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	12/16/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for 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** 45433 Based on interview and record review, the facility failed to protect the residents' right to be free from neglect for 1 of 3 residents (Resident 1) reviewed for neglect. The failure of the facility to address identified concerns for incontinence and personal hygiene resulted in a diminished quality of life and led to Resident 1 being removed, by family, from the facility Against Medical Advice (AMA) (occurs when a person decides to leave a medical facility before the medical team recommends discharge). Findings included . Record review showed Resident 1 had admitted to the facility on [DATE], with diagnoses of Wernicke's Encephalopathy (a neurological disorder caused by thiamine deficiency with mental confusion and unsteady gait), and adult failure to thrive (an individual experiences a substantial decline in overall health and functional abilities). Further review showed Resident 1 was removed from the facility, by family members, AMA, on 11/10/2024. Review of Resident 1's care plan, dated 10/31/2024, and revised on 11/11/2024 (one day after discharge AMA), showed that Resident 1 was independent with toileting and required supervision for personal hygiene. The care plan also showed an intervention to provide incontinence care after each incontinent episode. Further review of Resident 1's medical records did not show progress notes with any indication that any concerns related to resident care were discussed with the Interdisciplinary Team or with the medical provider. Documentation of a bowel evaluation on 11/05/2024 showed Resident 1 was occasionally incontinent of bowel, needed assistance with clean up afterwards and required a toileting schedule. No further documentation of a toileting schedule was found. Documentation of a care conference occuring on 11/06/2024 did not record any family concerns for care or increased need for assistance with toileting. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with a Collateral Contact (CC), on 12/16/2024 at 8:25 AM, they stated that they stayed at the facility, each day, with their family member from 9:00 AM until 3:00 PM. They stated that each day, starting 11/01/2024, they came to the facility they found Resident 1 naked, with just a sheet wrapped around them, they were often wet with urine, there was usually urine on the floor and the bed, the floor was sticky with urine and smelled strongly of urine. They further stated that on two occasions, there were discarded wet incontinence briefs on the floor next to Resident 1's bed. They stated that they brought Staff C, Resident Care Manager, into the room to witness the situation on at least two occasions and called after their visit on at least four occasions to share concerns. The CC further stated they brought Staff D, Social Services Director, into the room to witness the situation on several occasions (more than two but could not remember exact number) including the date they removed their family member from the facility. Both staff indicated to them with each complaint that there would be interventions put in place to remedy the situation. According to the collateral contact, nothing was done and the situation continued to happen, all but one day they were at the facility, until finally they chose to remove their family member from the facility, AMA, because they were worried something bad might happen. The CC further stated that on 11/10/2024 about 10:00 AM, they brought another family member with them and told the nursing staff and Staff D, that they wanted a medication list for Resident 1 and were taking them out of the facility related to the facility neglect of the resident. They reported they were told by the nursing staff and Staff D that the resident would not have home health services, any prescriptions for medications and no other arranged support as they were leaving AMA. Staff C was interviewed on 12/16/2024 at 12:38 PM with Staff D also present for the same interview. Staff C stated that the first time they knew about the family concerns related to possible neglect of Resident 1 was during the first care conference, shortly after admit. They stated that the family concerns included urine on the floor and the resident not being dressed. They further stated that they witnessed, on at least two occasions, urine on the floor of Resident 1's room. They stated that the Resident was confused and would urinate on the floor or try and urinate into the provided urinal but because of their unsteadiness would often bump or knock the urinal onto the floor, spilling urine.They further stated that Resident 1's family would frequently call with the same concerns of the resident being naked, wet with urine, urine on the floor and the strong urine odor instead of just coming to talk with them. Staff C further stated that nursing staff had reported to them that Resident 1 would remove their brief if it was wet and leave it on the floor. Staff C reported that they had verbally shared the family concerns with the facility Director of Nursing, Staff B, on at least one occasion and thought something would happen. They further stated that they had not created any kind of documentation surrounding the family concerns and they did not think it had been discussed in the daily Interdisciplinary Team meeting. Staff D was interviewed on 12/16/2024 at 12:38 PM, with Staff C also present. Staff D stated that they had been made aware of the family concerns during the first care conference, on a date they could not recall, but shortly after Resident 1 admitted . They further stated that they were aware of the family concerns for possible neglect and had spoken with Staff C but had not shared their concerns with the facility Administrator, who was next in their chain of command. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff D further stated that in retrospect there should have been a larger discussion with the Interdisciplinary Team present to determine interventions to help Resident 1. They further stated that they had not created any documentation during the Resident's stay, related to the family concerns, other than reporting the Resident leaving AMA because the family reported [they were] always naked, not dressed and urine everywhere. Staff A, Administrator, was interviewed on 12/16/2024 at 2:02 PM. They stated that they were not aware of the family concerns for Resident 1, and that the concerns had not been discussed in their daily meeting or at any other time with them present. They further stated that they had spoken with Staff B, Director of Nursing, earlier that day and Staff B had stated that the Resident Care Manager, Staff C, had shared the family concerns related to possible neglect on at least one occasion. They further stated that Staff B had been working with Resident 1, as their primary nurse, on 11/10/2024 and that they had asked a nursing assistant at the begining of their shift, around 7:00 AM, to help Resident 1 get cleaned up before the family got to the facility. According to Staff B, another nurse took over the post about 10:00 AM, before the resident left AMA that day, and by that time Resident 1 was again in need of incontinence care and cleanup. Reference (WAC) 388-97-0640(1) Refer to F 609 with date of 12/16/2024. Repeat deficency with date of 06/12/2024.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 45433 Based on interview and record review, the facility failed to ensure allegations of potential neglect were reported immediately to the State Agency as required, for 1 of 3 sampled residents (Resident 1) reviewed for neglect. This failure placed residents at risk for possible neglect. Findings included . Record review showed that on 11/11/2024 at 12:26 PM Staff D, Social Services Director, reported to the required State Survey Agency that Resident 1 had left the facility Against Medical Advice (AMA) because their family claimed that [they were] always naked, not dressed and urine everywhere. In an interview at 12:28 PM on 12/16/2024, Staff D, stated that they had first been made aware of Resident 1's family concerns for neglect on 11/06/2024 during a care conference. They stated that they had not reported the concerns to their Administrator, nor made a report to the required State Agency. In an interview at 12:28 PM on 12/16/2204, Staff C, Resident Care Manager, stated that they had been made aware of concerns for neglect related to Resident 1 on several occasions, including during a care conference on 11/06/2024. They stated that they had shared the concerns with their Director of Nursing, Staff B, but had made no report to the required State Agency. Record review did not show any report for possible neglect having been submitted by the facility related to the care of Resident 1. Reference: (WAC) 388-97-0640 (5)(a) Refer to F 600 with date of 12/16/2024.