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	06/27/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42802 45117 Based on observation, interview and record review, the facility failed to ensure a dignified dining experience for 4 of 6 sampled residents (Resident 1, 6, 9, 45) reviewed for dining. The failure to provide clothing protectors per the residents' preferences during meal service placed the residents at risk for embarrassment, humiliation, and an undignified dining experience. Findings included . Review of the facility policy titled, Resident Rights, dated 08/2022, showed each resident would be treated with respect and dignity, and care for each resident would be provided in a manner and in an environment that promoted maintenance or enhancement of their self-esteem and self-worth. <Resident 1> Review of the medical record documented Resident 1 was admitted to the facility on [DATE] with diagnoses including rheumatoid arthritis (a chronic inflammatory disorder usually affecting small joints in the hands and feet), fibromyalgia (a long-term condition that involves widespread body pain and fatigue), and depression. The 06/14/2024 comprehensive assessment showed Resident 1 was cognitively intact and required no assistance with eating. During an interview on 06/26/2024 at 10:20 AM, Resident 1 stated Staff A, Executive Director (ED), took away all of the clothing protectors for the residents and there was no dignity in the dining experience. Resident 1 stated the clothing protectors were brand new as of a few weeks ago but the staff were using bath towels to protect the residents clothing instead of the clothing protectors. Resident 1 stated no one spoke to the residents about removing the clothing protectors. <Resident 6> Review of the medical record documented Resident 6 was admitted to the facility on [DATE] with diagnoses including hemiparesis (weakness or the inability to move on one side of the body), contracture (a shortening and stiffening of a joint that prevents normal movement) of the left hand and anxiety. The 06/14/2024 comprehensive assessment showed Resident 6 was cognitively intact and required setup/clean-up assistance of one staff member for eating. (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 06/27/2024

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A concurrent observation and interview on 06/27/2024 at 8:45 AM, showed Resident 6 sitting in a chair at a table in the main dining room, with food spilled on their shirt and pants. Resident 6 stated the facility discontinued servicing the clothing protectors .no one had asked me about not having one and now I have spots on my clothes. There was a dime sized stain on the front of their shirt. Resident 6 stated I make messes for sure, and I know with the shirt protector, I could look forward to keeping away from making messes. They stated the clothing protectors used to be stored in the cabinet in the dining room, but they weren't there anymore. Resident 6 stated they had an old shirt that they wore over their good shirts to keep them clean. Resident 6 stated I think people would be happier with clean clothes; I know I would be. <Resident 9> Review of the medical record documented Resident 9 was readmitted to the facility on [DATE] with diagnoses including Parkinsonism (a movement disorder that can occur as a side effect of certain types of medication), chronic pain, and anxiety. The 04/09/2024 comprehensive assessment showed Resident 9 was cognitively intact and required setup/clean-up assistance of one staff member for eating. During a concurrent observation and interview on 06/27/2024 at 8:20 AM, showed Resident 9 in bed in a hospital gown, their breakfast tray on the bed table, and food spilled on their chest and abdomen. Resident 9 stated they used to have clothing protectors for spills but did not know what happened to them. They stated they had not had one for several weeks. Resident 9 stated they liked having the clothing protectors, it kept their clothes clean, and now they have stains on their clothing from not having one. Resident 9 stated they had asked Staff A if they could have a clothing protector but was told the clothing protectors did not go along with the nice dining area. Resident 9 stated they liked to eat soup, but I spill it on my clothing now and have to wait for staff to change me. <Resident 45> Review of the medical record documented Resident 45 was admitted to the facility on [DATE] with diagnoses including dyskinesia (uncontrollable movements caused by prolonged use of certain medications), gastro-esophageal reflux disease (GERD, a condition in which the stomach contents move up into the esophagus), and depression. The 3/18/2024 comprehensive assessment showed Resident 45 was cognitively intact and required setup/clean-up assistance of one staff member for eating. During an observation on 06/27/2024 at 9:09 AM, Resident 45 was at the South nurse's station. Resident 45 was wearing a purple zip up sweatshirt that had food debris and stains on the right side of the sweatshirt. Resident 45 stated, that is my breakfast on my shirt. During an interview on 06/27/2024 at 8:43 AM, Staff Q, Nursing Assistant, stated Staff A had gone into the dining room a few weeks ago and took all of the clothing protectors. They stated the residents preferred to have them. Staff Q stated they gave the residents a little red cloth napkin or towel if they wanted a clothing protector because that was all that was available. During an interview on 06/27/2024 at 9:15 AM, Staff S, Licensed Practical Nurse/Resident Care Manager, stated the residents used to have clothing protectors but they were told it was a dignity issue and they were removed. Staff S stated, I think they need the clothing protectors. People have nice clothes, and they are getting messed up. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/26/2024 at 2:23 PM, Staff A stated they did not have clothing protectors in the dining room because it was a dignity issue. Staff A stated they were transitioning to a fine dining experience that included using cloth napkins. During a follow up interview on 06/27/2024 at 9:20 AM, Staff A stated they informed the residents that they would no longer use the clothing protectors when they were in the dining room. Staff A stated, the way I presented it - it was not perceived that they could continue to have them. Reference: WAC 388-97-0180(1-4)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42802 Based on interview and record review, the facility failed to obtain consent for psychotropic medications prior to administration of the first dose, as required, for 3 of 5 sampled residents (Resident 19, 21, 333) reviewed for unnecessary medications. This failure placed the resident and representative at risk of not being fully informed of the risks and benefits of medications and making a fully informed choice about their medical care. Findings included . <Resident 21> According to a quarterly assessment dated [DATE], Resident 21 had moderate cognitive impairment and diagnoses which included diabetes, brain dysfunction and depression. A current physician order for daily Seroquel (an antidepressant) was written on 06/13/2024. A review of Resident 21's May 2024 Medication Administration Record (MAR) showed that the resident had been on Seroquel previously and it had been discontinued on 05/08/2024, and then was resumed on 06/13/2024. No consent was completed prior to the Seroquel being restarted on 06/13/2024. <Resident 19> According to a quarterly assessment dated [DATE], Resident 19 was alert, able to make their needs known and had diagnoses which included diabetes, anxiety and bipolar depression. A physician order for Effexor XR (an extended-release antidepressant) was written and started on 10/06/2024 and the dose increased 1 week later. Resident 19's EMR documented a consent for Effexor was completed on 10/25/2024, nineteen days after the first dose was administered. During an interview on 06/27/2024 at 8:45 AM, Staff X, Licensed Practical Nurse (LPN) stated that medication consents must be done before the first dose was given and when the dose changed. They further stated that even if the resident was on the medication in the past, they must have another consent done before the medication was restarted. During an interview on 07/27/2024 at 9:59 AM, Staff S, LPN, Resident Care Manager (RCM) stated that antidepressants required a consent before the medication was started or restarted. <Resident 333> (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 06/21/2024 admission assessment documented Resident 333 had diagnoses including traumatic brain injury and depression and received psychotropic medications daily. Resident 333 was severely cognitively impaired. A review of the Order Summary Report documented on 06/14/2024, Resident 333 was prescribed psychotropic medication (Effexor and Seroquel) to treat depression. Review of the June 2024 MAR documented Resident 333 received the first dose of Seroquel and Effexor on 06/14/2024. The consent for Seroquel was signed on 06/17/2024, three days after the medication was started. There was no consent for the Effexor. In an interview on 06/25/2024 at 11:09 AM, Staff T, Registered Nurse, stated consents for psychotropic medications were to be obtained when the medication was ordered. In an interview on 06/25/2024 at 11:14 AM, Staff B, Director of Nursing, stated the psychotropic informed consent should have been signed prior to the first dose and Staff B verified there was no consent for the Effexor and there should have been. Reference: WAC 388-97-0260 46115

