

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  02/21/2025
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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45433</b></p> <p>Based on interviews and record review, the facility failed to revise and implement a comprehensive plan of care to included resident specific information for 1 of 3 residents (Resident 1). The failure to establish and implement a care plan that was individualized, accurately reflected assessed care needs related to their ability and need for assistance to eat and provided direction to staff on this topic, placed the resident at risk to receive inappropriate and inadequate care to meet their individualized needs and preferences.</p> <p>Findings included .</p> <p>Review of Resident 1's electronic medical record showed that they admitted to the facility on [DATE] with diagnoses of right sided hemiplegia (almost complete paralysis of one side of body) and hemiparesis (weakness on one side of body) following a stroke, malnutrition and wounds on their left foot.</p> <p>Review of Resident 1's care plan dated 12/06/2024 showed they ate independently (did not need any assistance to eat).</p> <p>Review of progress notes showed that nurses who worked with Resident 1 wrote that the resident had a hard time or was unable to feed themselves while in bed and required assistance. This was noted in progress notes on:</p> <p>12/07/2024 at 4:15 PM needs to be fed.</p> <p>12/08/2024 at 3:32 AM requires assistance with meals .</p> <p>12/08/2024 at 6:16 PM Is fed puree diet .</p> <p>12/12/2024 at 5:27 PM Will feed self when up, wants to be fed when in bed.</p> <p>12/17/2024 at 10:37 PM Wants to be fed pm meal while in bed.</p> <p>12/18/2024 at 9:42 PM Is requesting/requiring to be fed by staff although [they] are quite capable to do this task.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>12/21/2024 at 1:43 PM Resident requires to be fed.</p> <p>12/22/2024 at 9:43 AM Resident requires to be fed.</p> <p>12/23/2024 at 10:31 AM Resident requires to be fed.</p> <p>12/27/2024 at 9:40 PM Wants to be fed when in bed.</p> <p>12/28/2024 at 12:28 PM Requests to be fed while in bed but otherwise is able to feed [themselves] when upright in chair.</p> <p>12/29/2024 at 10:11 AM Requests to be fed while in bed but otherwise is able to feed [themselves] when upright in chair.</p> <p>During an interview with Collateral Contact 1 (CC 1) on 02/21/2025 at 8:04 AM, they stated that when they had visited Resident 1 on several occasions the staff would sit them up in bed and put their food on the bedside table pulled over them and then leave. CC 1 stated that they thought the staff were under the impression Resident 1 could feed themselves when in bed. CC 1 thought the staff was not aware that Resident 1 couldn't raise their left arm high enough and lower their head low enough to get food in their mouth without it causing pain when they ate in bed. CC 1 further related that Resident 1 had severe osteoarthritis (a long-term degenerative condition where parts of the joint and surrounding tissues gradually deteriorate causing pain and stiffness) in their left shoulder and a torn rotator cuff (a rip in the group of four muscles that stabilize the shoulder joint and let you lift and rotate your arm) in their left shoulder which made it painful to raise their left arm and their right arm was paralyzed. They further stated that when the resident was positioned upright in a chair, they could lower their head enough to get food in their mouth without it causing too much pain in their left shoulder.</p> <p>Review of Resident 1's hospital history and physical dated 11/27/2024 at 5:14 PM showed the list of diagnosis included injury of left rotator cuff and Osteoarthritis of left shoulder, severe per MRI (magnetic resonance imaging).</p> <p>Review of Resident 1's facility medical record and care plan did not include the above diagnoses.</p> <p>During an interview on 02/21/2025 at 12:14 PM Staff F, Occupational Therapist, stated that they had written an Occupational Therapy goal for Resident 1 to eat independently after setup shortly after they admitted . They further stated that Resident 1 had told them that they needed full assistance to eat when in bed but were able to eat when seated upright in a chair at a table. Staff F further stated that therapy would verbally tell the Resident Care Manager who worked with the specific resident or write a therapy to nursing communication in the resident electronic medical record progress notes with recommendations for positioning. They thought that in this case the communication was verbal as there were not any progress notes in Resident 1's electronic medical record related to this.