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	03/10/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 45433 Based on interview, and record review the facility failed to provide the necessary care and services to ensure that a dependent resident received assistance with toileting for 1 of 3 residents (Resident 1). This failure placed the resident at increased risk for skin breakdown and unmet care needs. Findings included . Review of Resident 1's care plan, dated 01/13/2025, showed that they were cognitively intact, required extensive assistance to use the bathroom and had episodes of incontinence with interventions to include provide pericare (hygiene of the private parts following toileting) after each incontinence episode. Record review of a facility investigation showed that on 02/28/2025 at 6:00 AM Staff C, Licensed Practical Nurse, had gone in to provide care to Resident 1 and had found them lying in .urine soaked bed and clothing with the transfer sheet from [emergency room] still under [resident]. Further record review found that Resident 1 had gone to the emergency room , for a wound evaluation, and had returned to the facility at 6:00 PM on 02/27/2025. At that time the resident was transferred back into bed with the transfer sheet (a single use durable paper device placed under a person and used to assist with turning, moving and repositioning) left under them. Further record review of the facility investigation showed that Staff E, Nursing Assistant, reported that on the night shift (10:00 PM to 6:00 AM) from 02/27/2025 through 02/28/2025, Resident 1 did not use their call light to request assistance and so they did not provide any care to the resident. Record review of the same investigation did not show follow up or interview with Staff D, Licensed Practical Nurse, who was also assigned to work with the resident. Review of Staff D's medication administration record (MAR) documentation for Resident 1 showed 9 entered in the boxes for medications or monitoring to be completed for Resident 1 on that shift. (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 03/10/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/10/2025 at 1:20 PM, Resident 1 stated that they remembered the incident. They further stated that they would use their call light to request assistance if they wanted help, but that generally a nursing assistant would come in before midnight and then again in the early morning to help them change their incontinence brief. They stated that they preferred not to be bothered through the night as they could use the call light if they needed help. They stated that on this occasion they were put into bed about dinner time and fell asleep after dinner and didn't remember anyone coming into the room until morning, when the day shift nurse and another person helped them change all of their bedding and gown because it was all wet. They further stated that this was more of an inconvenience than anything else and that they did prefer to have assistance so that a full bed change did not need to occur early in the morning when they would rather be asleep. During an interview on 03/10/2025 at 1:34 PM, Staff C, Licensed Practical Nurse, stated that they had gone into Resident 1's room at the beginning of their shift on 02/28/2025 and found them soaked in urine and that the resident was not happy because they required a full bedding change, a new gown, and had to be cleaned up. They stated that it was the licensed nurse on duty who was responsible to make sure a resident was kept clean and as dry as possible during their shift and that they oversaw the care a nursing assistant provided. During an interview on 03/10/2025 at 1:45 PM, Staff A, Director of Nursing, stated that Staff E had their employment terminated after this incident. They stated that it was the expectation that resident's be checked every two hours during the night to make sure they were dry and were not in need of care. They further stated that it was the responsibility of the night shift nurse assigned to the resident to make sure all activities of daily living (ADL's) required had been completed by the assigned nursing assistant. They stated that Staff D had not worked at the facility since this incident and had not been spoken to or educated. They further stated that the code 9 Staff D had entered on Resident 1's MAR meant spit out. During an interview with Staff B, Risk Management Nurse, they stated that they had completed much of the investigation into the incident with Resident 1. They stated that it was the responsibility of the floor nurse to monitor that nursing assistants were completing their assigned ADL tasks. They stated that they would follow-up with the nurse, as well as the nursing assistant, moving forward when ADL tasks were not completed. Reference WAC 388-97-1060 (2)(c)