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to provide a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN, a notification that provides an estimated cost of continuing services which may no longer be covered by Medicare Part A.) for 2 of 3 sampled residents (46, 62) reviewed for beneficiary notice requirements. This failure placed the residents at risk for the inability to make informed financial and care decisions related to their continued stay. Findings included . <Resident 46> Review of the medical record showed Resident 46 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe), peripheral vascular disease (PVD, reduced blood flow to the extremities) and heart failure. The 05/30/2024 comprehensive assessment showed Resident 46 was cognitively intact and required partial to moderate assistance of one staff member for most activities of daily living (ADLs). Review of the medical record showed Resident 46's Medicare Part A skilled services started on 04/15/2024 and their last covered day was 05/30/2024. A SNFABN was issued to Resident 46 on 06/18/2024, 19 days after their last covered day. <Resident 62> Review of the medical record showed Resident 62 was admitted to the facility on [DATE] with diagnoses including psychotic/mood disturbance and anxiety. The 05/07/2024 comprehensive assessment showed Resident 62 was independent with ADLs and had a severely impaired cognition. Review of the medical record showed Resident 62's Medicare Part A skilled services started on 01/29/2024 and their last covered day was 02/22/2024. A SNFABN was not issued to Resident 62 as required. During an interview on 06/20/2024 at 3:39 PM, Staff N, Business Office Manager (BOM), stated they were responsible for issuing the SNFABN. Staff N stated they had a process of checking their email every morning and evening to identify those residents that were ending their Medicare Part A benefits so they could issue the SNFABN. Staff N stated Resident 62 was missed and did not receive a SNFABN. During an interview on 06/26/2024 at 2:08 PM, Staff A, Executive Director, stated they were aware of the failures for SNFABNs. They stated Staff N was responsible for issuing the SNFABNs the day after the resident's Medicare Part A coverage ended. Staff A stated the process had not been followed. Reference: WAC 388-97-0300(1)(e)(5)(6)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 47728 Based on interview and record review, the facility failed to ensure the right to receive unopened mail for 6 of 6 sampled residents (Resident 1,19,29, 42, 45, 47) reviewed for privacy. This failure resulted in a lack of privacy and potential diminished quality of life. Findings included . A review of the 03/14/2024 comprehensive assessment, Resident 1 was cognitively intact and able to direct their care. During an interview in Resident Council on 06/25/2024 at 2:00 PM, Resident 1 stated their mail was always opened before it was delivered to them. Residents 29, 42, 45, and 47 all verbally agreed with Resident 1's remark and stated their mail had also been opened when delivered to them. During an interview on 06/26/2024 at 3:00 PM, Resident 1 stated they were told by Staff N, Business Office Manager, all resident mail from the State was opened before being delivered to the residents. During an interview on 06/17/2024 at 1:56 PM, Resident 19 stated the facility opened their mail from Department of Social and Health Services (DSHS), mail from behavioral health and from welfare. Resident 19 stated they discussed this with Staff N. During an interview on 06/26/2024 at 3:43 PM, Staff P, Receptionist, stated they gave the mail to Staff N who sorted it and then gave it back to them for delivery. Staff P confirmed that the mail from DSHS addressed to residents had been opened. Staff N was on leave during this investigation and unavailable for interview. During an interview on 06/27/2024 at 9:13 AM, Staff A, Executive Director, stated mail was given to Staff P for distribution to the residents. When asked if the mail was delivered to residents unopened, Staff A stated it should be but letters from DSHS had been opened by Staff N because there had been some confusion about which mail was for residents and which mail was for the facility. Staff A stated residents had a right to privacy with their mail and the facility needed their permission to open their mail. Reference: WAC 388-97-0360, -0500(1)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42802 Based on interview and record review, the facility failed to exercise reasonable care for the protection of the resident's property from loss, and to reimburse the resident timely for the loss of a cell phone for 1 of 3 sampled residents (Resident19) investigated for personal property. This failure caused the resident to replace their cell phone from their own funds. Findings included . According to a quarterly assessment dated [DATE], Resident 19 had diagnoses that included diabetes and quadriplegia (paralysis that affects all four limbs) and was cognitively intact. During an interview on 06/17/2024 at 1:58 PM, Resident 19 stated that someone stole their cell phone in November 2023, and they had not received their reimbursement check yet and was told by Staff A, Executive Director, that it was in process. They further stated that since they needed a cell phone, they had bought another with their own funds. A review of the previous six months of missing property logs and grievance logs documented no entries for the resident about their cell phone. During an interview on 06/27/2024 at 10:51 AM, Staff L, Director of Social Services, stated that when a resident's property went missing, they filled out a form and gave it to Staff A. During an interview on 06/27/2024 at 12:57 PM, Staff A stated missing property forms were directed to them when completed. They considered replacing the item or reimbursing the cost, depending on what was found. Staff A stated that Resident 19's missing cell phone was brought to their attention several months ago, and they had not yet submitted the request for reimbursement. Staff A further stated that the check should have been given to the resident within five business days. Staff A acknowledged that the situation was not resolved timely. Reference: WAC 388-97-0880

