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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505114 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/30/2024 |
| 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45433</p> <p>Based on interview and record review the facility failed to assess a change in condition, respond to the change of condition and notify the medical provider in a timely manner for 1 of 5 residents (Resident 5) reviewed for quality of care. This failure placed the resident at risk for medical complications, unmet care needs and diminished quality of life. Findings included .</p> <p>Record review showed Resident 1 admitted to the facility on [DATE] with diagnoses of end stage renal disease, diabetes and seizures. Further review found that the resident took a medication to prevent seizure activity every 12 hours and had tested positive for a COVID-19 infection on 10/24/2024.</p> <p>During an interview on 10/30/2024 at 9:30 AM, Staff E, Resident Care Manager, stated that during the morning of 10/28/2024 they had gone in to give Resident 5 their diabetes medication and could tell that they were not feeling well. A few minutes later a nursing assistant had come and gotten them and told them Resident 5 was vomiting and was having a seizure. They further stated that after Resident 5 was transported to the hospital they found that they had also vomited the day before and had not taken their seizure medication for, what they thought, had been two days. They stated that when a resident vomits, especially when they have a COVID-19 infection and take a seizure medication, the medical provider should be notified. They stated they could not tell if the medical provider had been notified of Resident 5's change in condition.</p> <p>During an interview on 10/30/2024 at 11:07 AM, Staff D, Resident Care Manager, stated that they had taken over the section that Resident 5 was residing in on the morning of 10/28/2024. They stated that they had not received a report from the off going nurse that the resident had vomited the night before, nor that they had not received a dose of seizure medication. They further stated that Resident 5 had not been able to take their seizure medication, or any by mouth medication the morning of 10/28/2024 because they were nauseous. They stated that if they had known Resident 5 had vomited the night before or that they had missed a dose, and now a second dose, of seizure medication they would have notified the medical provider, but they did not talk to the medical provider until Resident 5 had vomited and had a seizure later that morning.</p> <p>Record review of the provider medical book where nurses can write concerns they would like followed up on by the medical providers did not find any entries for Resident 5 for 10/26/2024 through 10/28/2024.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 10/30/2024 at 9:50 AM, Staff C, Nurse Practitioner, stated that they had not seen Resident 5 on 10/27/2024 and had not been notified of any concerns with the resident. They reviewed their notes and confirmed this was true. They also confirmed that they had not been notified, in any way, of Resident 5 vomiting and not taking their seizure medication on 10/27/2024. They further stated that they, or one of the other medical providers, should have been notified that Resident 5 had nausea, vomiting and had missed their seizure medication.</p> <p>Reference WAC 388-97-1060(1)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide and implement an infection prevention and control program.</p> <p>47309</p> <p>Based on observation and interview, the facility failed to ensure quarantine and isolation precautions were followed for 4 of 5 Residents (Residents 1, 2, 3 and 4) and proper personal protection equipment (PPE's) was used by 1 of 5 staff (Staff H), during a COVID outbreak, in accordance with Centers for Disease Control (CDC) guidelines. This failure placed residents and staff at risk for contracting COVID-19, a respiratory disease caused by a virus.</p> <p>Findings included .</p> <p>On 10/30/2024 record review showed that the facility had nine residents with a current COVID-19 infection in the facility.</p> <p>According to the June 2024 Center for Disease Control Infection Control Guidance: SARS-CoV-2 showed residents exposed to COVID-19 should be maintained in Transmission-Based Precautions for 7 to 10 days depending on the testing strategy of the facility. The publication further states that residents who test positive for COVID-19 should have their room door closed if it is safe to do so.</p> <p>On 10/30/2024 at 8:58 AM Resident 1 was observed to be lying in bed next to the door with their room door wide open. At 9:00 AM Resident 2 was observed to be seated in their wheelchair in front of their TV with their room door wide open. Both residents had Aerosol Precaution signs outside their doors, indicating they had a current COVID-19 infection. The signs indicated that the room doors should be closed.</p> <p>Record review for Residents 1 and 2 did not indicate there were any safety reasons that their room doors could not be closed.</p> <p>On 10/30/2024 at 9:05 AM Staff H, Physical Therapy Assistant, was observed to be in a double occupancy room with a Quarantine Precaution sign outside the door wearing a surgical mask on and no other PPE. The sign outside the door indicated that all staff and visitors should wear an N95 respirator, eye protection, gown and gloves. Staff H was observed to speak with Resident 4 for about five minutes and help them move to the edge of the bed. Resident 4 was not wearing a mask or any kind of PPE. The other side of the room was observed to have the privacy curtain pulled with a gap between the floor and the curtain of about 18 inches, the same gap was observed near the ceiling.</p> <p>During an interview with Staff H on 10/30/2024 at 9:10 AM they stated that Resident 4 was not in Quarantine Precautions but their roommate, Resident 3 was, and they didn't think they had to wear PPE when working with Resident 4.</p> <p>Record review showed that Resident 3's roommate had tested positive for a COVID-19 infection on 10/24/2024. Resident 3's roommate was then moved to another room and Resident 3 was left in the original room. Resident 4 admitted several days later and was placed in the Quarantine room, although they were not in quarantine for COVID-19, but now had been potentially exposed to the virus. Further record review did not reveal a care plan, or any orders related to Quarantine precautions for Resident 3 or 4.</p> <p>(continued on next page)</p> |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During an interview on 10/30/2024 at 9:15 AM, Staff F, Registered Nurse stated that five residents in their section were positive for COVID-19. They stated that they did not have anything on their report sheet indicating if Residents 3 and 4 were in any kind of precautions and stated that there were not orders in the electronic medical record of either resident indicating they were in any kind of precautions. They further stated that residents who had tested positive for a COVID-19 infection should have their door closed to prevent the spread of the virus.</p> <p>During an interview on 10/30/2024 at 10:00 AM, Staff A, Administrator confirmed by phone with Staff I, Corporate Infection Control Nurse, that residents who were in Quarantine Precautions, related to exposure to COVID-19, should have orders in their electronic health record, should have a care plan focus and interventions and staff should be wearing N95 respirator, eye protection, gown and gloves when caring for any resident in the room.</p> <p>During an interview at 12:15 AM with Staff B, Director of Nursing, they stated that residents who test positive for a COVID-19 infection should have their room door closed, if it was safe to do so.</p> <p>Reference: WAC 388-97-1320(2)(b)</p> | | |