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/21/2025 at 12:52 PM Staff C, Resident Care Manager, stated that Occupational Therapy would make recommendations for residents they worked with, and the nursing department would put them on the resident care plan. They further stated that Occupational Therapy had come to them and told them to have Resident 1 get out of bed for at least one meal per day and Staff C was aware Resident 1 ate better seated upright at a table. They stated that it was in Resident 1's care plan to get them up for at least one meal a day. Staff C stated that they were not aware of a diagnosis for Resident 1 of left shoulder osteoarthritis or a left rotator cuff tear.</p> <p>Further review of Resident 1's comprehensive care plan, with all revisions included, did not show direction for the best position for Resident 1 to eat, their need for assistance with eating when in bed or any occupational therapy recommendations.</p> <p>Reference WAC 388-97-1020 (1), (2)(a)(b)</p> <p>Refer to F740 and F791 for additional information.</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45433</p> <p>Based on interview and record review, the facility failed to ensure behavioral health needs were met for 1 of 3 residents (Resident 1) reviewed for behavioral-emotional health. Failure to seek mental health services after the resident was identified in a facility assessment as having symptoms of moderate depression, failure to seek mental health services in a timely manner after the medical provider ordered mental health services to occur, failure to identify behavioral health needs and utilize person-centered interventions developed by an interdisciplinary team (IDT). This failure placed at risk for potential skin injury and decreased quality of life.</p> <p>Findings included .</p> <p>Review of Resident 1's electronic medical record showed that they admitted to the facility on [DATE] with diagnoses of right sided hemiplegia (almost complete paralysis of one side of body) and hemiparesis (weakness on one side of body) following a stroke, mild dementia, anxiety, malnutrition and infected wounds in the bone (osteomyelitis) of their left foot.</p> <p>Review of assessments completed for Resident 1 showed that on 12/09/2025 a depression screen was completed (PHQ-9) by Staff M, Social Services Assistant, with a score of 17, indicating the resident had moderately severe depression symptoms. Further review showed an assessment for cognition (BIMS) on the same day with a score of 13, indicating the resident's cognition was intact.</p> <p>Further review of assessments completed for Resident 1 showed that on 12/06/2024 Staff F, Occupational Therapist, completed a more thorough cognition assessment (SLUMS) which indicated the resident had a mild neurocognitive disorder (mild dementia). The same assessment was completed after the resident was noted to have refusals of care and participation with therapy on 01/13/2025 with a score that indicated dementia, a decline in cognition from the previous assessment.</p> <p>Review of an admit skin assessment dated [DATE] showed the following wounds:</p> <ol style="list-style-type: none"> <li>1) Dry, scabbed areas to both inner/upper buttock cheeks.</li> <li>2) Open area on the left heel.</li> <li>3) Scabbed over (eschar) wound to left 2nd toe.</li> </ol> <p>Review of nursing progress notes from admit 12/05/2024 through 12/11/2024 indicated Resident 1 had some preferences for care but no concerns for refusals of care were noted. Further review of nursing progress notes showed that on:</p> <p>12/16/2024 at 10:30 AM, Staff N, Licensed Practical Nurse, wrote Resident 1 refuses meds intermittently.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>12/16/2024 at 10:39 PM, Staff K, Registered Nurse, wrote, refused to take cipro (antibiotic prescribed to treat bone infection in left foot) and hydralazine (medication to control blood pressure) at bedtime.</p> <p>12/17/2024 at 10:37 pm, Staff K, wrote, .does not have a good understanding about the need to take [their] antibiotic. Often refuses meds.</p> <p>12/18/2024 at 9:42 PM, Staff O, Registered Nurse, wrote, .refusing [their] antibiotics on pm shift states [they] can tolerate on days but can't on evenings. They further wrote that the resident was argumentative, it has become a behavior [they are] doing regarding everything staff does for [them] and with [them].</p> <p>12/21/2024 at 1:43 PM, Staff P, Licensed Practical Nurse, wrote, .repositioned as much as [they] will allow.</p> <p>12/22/2024 at 9:43 AM, Staff P, wrote, Resident is non-compliant with repositioning at times.</p> <p>12/23/2024 at 10:31 AM, Staff P, wrote, .repositioned as much as [they] will allow.