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42802 Based on observation, interview and record review, the facility failed to ensure Preadmission Screening and Resident Reviews (PASARR) were completed or implemented as required for 2 of 6 sampled residents (Resident 12, 21) reviewed. Resident 21 did not have a PASARR completed prior to admission to the facility, and Resident 12 had Level II behavioral health recommendations that were not implemented. This failure placed the residents at risk for a decline in their mental health and a decrease in their quality of life. Findings included . <Resident 12> Resident 12 was admitted on [DATE] and had diagnoses including depression. A review of the 03/31/2024 hospital discharge summary documented Resident 12 had been found at home wielding a knife and intended to harm themself. The resident was placed on a 72-hour psychiatric hold, and the hold was discontinued after the resident was assessed by the psychiatrist. A PASARR Level I screen completed on 03/27/2024, documented Resident 12 had mental illness indicators and exhibited functional limitations because of this. A Level II review was indicated based on the initial screening. A Washington State Health Care Authority Level II Notice of Determination completed on 03/29/2024 documented Resident 12 met requirements for nursing facility level of care and required specialized behavioral health services while they resided at a nursing facility. The 04/03/2024 Social Service Admission Evaluation by Staff L, Director of Social Services, documented in the section Psychiatric Diagnosis listed in the Medical Record that Resident 12 had depression and that a PASARR Level I screen was completed. The next questions regarding if specialized services were indicated on the PASARR, the date of the last psychiatric visit and need for a psychiatric evaluation were left blank. Behavioral health provider progress notes and documentation of visits were unable to be located during further review of Resident 12's record and these were requested on 06/24/2024 at 10:03 AM, 2:40 PM, and on 06/25/2024 at 8:48 AM. None were provided. During an interview on 06/21/2024 at 9:17 AM, Resident 12 stated they remembered not feeling well mentally during 04/2024 and being taken to the hospital. The resident stated when their pain was bad, it caused them to feel more depressed. Resident 12 stated they had not seen a counselor or anyone from behavioral health since they had entered the facility that they remembered. During an interview on 06/25/2024 at 3:09 PM, Staff J, Transportation/Central Supply, stated they were asked on 06/24/2024 to make a behavioral health appointment for Resident 12. The appointment date was 07/30/2024 at 7:30 AM. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/26/2024 at 10:13 AM with Staff A, Executive Director, and Staff L, Staff A stated Social Services was responsible for reviewing PASARRs for any recommendations when residents were admitted . Staff A stated it was important for residents to receive behavioral health services when recommended in order to provide quality care. Staff A stated Resident 12's behavioral health appointment and care got missed. <Resident 21> Resident 21 was admitted to the facility on [DATE] from a local hospital. According to a comprehensive admission assessment dated [DATE], Resident 21 had moderate cognitive impairment and diagnoses which included depression and encephalopathy syndrome (brain disease, damage or malfunction). A review of the resident's Electronic Medical Record (EMR) documented a PASARR Level 1, completed by the facility social services staff. This form was dated 01/29/2024, 5 days after the resident was admitted . No earlier PASARR form was found in Resident 21's EMR. During an interview on 06/27/2024 at 10:51 AM, Staff L, Director of Social Services, stated the PASARR should be completed by the hospital that sent the resident. The facility social worker reviewed them, and filled out the form if the hospital did not. Staff L stated the resident was admitted before they were in that position, so were not sure why it was not done prior to admission. Reference: WAC 388-97-1915(4) 46033

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 42802 Based on observation, interview and record review, the facility failed to ensure care plan interventions were followed for 3 of 4 sampled residents (Resident 39, 54, 67) reviewed for care planning. Failure to follow the care planned interventions regarding positioning, mobility, and displays of affection placed residents at risk for unmet care needs and decreased quality of life and caused other residents to be uncomfortable. Findings included: <Resident 54> Per the 05/15/2024 comprehensive assessment, Resident 54 had diagnoses including stroke and paralysis on one side, was mildly cognitively impaired and participated in decisions regarding their care. Resident 54 required substantial assistance with most activities of daily living (ADLs). The 04/24/2024 care plan documented Resident 54 had a self-care deficit and was totally dependent on staff for bed mobility and transfers and required a mechanical lift device for transfers. Staff were instructed to get Resident 54 up in their wheelchair for breakfast until after lunch. A physical therapy (PT) progress note dated 04/23/2024 recommended Resident 54 be up in their wheelchair daily after breakfast until after lunch. Further record review showed no documentation of attempts to get resident up in their wheelchair, or resident refusals to get up in their wheelchair. On 06/17/2024 at 2:45 PM, Resident 54 was observed lying in bed. A sign on the wall over their bed read I like to get in my wheelchair. Resident 54 stated they were not assisted to their wheelchair and did not go to any activities because they did not get help getting up. On 06/24/2024 at 1:46 PM, Resident 54 was observed lying in bed awake, and stated they had been awake most of the day, but staff had not assisted them to their wheelchair. Additional observations of Resident 54 lying in bed were made on 06/20/2024 at 3:11 PM, 06/21/2024 at 9:15 AM, 06/24/2024 at 10:20 AM, 06/25/2024 at 9:24 AM, 06/25/2024 at 10:27AM, and 06/26/2024 at 11:26 AM. During an interview on 06/25/2024 at 11:03AM, Staff BB, Nursing Assistant, stated they had been working with Resident 54 since their admission. Staff BB stated Resident 54 required a mechanical lift and extensive assistance of two staff to get them out of bed. Staff BB stated the plan was to have Resident 54 get out of bed, and increase their tolerance, but they often refused. Staff BB stated they did not report or document the resident's refusals. (continued on next page)

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During an interview on 06/26/2024 at 2:31 PM, Staff CC, Medication Technician, stated Resident 54 required two staff to move in bed. Staff CC stated Resident 54 did not refuse to get up and was assisted out of bed to their chair that day. Staff CC was unsure why Resident 54 had not been assisted to their chair at other times.

