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	05/27/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure swallow interventions were developed and implemented for 1 of 3 residents (Resident 1). This failure placed residents at risk for inconsistent implementation of care and services from staff, poor oral intake, poor nutrition and potential harm.Findings included . Review of the facility census showed Resident 1's first admitted to the facility, from a local hospital, on 04/02/2026. Further review showed they were re-admitted to the same hospital on [DATE] and returned to the facility on [DATE] with new orders, dated 04/19/2026 at 4:34 PM, for aspiration precautions (measures taken to prevent inhalation of food, liquids, or other substances into the airway, which can lead to choking or aspiration pneumonia. Aspiration occurs when these substances enter the airway instead of the esophagus, potentially causing serious respiratory issues). Under the discharge instructions was written, establish care with gastroenterology, recommend esophageal manometry (a diagnostic procedure that measures how well the esophagus is functioning) to further work up dysphagia (difficulty swallowing, which can range from mild discomfort to an inability to swallow food or liquids).Record review of a facility medical provider note, written by Staff C, Nurse Practitioner, on 04/24/2026, showed the resident required dysphagia precautions, with dysphagia management (severe esophageal dysmotility (impairment of the esophagus's ability to move food and liquid from the mouth to the stomach through coordinated muscular contractions), aspiration risk). In the same note Staff C wrote under the diagnosis of disease of esophagus, unspecified, that the resident had experienced dysphagia for 1.5 months and on 04/19/2026 an esophagram (a live-action X-ray used to evaluate the function and structure of the esophagus) showed severe dysmotility with symptomatic retention of barium tablet (a contrast used in medical imaging to help visualize the esophagus and stomach) suggesting stenosis (narrowing). Staff C went on to write that the resident required aspiration precautions and must be upright for all oral intake.Record review of Resident 1's order summary for 04/01/2026 through 05/31/2026, did not show any orders related to aspiration, swallowing or dysphagia precautions.Record review of Resident 1's care plan, dated 04/02/2026, with updates on 04/22/2026, did not show any focus or interventions related to swallowing difficulty, dysphagia or aspiration precautions.Further review of Resident 1's facility medical record, on 05/27/2026 at 10:32 AM, showed diagnoses of chronic respiratory failure (long-term condition where the lungs cannot maintain adequate oxygen levels or remove enough carbon dioxide from the lungs), disease of esophagus, unspecified (a problem with the tube that connects the throat to the stomach), and mild cognitive impairment (manifests through memory loss, difficulty concentrating and changes in behavior).In an observation and interview on 05/27/2026 at 12:40 PM, Resident 1 was observed lying in bed with the head of their bed at about 45 degrees. Their partially finished lunch tray was on the bedside table next to them and their family member, Collateral Contact 1 (CC1), was in the room with them. Resident 1 stated during this interview they had experienced increasing difficulty swallowing, had gone to the hospital after they had first admitted to the facility, and had returned on swallow precautions. They further stated not all the facility staff seemed to be aware of these precautions. They stated they had to take small bites and could only take 1-2 pills at a time. Resident 1 stated if they failed to do this, they would feel the (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	food/pills stuck in their throat, it would cause discomfort and then whatever they had swallowed would come back up into their throat and mouth.During the same interview, on 05/27/2026 at 12:40 PM, CC1 stated Resident 1 had been having increasing trouble swallowing and had gone to the hospital on [DATE]. They stated during that stay the resident had been on aspiration precautions which included: not having the head of the bed flat, sitting all the way upright for all food and liquids, taking small bites and chewing thoroughly, having foods cut up into bite size pieces and staff being present when the resident swallowed their pills as this was especially difficult for Resident 1. They further stated they had told the medical providers that staff did not seem to know about the swallow precautions on at least two occasions and nothing had changed. During an interview on 05/27/2026 at 1:27 PM, Staff D, Registered Nurse, stated they had worked with Resident 1 during their stay at the facility and were aware the resident had swallowing difficulty and had to be upright when they ate or took pills. Staff D stated they knew this because Resident 1 was very aware and the Resident and their family members had told them. Upon review of Resident 1's orders, Staff D reported they could not find any orders for aspiration/swallow precautions and there should be orders in place. They further stated a resident with swallow difficulties could potentially swallow food or fluid into their airway if they were not sitting upright when they ate and drank and this could cause an emergency situation. During an interview with Staff B, Director of Nursing, on 05/27/2026 at 1:50 PM, they reviewed Resident 1's medical chart and stated the resident had readmitted with the need for aspiration precautions. Staff B stated they did not see orders, any care plan focus or interventions or a corresponding diagnosis. Staff B further stated a resident on aspiration precautions would typically have orders to include sitting upright for all food/fluid/pill intake, along with any other resident specific orders. Staff B stated the failure to do this could cause the resident to swallow fluid/food into their airway and potentially cause aspiration pneumonia (a lung infection that occurs when food, fluid or vomit is inhaled into the lungs).During an interview with Staff A, Administrator, on 05/27/2026 at 2:00 PM, they stated the regular staff who entered diagnoses and associated care plan updates had been on leave during the time period Resident 1 was admitted and then re-admitted and there had been another staff filling in for them. Reference WAC 388-97-1060 (3)(h)