</p> <p>12/27/2024 at 9:40 PM, Staff K, wrote, Will refuse meds at times.</p> <p>12/28/2024 at 11:53 PM, Staff Q, Registered Nurse, wrote, Writer called to [patient's] room by aide due to [patient] requesting to not be repositioned. [Patient] was educated on the importance of repositioning and [patient] verbalized understanding and refused to be turned at the moment and requested we do not come back in to try to reposition for the rest of the night .</p> <p>12/29/2024 at 05:56 AM, Staff Q, wrote .did continue to refuse being repositioned.</p> <p>12/29/2024 at 12:01 PM, Staff C, Resident Care Manager, wrote, becomes very theatrical, waves left arm in air, becomes argumentative [and] irrational, is not receptive to instructions or directions.</p> <p>12/29/2024 at 1:00 PM, Staff C, wrote, Assistance aborted as [they] are non-compliant and argumentative.</p> <p>12/29/2024 at 3:38 PM, Staff C, wrote that the residents family came to visit and was concerned about the resident's orientation and behaviors and requested they be sent to the hospital for evaluation.</p> <p>12/30/2024 at 12:20 PM, Staff P, wrote that the resident had been evaluated at the hospital, was diagnosed with a urinary tract infection.</p> <p>12/30/2024 at 2:10 AM, Staff P wrote that the resident was refusing care and refusing to turn on their side to take pressure off the wounds on their bottom and foot. Staff P wrote that Resident 1 stated, I can't do anything for myself, and I can't eat anymore.</p> <p>12/31/2024 at 10:39 AM, Staff R, Licensed Practical Nurse, wrote, .resident refused all medications .resident non-compliant with [Physical Therapy].</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>12/31/2024 at 10:14 PM, Staff K, wrote, Resident very angry today, refusing cares .some bleeding noted on [right buttock].</p> <p>01/04/2025 at 10:44 PM, Staff K, wrote, 'Has not been eating well of meals today. Will not attempt to feed [themselves], refuses when staff tried to assist [them].</p> <p>01/05/2025 at 10:02 AM, Staff P, wrote, Resident refused to eat breakfast then pushed [their] tray of food and drinks onto the floor .[they] are non-cooperative with staff and refuses to let the staff help [them].</p> <p>01/07/2025 at 10:32 AM, Staff R, wrote, resident refused breakfast and verbalized ['I'm] too disabled to eat encouraged attempt x3.</p> <p>01/08/2025 at 1:03 PM, Staff R, wrote, resident refuses to consume and drink food on my shift today, attempt x3 .</p> <p>01/08/2025 at 10:32 PM, Staff K, wrote, Has refused all medications this shift, refusing to eat .family members present part of evening, aware of [their] behaviors, refusals.</p> <p>01/09/2025 at 10:22 AM, Staff R, wrote, resident refuses to eat, attempt x3 .</p> <p>01/10/2025 at 10:22 AM, Staff R, wrote, resident refuses to eat, attempt x3 .</p> <p>01/11/2025 at 9:38 AM, Staff C, wrote, Caregiver and this writer attempted to feed resident, and [they] would turn [their] head away and state, not now. Then ask for a bite or drink, and when selection was offered to [them], [they] again would turn [their] head away and state, not now.</p> <p>01/12/2025 at 9:26 PM, Staff C, wrote, When in bed resident is encouraged to allow repositioning every [two] hours but [they] have been non-compliant with this .Coccyx (tailbone area) is abraded and sore and wound team will evaluate .Eating/fluid intake is poor and resident states [they] do not have an appetite.</p> <p>01/12/2025 at 9:39 PM, Staff C, wrote, Coccyx with large area of excoriation [related to] non-compliance with position changes.</p> <p>01/15/2025 at 5:32 PM, Staff K, wrote, 'Has been refusing to eat, may take 1-2 bites only .</p> <p>01/16/2025 at 10:33 AM, Staff R, wrote, .resident refused to eat breakfast attempt x3 .</p> <p>01/16/2025 at 10:13 PM, Staff K, wrote, .has new area of concern on [their] right heel.</p> <p>Review of Resident 1's medication administration record (MAR) for December 2024 showed that they refused antibiotic medications prescribed to treat their left foot bone infection on 10 of 46 administrations. The same MAR also showed refusals to be repositioned 11 of 80 shifts.</p> <p>Review of Resident 1's January 2025 MAR showed all antibiotics to treat the urinary tract infection (can cause confusion in elderly) were administered, with end date of 01/06/2025.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's physician orders showed on 12/04/2024 an order written, may have psych consult and treatment as needed. On 01/06/2025, Staff I, Advanced Registered Nurse Practitioner (ARNP), wrote an order for Behavioral Health Consult for behaviors; trying to fall out of bed; refusing meals; combative with staff; pulling on [foley catheter]; refusing care one time only for Behavioral disturbances.