<Residents 39 and 67>

A 04/12/2024 comprehensive assessment documented Resident 39 had diagnoses including dementia and anxiety and was severely cognitively impaired. Resident 39 had wandering behaviors and rejected care at times.

The 05/28/2024 care plan documented Resident 39 demonstrated a need for companionship/affection with other residents by hand holding, kissing and touching another resident. Resident 39 was romantically involved with Resident 67, and their guardian was aware of the relationship and gave approval. Staff were instructed to ensure public displays of affection were appropriate, and neither resident was allowed to go into the other's room.

A 03/26/2024 comprehensive assessment documented Resident 67 had diagnoses including seizures and depression and had severe cognitive impairment. Resident 67 wandered and rejected care at times.

The 05/28/2024 care plan documented Resident 67 demonstrated a need for companionship/affection that included kissing, touching and holding hands with another resident. Resident 67 expressed romantic feelings toward Resident 39, their guardian was aware and approved. Staff were instructed to interrupt and redirect both residents if public display of affection became inappropriate and neither resident was allowed to go into the other's room.

On 06/25/2024 at 3:15 PM Resident 39 was observed walking down the hall and Resident 67 asked where they were going. Resident 39 stated they were going to their room. Resident 67 replied I'm coming with you. The two residents entered Resident 39's room. Resident 39 stated that Resident 67 was their spouse, then shut the door.

During an interview with Resident Council members on 06/25/2024 at 2:00 PM, Residents 47, 1 and 42 expressed that Resident 39 and Resident 67 groped each other and made out in the hallway and dining room and having to watch this concerned them.

During an interview on 06/27/2024 at 3:26 PM, Staff DD, Nursing Assistant, stated Resident 39 and Resident 67 were care planned regarding their affection for each other. Staff DD stated if observed, they were to direct the residents to go to somewhere private and stated they could be in the same room resident together. Staff DD stated there had been complaints from other residents regarding them showing affection to one another in the dining room and there had been a meeting about it. Staff were directed to notify the nurse if needed.

During an interview on 06/27/2024 at 3:16 PM Staff G, Licensed Practical Nurse, stated Residents 39 and 67 were not supposed to go in each other's rooms. Staff G stated they tried to stay near Resident 67's room to ensure it did not happen.

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	505114	A. Building B. Wing	06/27/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/27/2024 at 3:36 PM Staff A, Executive Director, stated they tried to discourage Resident 39 and Resident 67 from going into one another's rooms as care planned and they expected staff to supervise Residents 39 and 67. Reference: WAC 388-97-1020(1), (2)(a)(b) 47728

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to ensure a safe discharge for 1 of 2 residents (Resident 56) and failed to honor discharge preferences for 1 of 2 residents (79) reviewed for discharge planning processes. These failures placed the residents at risk for lack of necessary care and services, an unsafe living environment, and dissatisfaction with their living situation. Findings included . Review of a facility policy titled Against Medical Advice (AMA) Discharge, revised 05/11/2023, documented that if a resident wanted to be discharged to a setting that appeared unsafe, the facility must determine if a referral to Adult Protective Services (APS) or other state entity charged with investigating abuse and neglect, was necessary. The referral would be made at the time of discharge. <Resident 56> Review of the medical record showed Resident 56 was admitted to the facility on [DATE] with diagnoses including encephalopathy (a condition that affects brain function), bipolar disorder (a mental illness characterized by periods of depression and abnormally elevated mood), and adult maltreatment (abuse and/or exploitation of an adult). The 06/15/2024 comprehensive assessment showed Resident 56 was cognitively intact and required supervision of one staff member for activities of daily living (ADLs.) A social services progress note dated 03/11/2024, documented the resident wanted to discharge to home with their spouse, however there was an open APS investigation and restraining order in place against the spouse. A nursing progress note dated 06/15/2024, documented that Resident 56 and their representative (a different family member, not the spouse) had verbalized that Resident 56 wanted to discharge from the facility. A nursing progress note dated 06/16/2024, documented that Resident 56 was alert and orientated, pleasant, and cooperative, and planned to discharge tomorrow to the care of their representative. A nursing progress note dated 06/17/2024, documented Resident 56 signed the AMA paperwork and left the facility with their representative. During an interview on 06/25/2024 at 9:17 AM, Staff I, Resident Care Manager, stated Resident 56's discharge was unplanned, AMA . Staff I stated the resident representative picked up Resident 56, Staff I stated they did not know where they were going to live after discharge. Staff I stated social services was aware of the AMA discharge but was not sure if APS was notified. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/25/2024 at 9:23 AM, Staff M, Social Services Assistant, stated the facility staff were notified of their desire to discharge, by the resident at a care conference on 06/17/2024 (the day they left AMA). Staff M stated they met with Resident 56's representative later that same day to discuss options related to their discharge. Staff M stated they were aware of the safety concerns with Resident 56's spouse. Staff M further stated that they did not call APS to report the discharge. Staff M stated they did not call APS when a resident left AMA, and were not sure if that was the process. During an interview on 06/26/2024 at 2:10 PM, Staff A, Executive Director, stated the process for AMA discharges included notifying APS. Staff A stated social services did not follow the process. 46115 <Resident 79> Per record review, Resident 79 admitted to the facility on [DATE] with diagnoses which included heart failure, anxiety and depression. Per the 06/05/2024 admission assessment, Resident 79 required assistance with activities of daily living and was able to make their needs known. Per the 05/29/2024 care plan, Resident 79 desired to discharge back home to another state. The care plan documented potential for concern because the resident had no support there. During an interview on 06/18/2024 at 11:01 AM, Resident 79 stated they had requested to move to the facility where their family member worked. Resident 79 stated that it was taking a long time to be moved. A progress note dated 06/20/2024 at 10:16 AM documented discharge paperwork had been faxed to the facility for discharge. In an interview on 06/25/2024 at 8:48 AM, Staff L, Social Service Director, stated discharge planning was assessed upon admission to the facility. Staff L stated Resident 79 mentioned they wanted to discharge within the first few days of being in the facility. Staff L added the discharge could have occurred sooner than it did. In an interview on 06/25/2024 at 8:55 AM, Staff A, Administrator, stated the discharge process started upon admission and within a few days of the resident's request to discharge. Staff A confirmed discharge planning should have occurred earlier than it did. Reference: WAC 388-97-0080

