19/2024 admission assessment showed Resident 4 admitted related to encephalopathy (brain dysfunction that could appear as confusion and memory loss) and a UTI. The assessment further showed Resident 4 had recurrent UTIs, had an indwelling catheter in place related to acute urinary retention or bladder outlet obstruction (blockage at the neck of the bladder), and estimated duration of catheter use was to be determined by a urologist. Review of the 07/19/2024 baseline care plan showed Resident 4 was to receive catheter care and needed a urologist appointment. Review of facility provider orders showed 07/19/2024 orders for Resident 4 to have catheter care completed each shift, urine collection bag was to be changed as needed, catheter placement checked, and catheter system changed as needed for blockages, leaks, or encrustation. All catheter related orders were discontinued on 07/25/2024. Review of the July 2024 medication administration record (MAR) showed Resident 4 had catheter care orders 07/19/2024 through 07/24/2024. The MAR showed Resident 4 refused catheter care on 07/19/2024, omissions in catheter care documentation on 07/20/2024 and 07/22/2024. Review of July 2024 bladder activity documentation showed Resident 4's bladder continence was not rated on 07/20/2024 due to Resident 4 having a full-time indwelling catheter. Review of the 07/22/2024 catheter justification evaluation showed Resident 4 had an indwelling catheter placed in the hospital for acute urinary retention and a urologist appointment was being scheduled to determine the need for the catheter. (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 09/12/2024
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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 07/23/2024 provider progress note showed Resident 4 admitted related to acute urinary retention with a UTI, a urinary catheter was placed, Resident 4 failed catheter removal voiding trial and had the catheter reinserted. Resident 4 was unable to return to their previous living setting related to catheter management issues. Review of the 07/27/2024 bladder data collection evaluation showed Resident 4 was frequently incontinent of urine and most of the assessment was left blank. The assessment did not identify Resident 4 had an indwelling catheter or history of recent urinary retention. Review of July 2024 through August 2024 nursing progress notes showed Resident 4 was forgetful. On 07/19/2024 Resident 4 admitted to the facility with a new indwelling urinary catheter related to urinary retention and needed a follow up appointment with urology. On 07/22/2024 staff attempted to schedule a urologist appointment. On 07/23/2024 Resident 4's catheter drained dark urine and Resident 4 voiced their goal was to return to their previous living setting once reconditioned. On 07/25/2024 nursing staff cancelled the urologist consult. Resident 4 was scheduled to discharge back to their previous living setting on 08/06/2024. On 08/06/2024 at 8:29 AM Resident 4 reported feeling feverish, their face was flushed, refused breakfast, and staff would monitor for signs and/or symptoms of infection. Resident 4 discharged back to their previous living setting five hours later. No documentation was found showing Resident 4 had their indwelling urinary catheter removed or discontinue, urologist consult was scheduled or discontinued by the provider, was monitored for urinary retention, or received routine urinary catheter care. Further review of provider orders July 2024 through August 2024 showed no provider order for Resident 4 to have their urinary catheter or urologist consult discontinue. In an interview on 08/27/2024 at 10:07 AM, Resident 4 acknowledged having a catheter in place, but they were trying to have it removed. Resident 4 stated they did not have a catheter in July 2024 prior to admission to the facility and denied having urinary difficulties or issues. In an interview on 09/12/2024 at 9:49 AM, Staff C, Nursing Assistant, stated when a resident had a catheter in place staff were to provide catheter care by cleansing the tubing entering the body and emptying the urine collection bag. In an interview on 09/12/2024 at 10:13 AM, Staff D, Licensed Practical Nurse, stated resident's urinary status was assessed based on information received from the hospital. Staff D stated residents should void at least once a shift if they did not a bladder scan was completed, and they were assessed for abdominal discomfort. Staff D further stated if a resident had a urinary catheter staff were to provide routine catheter care, ensure proper urine drainage, urine collection bag emptied, and urine output monitored. Staff D reviewed Resident 4's medical record. Staff D stated Resident 4 originally admitted to the facility on [DATE] related to urinary retention, new urinary catheter placement, and needed to follow up with urology. Staff D further stated Resident 4's previous living setting was unable to manage urinary catheters. Staff D was unable to locate a provider order to discontinue Resident 4's urinary catheter or the urologist consult. Staff D acknowledged Resident 4's urinary catheter was not discontinued in the facility because they required a urology follow-up and Resident 4 discharge back to their previous setting with the indwelling urinary catheter in place. (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 09/12/2024
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/12/2024 at 11:37 AM, Staff B, Director of Nursing, reviewed Resident 4's medical record. Staff B stated Resident 4 admitted because their previous living setting was unable to manage urinary catheters but Resident 4 did not admit to the facility with a urinary catheter. Staff B acknowledged Resident 4 was not monitored for urinary retention, did not see a urologist, and Resident 4 returned back to their previous living setting on 08/06/2024. In a follow-up interview on 09/12/2024 at 12:13 AM, Staff B, stated Resident 4's urology consult was cancelled by nursing staff because Resident 4 did not have a urinary catheter, the provider was notified Resident 4 did not have a catheter in place, and no new provider orders were received. Staff B was unable to locate documentation the provider was informed Resident 4 had no urinary catheter or that the urology consult had been cancelled by nursing staff. Staff B expected staff to accurately assess a resident's urinary status, follow-up and monitor urinary retention per provider orders. Reference WAC 388-97-1060 (3)(c) This is a repeat citation from 06/27/2024. Refer to F660 for additional information.