</p> <p>Review of Medical Provider notes showed that on 12/24/2024, Staff H, ARNP wrote that Resident 1 was refusing medications, had been advised of the need to continue the prescribed medications with risks of not taking the medications being increased blood pressure, stroke, death. It was noted that the resident told the ARNP that [they] don't need anything. The resident was noted to sign a resident choice of medication, treatment, and/or dietary restriction form on 12/25/2024 related to refusal to take one blood pressure medication which was then discontinued.</p> <p>Further review of medical provider notes showed that on 01/06/2025, Staff I, ARNP wrote, behavioral health evaluation ordered due to ongoing staff concerns with patient's labile (unpredictable, uncontrollable and rapid shifts in emotion) behaviors.</p> <p>Further review of medical provider notes showed that on 01/09/2025, Staff I, wrote, Inadequate [by mouth] intake with subsequent 12-pound weight loss since admit. Staff I further wrote, Poor insight and significantly impaired judgement with presence of delusional thinking. Staff I further wrote, Monitor closely for any mood/behavioral changes that may increase patient's risk for unintentional or intentional self-injury.</p> <p>Review of wound care notes from 12/26/2024, 01/02/2025, 01/09/2025 and 01/16/2025 , all written by Staff E, Wound Care Physician Assistant, showed that the resident's heel wound had started to improve but then stalled related to poor food intake and refusals of care, they further noted that the wound on Resident 1's left 2nd toe had declined significantly to the point where there was bone and tendon exposed. They further wrote that on 01/16/2025 they evaluated a new pressure sore on Resident 1's right heel, Patient's left heel is stalled. Left second toe joint and bone exposed. Increase in maceration to the peri (edge) wound. Patient has a high probability of osteomyelitis (bone infection), [they] now [have] a new wound to [their] right heel has a fluid filled blister that is open and unstable .I think it is a good time to discuss with family how they would like to proceed with care.</p> <p>Review of recorded weights for Resident 1 showed that there was a steady decline, with the Dietician and nursing staff aware of the weight loss and adding supplements and a medication to possibly increase appetite on 01/09/2025. Review of weights showed admit weight of 135.8 pounds, low of 120 pounds on 01/10/2025, which rebounded to 127 pounds on 01/30/2025.</p> <p>Review of Resident 1's care plan, dated 12/06/2024, showed the resident ate independently, on 12/23/2024 a focus was added that Resident 1 was resistive to care (with refusals to take medications, eat meals and leave boots on feet to protect their wounds) without personalized interventions to address the resistance. On 01/08/2025 a new focus was added for Resident 1 for experiencing hallucinations, delusions, and/or paranoia that was related to their urinary tract infection (per January MAR a full course of antibiotics was completed on 01/06/2025 and no further treatment or signs or symptoms of a urinary tract infection were mentioned after this), no focus or interventions were present related to the resident's behavior issues, diagnosis of mild dementia, positive depression screen or order for a mental health evaluation (ARNP order on 01/06/2025).</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the resident's Power of Attorney on 02/21/2025 at 8:04 AM, they stated that they were concerned because of Resident 1's dramatic decline physically and mentally. They stated that Resident 1 had a history of anxiety and very mild dementia, but had never had symptoms of depression and had never refused to eat. They stated at the end of the interview that their main concern during Resident 1's stay was their mental decline, [they] seemed to get so much worse. They further stated that their concerns for the resident's decline had led them and other family members to request the resident be sent to the local hospital on 01/30/2025 and that the resident was still there and did not plan to return to the facility.</p> <p>During an interview with Staff D, Social Services Director, with Staff A, Administrator present, on 02/21/2025 at 12:25 PM, Staff D stated that they did not administer the depression screen for Resident 1, that their assistant, Staff M had completed the assessment. They further stated that when a resident had a score on the assessment indicating they had symptoms of depression the facility process was to ask the resident or their family if they would like behavioral health services. They stated that this would be documented in the resident's electronic health record. They further stated that they had not had this conversation with the resident or their family and if it had occurred it would be documented in a note in the resident's electronic health record.