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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	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42802 Based on observation, interview and record review, the facility failed to provide residents with assistance completing their activities of daily living (ADLs) for 2 of 4 sampled residents (Resident 60, 75) reviewed. Specifically, Resident 60 was not provided showers and assistance, cueing, supplements and referrals necessary to promote their nutrition, and Resident 75 was not provided showers. This failure put residents at risk for skin breakdown, unintended weight loss and decreased quality of life. Findings included . <Resident 60> According to a 04/20/2024 quarterly assessment, Resident 60 had diagnoses including adult failure to thrive, osteoporosis (weak bones) and hypothyroidism (low levels of thyroid hormone.) Resident 60 was mildly cognitively impaired and did not reject care. The assessment further documented they required set-up/clean-up assistance for eating, maximum assistance with showering/bathing, and toileting hygiene. Resident 60 was incontinent of both bowel and bladder. The 01/22/2024 comprehensive care plan instructed staff to provide extensive assistance for personal hygiene and toileting, check the resident every two hours and assist with toileting as needed, and provide peri care after each incontinent episode. Staff were to provide nutritional supplements as ordered, monitor and record food and fluid intake, monitor weights per order, and report to the nurse any signs of difficulty swallowing or refusing to eat. The resident was to be up in their wheelchair for all meals and could eat independently. The care plan did not specify how often Resident 60 was to be bathed or showered. A 30-day look back review of the Nursing Assistant (NAC) bathing task completed on 06/25/2024 showed Resident 60 received one shower during that period, on 05/30/2024. The following weights were recorded for Resident 60: -01/14/2024 200.0 pounds (lbs.) when admitted , -03/08/2024 184.0 lbs., -04/15/2024 171.0 lbs., -05/13/2024 168.0 lbs., and -06/04/2024 177.0 lbs., an 11.5% loss since admission. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/25/2024, an order was given for Resident 60 to receive a high protein/high calorie drink four times a day for a supplement; they met criteria for being at risk for malnutrition. The resident had orders for supplemental vitamins and on 05/20/2024, mirtazapine was added for an appetite stimulant. On 06/11/2024, Resident 60's diet was changed to include softer textures for dysphagia (difficulty swallowing). The orders did not include how often Resident 60 was to be weighed. Review of the June 2024 Medication Administration Record (MAR) through 06/25/2024, there were 100 opportunities for the high protein/high calorie drink (4x's a day for 25 days). The MAR showed 11 entries were signed by the nurse with a code 8 on 06/05/2024, 06/06/2024, 06/13/2024, 06/17/2024, 06/18/2024, and 06/25/2024. The key to the codes documented that Code 8 instructed one to see the progress notes. A review of corresponding progress notes documented the high protein/high calorie drink was on order, or out of stock. Further review of nursing progress notes documented on 06/10/2024, nursing requested the Speech Therapist (ST) to see Resident 60 for decreased food intake and for stating when they ate it was hard to swallow. On 06/11/2024, Staff U, ST, documented they downgraded Resident 60's diet, not related to their ability to swallow. The Resident presented with jaw pain that had been present for a number of months and preferred softer textures. Therapy was not indicated, but Staff U recommended a referral to dental or an Ear-Nose-Throat (ENT) provider. On 06/17/2024 at 10:12 AM, Resident 60 was observed lying in their bed. They had covers pulled up around their chin and stared when asked simple yes or no questions. There was a strong smell of urine in the room, especially when near the resident. On 06/18/2024 at 9:02 AM, Resident 60 was lying in bed, flat on their back. There was a strong smell of urine present. The resident's breakfast tray was on their overbed table, still covered and uneaten. There were no staff present to assist the resident or cue them. The NAC meal intake task documented the resident ate 26-50%. On 06/20/2024 at 9:21 AM, Resident 60 was in bed and the room smelled strongly of urine. Their breakfast tray was unopened on their overbed table, uneaten. At 1:58 PM, the resident was asleep, lying flat on their back in bed. Their lunch tray was on their overbed table uneaten; the sandwich was still wrapped in plastic, the drinks were full, only bites of watermelon were consumed from a small bowl. No staff were present to assist or cue the resident. The NAC meal intake task documented the resident refused both breakfast and lunch. On 06/21/24 at 8:51 AM, Resident 60 was asleep in bed. When the door was opened, there was a strong smell of urine. At 12:56 PM, Resident 60 was sitting upright in bed, their lunch was in front of them, but they were dozing. One drink of three had been consumed, and only bites of taco salad were eaten. There was no staff present to assist the resident. The NAC meal intake task documented Resident 60 ate 76-100% of their lunch. On 06/24/2024 at 9:37 AM, Resident 60 was asleep in their bed, a strong urine smell was present. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/25/24 at 11:32 AM, lunch trays were delivered to the nursing unit. At 12:13 PM, Resident 60 was provided their lunch and was assisted to sit up on the edge of their bed. At 12:18 PM, Resident 60 had returned to lying down in their bed. They had taken bites of a cucumber salad. When asked if they were going to eat, they shrugged their shoulders. At 12:40 PM, no staff had been in to cue or assist Resident 60 and they had not been offered an alternative meal. The NAC meal intake task documented Resident 60 ate 76-100% of their lunch. During an interview on 06/26/2024 at 09:13 AM, Staff J, Transportation/Central Supply, stated they were responsible for making out-of-facility appointments for residents and had never been asked to make a dental or ENT appointment for Resident 60 since 06/11/2024 or ever. In a follow-up interview on 06/27/2024 at 10:07 AM, Staff J stated they ordered 4 cases of the high protein/high calorie drinks every Tuesday. Staff J had not been told there were times the drinks were out of stock. They stated had they known, they had means to replace them such as getting them from a sister facility, or just ensuring there were not more in the back storage room that the staff were unaware of. During an interview on 06/27/24 at 11:33 AM, Staff W, Licensed Practical Nurse (LPN), stated Resident 60 needed to be pushed to eat and required constant verbal reminding. Staff W stated the resident lost their concentration but did much better when they