

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  04/01/2026
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation and interview, the facility failed to maintain a clean and sanitary environment for 3 of 4 residents (Resident 2, 3 and 4). This failure placed residents at risk of lack of dignity, unmet care needs, and diminished quality of life. Findings included. &lt;Resident 2&gt;Review of Resident 2's electronic medical record on 04/01/2026, showed they admitted to the facility on [DATE] after they suffered a fracture of their right upper leg. Other diagnoses included a developmental disability with disorders of speech and language. During an interview on 04/01/2026 at 10:42 AM, with Collateral Contact 1 (CC1), who had provided support for Resident 2 during their stay in the facility, they stated they had been in the facility almost daily to provide support to Resident 2 as they were nonverbal. They further stated that each day they had been there, Resident 2's floors had been sticky and dirty. They stated they had pointed this out to nursing staff but had seen little improve. During an observation on 04/01/2026 at 1:03 PM, the floor was sticky, had black scuff marks in various locations, had some sticky clear red liquid spilled in droplets on the floor and some small pieces of paper towel, hair and dust scattered about the room. &lt;Resident 3&gt;Review of Resident 3's electronic medical record on 03/10/2026, showed they were admitted to the facility on [DATE]. Further review of the same record showed the resident was cognitively intact. During an interview on 04/01/2026 at 1:25 PM, Resident 3 stated that their bathroom floor was often dirty with dried urine and dirt. They stated the floor in their room had a hole in it that had been repaired with duct tape that was starting to peel away and they felt it was becoming a tripping hazard. During an observation on 04/01/2026 at 1:25 PM, the Resident's bathroom, shared with the room next door, was visualized with a bariatric commode (a chair for larger individuals that covers the toilet to allow for stability and ease of self-transfer on and off the toilet ) covering the toilet and almost touching the walls of the bathroom on each side. Under the commode, at the base of the toilet and under the toilet dried yellow urine stained with dirt, hair and other debris was observed from wall to wall. A strong foul odor was also present. Duct tape, approximately 3 by 6 inches, was observed in the middle of the floor with peeling edges and dirt adhered to it. Scuff marks and general small debris were also visualized throughout the floor in the room. The smell from the bathroom was also present in the resident's room. &lt;Resident 4&gt;Review of Resident 4's electronic medical record on 04/01/2026, showed they were admitted to the facility on [DATE]. Further review of the same record showed the resident was cognitively intact. During an interview on 04/01/2026 at 1:10 PM, Resident 4 stated that they shared a bathroom with the room next door and it was often dirty with dried urine and smelled bad. They further stated the floor in their room was cracked and was often dirty. During an observation on 04/01/2026 at 1:10 PM, the Resident's bathroom, shared with the room next door, was visualized with a bariatric commode covering the toilet and almost touching the walls of the bathroom on each side. Under the commode, at the base of the toilet and under the toilet dried yellow urine stained with dirt, hair and other debris was observed from wall to wall. A strong foul odor was also present. Further observation of the resident's room showed cracked flooring, with the visible cracks embedded with dirt, scuff marks and general small debris were also visualized throughout the floor in the room. The smell from the bathroom was also present in the resident's (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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>room. During an interview with Staff C and Staff D, Nursing Assistants, on 04/01/2026 at 12:15 PM they stated the housekeeping supervisor had been sick and there seemed to be a language barrier with some of the housekeeping staff. They stated they thought there was a misunderstanding and housekeeping thought the nursing staff should be cleaning up urine spills in the bathrooms. During an Interview with Staff A, Administrator, on 04/01/2026 at 2:30 PM, they stated that their expectation was that resident bathrooms and rooms would be cleaned, at least daily, or as needed to maintain a sanitary environment. Reference WAC 388-97-0880</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record review the facility failed to ensure pharmacy services were provided to meet the needs of 1 of 3 residents (Resident 1). The failure to ensure medications were acquired and administered as ordered placed residents at risk for adverse events related to missed medications. Findings included . &lt;Resident 1&gt;Review of Resident 1's electronic medical record, on 03/11/2026, showed they admitted to the facility on [DATE] and had diagnoses of surgical repair of a fracture in their mid-spine, ankylosing spondylitis (chronic, inflammatory, autoimmune disease that causes arthritis in the spine) and chronic respiratory failure (a prolonged, often progressive inability of the respiratory system to maintain proper gas exchange). The same record showed Resident 1 was cognitively intact. In a telephone interview, on 03/26/2026 at 10:15 AM, Resident 1 stated their medical provider ordered medications were not available for several days after they admitted on [DATE]. Review of Resident 1's Medication Administration Record (MAR) for February 2026 showed the following missed medications: Enoxaparin (an anticoagulant used to prevent blood clots after surgery) -missed 02/08/2026 and 02/09/2026 at 7:00 PM. Mirtazapine (an antidepressant medication) -missed 02/08/2026 at 7:00 PM. Cyclobenzaprine (a muscle relaxer used to prevent muscle spasms) -missed 02/08/2026 at 7:00 PM and 02/09/2026 at 6:00 AM. Pregabalin (a medication used to treat pain) -missed 02/08/2026 at 7:00 PM and 02/09/2026 at 7:00 AM. Sildenafil (a medication used to treat high blood pressure) -missed 02/08/2026 at 3:00 PM and 11:00 PM, 02/09/2026 at 7:00 AM. Butrans patch (a patch used to help with pain control) -missed 02/20/2026 at 12:00 PM. In an interview on 04/01/2026 at 1:45 PM, Staff B, Director of Nursing, stated the facility had a new pharmacy, their services had been good, and they were not sure why Resident 1 had missed medications when they first admitted . They further stated the expectation was that resident specific medications, ordered by a medical provider, should be available to be administered the same day a resident admits to the facility. Reference: (WAC) 388-97-1300 (1)(a)(b)(i)(ii)</p>