</p> <p>During the same interview Staff D stated that they were not aware of the order on 01/06/2025 for a behavioral health evaluation for Resident 1 and that the provider should tell them or the facility Administrator if such an order was placed. Both the Administrator and Staff D indicated that they had not been notified of the order or the need for Resident 1 to have a behavioral health evaluation.</p> <p>During an interview on 02/21/2025 at 12:52 PM, Staff C, stated that they were not aware of the order for the behavioral health evaluation written on 01/06/2025. They further stated that Resident 1's refusals to eat, take medication, reposition in bed and accept other care seemed to be behavioral.</p> <p>During an interview with Staff A, Administrator on 02/21/2025 at 1:34 PM they stated that they were not aware of the need for Resident 1 to have a behavioral health evaluation, that they had not been notified of the medical provider order and that the behavioral health assessment had not occurred, nor had the referral to behavioral health occurred after the positive depression screen on 12/09/2024.</p> <p>Reference (WAC) 388-97-0960(1)</p> <p>See SOD for 656 and 791.</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45433</b></p> <p>Based on interview and record review, the facility failed to follow-up on necessary dental services for 1 of 3 residents (Resident 1). Failure to follow-up on a referral to a dentist for ill-fitting dentures, that had caused an open sore, placed the resident at increased risk for continued dental problems, difficulty chewing, associated health complications, and diminished quality of life.</p> <p>Findings included .</p> <p>Resident 1 admitted to the facility on [DATE], with diagnoses including right sided weakness and paralysis after a stroke, severe malnutrition, dysphagia (difficulty swallowing) and chronic ulcers of their left foot and heel.</p> <p>Record review showed on 12/08/2024 at 6:16 PM, Staff K, Registered Nurse wrote in a progress note, c/o (complaint of) mouth pain, refuses to take upper denture out.</p> <p>Record review showed on 12/09/2024 10:49 AM Staff L, Transportation Assistant, wrote in a progress note that the first available dental appointment had been made for Resident 1 on 12/13/2024.</p> <p>Record review showed on 12/13/2024 at 8:34 AM Staff L wrote in a progress note that Resident 1's dental appointment was canceled by the dental provider and was re-scheduled for 12/17/2024.</p> <p>Record review showed on 12/17/2024 a dental exam was completed by Staff J, Dentist. They noted the resident reported pain and swelling under their upper denture for more than four weeks. The dentist noted an open sore present at the area where the upper denture fits against the back of the jaw and meets the cheek (buccal vestibule around site #6) and noted that the resident needed their upper denture adjusted.</p> <p>Record review showed on 12/18/2024 at 1:44 PM, Staff C, Resident Care Manager wrote in a progress note that Resident 1 needs to see a Denturist to adjust [their] dentures.</p> <p>No further documentation was found related to the denture adjustment or the mouth sore.</p> <p>In an interview with Staff C on 02/21/2025 at 12:52 PM they stated that they had put in for a dentist appointment and transportation but that they could see from reviewing progress notes that Staff L had not followed up on the request. They further stated that there was no documentation of staff having monitored the sore in the resident's mouth caused by the poorly fitted denture. Staff C stated that Resident 1 had discharged to the hospital from the facility on 01/30/2025.</p> <p>In an interview with Staff B, Director of Nursing, on 02/21/2025 at 1:18 PM they stated that Staff C had requested an appointment be made for Resident 1 but that they could not see any indication that [Staff L] followed up.</p> <p>In an interview with Staff A, Administrator, on 02/21/2025 at 1:34 PM, they stated that the denture appointment for Resident 1 was not followed up on and that Staff L was no longer employed at the facility.</p> <p>(continued on next page)</p>		

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  02/21/2025
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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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Refer to WAC 388-97-1060(1)(3)(j)(vii)</p>		