were out of bed in their wheelchair. Staff W was unaware the care plan instructed staff to get Resident 60 up for every meal. Staff W was unsure if Resident 60 had lost weight but assumed they had because they had nutritional drinks ordered, however, they ran out of the shakes from time to time. Staff W was aware the resident smelled like urine and stated the resident needed to be checked and changed and was to be toileted every 2 hours. Staff W stated the nurses and the Resident Care Managers (RCMs) were responsible for ensuring resident care was completed. During an interview on 06/27/2024 at 1:11 PM, Staff U, Speech Therapist (ST) stated they had received a referral from nursing because of possible difficult swallowing and decreased intake. Staff U stated Resident 60 reported pain in their jaw and pointed to the right side of their mouth towards their teeth. Because the resident was unable to be more specific about the pain, Staff U stated that was the reason they recommended both dental and ENT referrals. Staff U had changed the resident's diet texture in case the chewing was causing the pain. Staff U stated it was not a problem with their ability to swallow. They were unaware if the referrals had been made. During an interview on 06/27/2024 at 1:44 PM, Staff K, Registered Dietician (RD), stated they had recommended that Resident 60 get the high protein/high calorie shakes four times a day. They stated the resident's weight loss had stabilized, but the nutritional risk was a combination of factors. The resident could be offered a later breakfast if they preferred to sleep, or if made aware the resident was refusing meals or not getting their shakes, Staff K could make changes to their plan of care if they are notified of this. Staff K stated a resident's nutrition consisted of two parts; providing enough calories, and also providing the correct amount of assistance to eat the calories. Staff K stated they would have expected the dental or ENT referrals to have been made as jaw or dental pain could impact their nutritional status. During an interview on 06/27/2024 at 2:39 PM, Staff V, NAC, stated they did smell urine on Resident 60 and they encouraged the resident to change their clothes. If the resident preferred to wear the same clothes, they did not fight them. At this time, the shower binder at the desk was reviewed, and there were none entered for Resident 60. Staff V stated Resident 60 was to receive their showers on the evening shift and was due for one that evening. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/27/2024 at 3:04 PM, Staff I, LPN, RCM, reviewed saved documents from the shower binder and stated the last shower Resident 60 received was on 05/30/2024. Staff I stated Resident 60 was scheduled for showers on Mondays and Thursdays and did not see on the documents where Resident 60 had refused or received any showers in June. They stated if showers were not given, it would contribute to the smell of urine and could contribute to skin breakdown. Staff I stated Resident 60 only got out of bed for lunch; they were unsure how the resident ate if in their bed and were unsure if staff got the resident out of bed for supper. They had not discussed changing mealtimes later in the morning if Resident 60 slept late. Staff I stated Resident 60 would benefit from cueing during their meals and they expected the staff to assist the residents with showers and eating when they needed it. <Resident 75> According to an admission assessment dated [DATE], Resident 75 had diagnoses including necrosis/gangrene (tissue death) of the left and right fingers and amputation of both legs below the knees, due to frostbite injury. Resident 75 was alert, made their needs known and required staff assistance with activities of daily living (ADLs) such as bathing and grooming. A review of Resident 75's Electronic Medical Record (EMR) documented no bathing restrictions were ordered, had no data recorded on the bathing task record, and no bathing refusals were documented. A review of Resident 75's care plan instructed staff to provide Resident 75 with a sponge bath when a full bath or shower could not be tolerated but did not contain what days or how frequently the resident was to receive a shower. A schedule in the North Hall shower binder documented that Resident 75 was to receive a shower on Tuesdays and Fridays, on evening shift. A review of the shower log from 05/03/2024 through 06/24/2024 showed no showers were given or refused for Resident 75. During an interview on 06/17/2024 at 10:10 AM, Resident 75 was resting in bed. All their fingers were black and curled toward their hand, with very restricted movement. Resident 75 stated their main complaint was that they only had one shower since their admission to the facility 45 days ago. Resident 75 stated that when they asked for a shower, staff responded that they would check the bathing schedule, but the resident did not hear anything back. On 06/20/2024 at 9:02 AM, Resident 75 was observed wearing the same shirt as 2 days earlier. They had an open area on their hand that had some yellowish drainage. There were numerous spots of blood and yellow stains on their blanket and sheets. On 06/24/2024 at 9:25 AM, there were yellow stains observed on the bottom of Resident 75's blanket. During a follow-up interview on 06/25/2024 at 12:02 PM, Resident 75 stated they did not remember what day or who showered them, but it was about a week ago. When asked if they had ever refused a shower, they laughed and said they would never refuse a shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/25/2024 at 10:18 AM, Staff Q, Nursing Assistant (NAC) stated that showers were documented in the EMR and on a paper shower log, in a binder at the nurse station. They further stated the paper shower log would be the most complete and bed linens were changed on shower days and as needed. During an interview on 06/27/2024 at 8:57 AM, Staff R, NAC, stated that Resident 75 got their showers on evening shift, but staff should have seen the hall shower schedule, even if it was not in the computer. During an interview on 06/26/2024 at 2:41 PM, Staff S, Licensed Practical Nurse (LPN), Resident Care Manager (RCM) reviewed the schedule for Resident 75's showers and verified there were no showers and no refusals documented for Resident 75. Staff S reviewed the bathing order for Resident 75 in the EMR and found that it had been put in the computer to occur as needed, not on a set schedule. Staff S stated that it was unacceptable that Resident 75 had gone so long without a shower, and facility staff should have caught it. During an interview on 06/27/2024 at 3:19 PM, Staff B, Director of Nursing, stated that facility protocol for bathing frequency went according to the resident preference, but their usual practice was twice a week. Staff B stated Resident 75 should have been receiving their showers. Reference: WAC 388-97-1060(2)(c) 46033

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 47728 Based on observation, interview and record review, the facility failed to ensure a resident received an ongoing program of activities that met their interests for 1 of 2 sampled residents (Resident 54) reviewed for activities. This failure placed the residents at risk for social isolation, mental decline, and diminished quality of life. Findings included . A 05/15/2024 comprehensive assessment documented Resident 54 had diagnoses including stroke and hemiplegia (paralysis or loss of strength on one side of the body). Resident 54 was severely cognitively impaired, used a manual wheelchair, and required maximum assistance from staff for mobility in their wheelchair. It was very important to Resident 54 to be involved in activities that included: reading, listening to music, being around animals, being outdoors, practicing religion, and doing their favorite activities. Review of the 06/03/2024 care plan documented Resident 54 would engage in independent leisure activities such as watching television (TV) and spending time with visitors and would accept 1 to 1 visits with activity staff. Staff were instructed to ensure activities were compatible with the resident's known interests and preferences and were to escort/transport Resident 54 to activities as needed. Review of the 05/14/2024 Life Enrichment Review documented Resident 54 had attended no activity programs over the prior quarter. On 06/17/2024 at 2:45 PM, Resident 54 was observed lying in bed and stated they did not attend any activities because they did not receive help getting up into their wheelchair. They stated the only thing to do was watch TV. Activities programs were observed in process in the Activities room and main dining room on 06/20/2024 at 1:27 PM, a summer party on 06/21/2024 at 2:00 PM, coloring on 06/24/2024 at 2:33 PM, and bean bag toss on 06/26/2024 at 10:06 AM. Resident 54 was not in attendance. Resident 54 was observed lying in bed watching TV or napping on 06/24/2024 at 10:20 AM and 1:46 PM, 06/25/2024 at 9:37 AM and 10:27 AM, and on 06/26/2024 at 11:26 AM. At that time, Resident 54 stated they liked to read but had no reading material. They stated large print was nice, but they had not been offered any reading material or audio books. During an interview on 06/26/2024 at 3:35 PM, Staff O, Life Enrichment Director, stated activities for Resident 54 consisted mainly of in room visits. Staff O stated they no longer offered pet visits, and they were unsure if Resident 54 listened to music in their room. Staff O stated they had not provided or attempted to obtain any reading material or audiobooks for Resident 54, the resident slept most of the time. They stated when Resident 54 was first admitted they were invited to activities and refused, so staff no longer invited them to activities. Staff O acknowledged that Resident 54 should be invited to activities-a person could change their mind over time or get bored. Reference: WAC 388-97-0940(1)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42802 Based on interview and record review, the facility failed to implement a bowel management protocol when indicated for 2 of 3 residents (Resident 21, 75) reviewed for constipation. This failure placed residents at risk for worsening conditions, and unintended health consequences when unable to have bowel movements. Findings included . <Resident 21> A quarterly assessment dated [DATE] documented Resident 21 had diagnoses which included diabetes, brain dysfunction and a history of stroke. Resident 21 was cognitively impaired and required staff assistance with activities of daily living, including toileting. The June 2024 medication administration record (MAR) documented Resident 21 had the following orders: -Milk of Magnesia (MOM, a liquid laxative) as needed for constipation, if no bowel movement (BM) on the 3rd day. -Bisacodyl suppository (laxative) rectally every 24 hours, as needed for constipation, if no results from MOM after 12 hours -Fleet enema (liquid laxative) instilled rectally every 24 hours as needed for constipation, if no results from suppository in 4-6 hrs. The Nursing Assistant bowel task documentation in the electronic medical record (EMR) showed Resident 21 did not have a BM from 06/11/2024 until late on 06/16/2024, a period of 6 days. The June 2024 MAR showed that from 06/11/2024 until 06/16/2024, Resident 21 had been given no MOM when indicated. The Bisacodyl suppository was administered on 06/16/2024 at 10:45 PM, the sixth day without a BM, and was effective. There were no corresponding entries in the EMR that documented Resident 21 was offered laxatives, or the the resident refused them. <Resident 75> An admission assessment dated [DATE] documented Resident 75 had diagnoses including necrosis/gangrene (tissue death) of the left and right fingers and amputation of both legs below the knees, due to frostbite injury. Resident 75 was cognitively intact and required staff assistance with activities of daily living including toileting. Resident 75 received opioid pain medication, medications that could potentially cause constipation. The May and June 2024 MARs documented Resident 75 had the following orders: - Miralax (a powdered laxative, to be mixed with water) every 12 hours as needed for constipation, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Senna (laxative in pill form) every 12 hours as needed for constipation, -MOM as needed, if no BM on the 3rd day, -Dulcolax (laxative suppository, to be given rectally) as needed on day 4, if no results from MOM after 12 hours. -Fleets enema if no results from Dulcolax in 4-6 hours. The Nursing Assistant bowel task documentation documented Resident 75 did not have a BM from 05/29/2024 to 05/31/2023, a period of 3 days, from 06/09/2024 to 06/12/2024, a period of 4 days, and from 06/17/2024 to 06/21/2024, a period of 5 days. A review of the MARs from 05/29/2024 through 06/20/2024, showed Resident 75 received none of their as needed medications for relief of constipation when indicated. There were no corresponding entries in the EMR that Resident 75 was offered the medications and refused During an interview on 06/25/2024 at 10:18 AM, Staff Q, Nursing Assistant (NAC) stated that the NACs kept track of resident BMs in the task portion of the EMR. They stated nurses notified them if a resident was due for a BM. During an interview on 06/27/2024 at 9:59 AM, Staff S, Licensed Practical Nurse (LPN), Resident Care Manager (RCM) stated that they checked the bowel list on the EMR every day. A resident showed on that list if no BM was documented for 64 hours, and they notified the floor nurse to follow up. The floor nurse should have given the as needed medications as ordered, and if not given or offered and refused, that should be documented. Staff S stated they expected staff to follow the medication orders and give them when indicated. Reference: WAC 388-97-1060(1)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 46115 Based on observation, interview, and record review, the facility failed to schedule a vision appointment for 1 of 1 sample residents (Resident 59), reviewed for vision services. This failure placed the resident at risk for worsening vision and decreased quality of life. Findings included . According to the 3/20/2024 quarterly assessment, Resident 59 was cognitively intact and able to make their needs known. In an interview on 06/18/2024 at 2:15 PM, Resident 59 stated they had mentioned to Staff I, Resident Care Manager, and Staff T, Transportation about a month ago they needed a vision appointment set up. During an observation on 06/20/2024 at 9:41 AM, Resident 59 stated their eye caused them intermittent pain. In an interview on 06/25/2024 at 2:09 PM, Staff I, Resident Care Manager, stated Staff T was responsible for making all needed appointments for the residents. During an interview on 06/25/2024 at 2:20 PM, Staff T, Transportation, stated they were not aware that Resident 59 had vision pain, but was aware they had blurry vision. Staff T stated Resident 59 had an eye exam on 04/11/2024 and needed retinal surgery. Staff T added the eye clinic had phoned the resident's old cell phone number on 04/17/2024 and 04/20/2024 and after two phone calls they had closed the referral. Staff T stated an appointment should have been made sooner. In an interview on 06/25/2024 at 2:37 PM, Staff B, Director of Nursing, stated Staff T was responsible for making appointments and they could have done better. In an interview on 06/27/2024 at 9:50 AM, Staff T stated if a resident returned from an appointment without paperwork, the resident care manager would have myself or medical records follow up with the clinic and that never happened. Staff T stated that's why Resident 59 missed her appointment. Reference: WAC 388-97-1060(3)(a)

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	505114	A. Building B. Wing	06/27/2024

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Aurora Valley Care	414 S University Rd Spokane, WA 99206

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 46115 Based on observations, interviews and record review, the facility failed to remove a urinary catheter (a small flexible tube inserted into the bladder to drain urine) and provide bladder training as ordered for 1 of 1 sampled residents (Resident 2), reviewed for catheter use. This failure placed the resident at increased risk of acquiring potentially preventable catheter associated urinary tract infections and a diminished quality of life. Findings included . A 04/30/2024 admission assessment documented Resident 2 had diagnoses including obstructive uropathy (a condition in which the flow of urine is blocked, and the urine retained in the bladder) and had an indwelling urinary catheter. The assessment also documented Resident 2 was cognitively intact and able to make their needs known. A progress note dated 04/13/2024 at 10:30 AM documented Resident 2 had complained of abdominal pain and a bladder scan (a way of measuring urine in the bladder using ultrasound waves) was completed. The bladder scan revealed 1 liter of urine was retained in the bladder. A urinary catheter was placed, and the pain had resolved. A 04/21/2024 hospital progress note documented the resident's urinary catheter had been placed weeks ago when the resident was unable to void and needed to be removed for bladder training (techniques to restore bladder control after use of a urinary catheter.) The 04/22/2024 transition of care orders from the hospital documented Resident 2 had a urinary catheter and needed bladder training. In an interview on 06/17/2024 at 9:51 AM, Resident 2 stated they were going home that day, and the urinary catheter was going to be removed. Resident 2 stated they did not have a urinary catheter prior to going to the hospital. On 06/17/2024 at 3:14 PM, Resident 2 was observed yelling at the nurse when told their urinary catheter would not be removed prior to discharge. On 06/17/2024 at 3:27 PM, Resident 2's family member stated orders had been given for the catheter to have been removed and nobody followed up on it. In an interview on 06/24/2024 at 3:47 PM, Staff AA, Licensed Practical Nurse, verified the order on 04/22/2024 and stated the urinary catheter should have been removed and bladder training attempted. During an interview on 06/25/2024 at 9:45 AM, Staff B, Director of Nursing confirmed the urinary catheter should have been removed and bladder training attempted. Reference: WAC 388-97-1060 (3)(c)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42802 Based on interview and record review, the facility failed to ensure physician visits were completed every 30 days, for the first three months after admission, then every 60 days, as required, for 8 of 14 sample residents (Resident 12, 15, 21, 24, 39, 42, 52, 60) reviewed for physician visits. This failure placed the residents at risk for delayed identification and treatment of medical needs. Findings included . <Resident 12> Resident 12 was admitted on [DATE] and had diagnoses including depression and stroke. There were no physician visits documented in Resident 12's Electronic Medical Record (EMR). <Resident 15> Resident 15 was admitted to the facility on [DATE] with diagnoses of dementia, malnutrition and failure to thrive (a syndrome of overall decline.) A review of Resident 15's EMR documented physician visits on 08/09/2023, 11/07/2023 (90 days later), 02/05/2024 (90 days later) and 06/04/2024 (120 days later). <Resident 21> Resident 21 was admitted to the facility on [DATE] with diagnoses including diabetes, depression and encephalopathy syndrome (brain disease, damage or malfunction). A review of Resident 21's EMR showed no physician visit notes during their five months in the facility. <Resident 24> Resident 24 was admitted on [DATE] and had diagnoses including stroke and morbid obesity. Resident 24's EMR documented Resident 24 was not seen by the physician from 01/2023 until 08/30/2024, or from 02/01/2024 until 05/30/2024. <Resident 39> Resident 39 was admitted into the facility on [DATE] with diagnoses including diabetes, heart failure and dementia. According to the Resident 39's EMR, no physician visit documentation was found since 03/12/2024, over three months prior. <Resident 42> (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 42 was admitted on [DATE] and had diagnoses including end stage kidney disease dependent on dialysis. A review of the EMR documented the Resident was seen by the physician on 02/01/2024 and greater than 90 days later on 05/08/2024. <Resident #52> Resident 52 was admitted on [DATE] and had diagnoses including diabetes and chronic kidney disease. A review of the EMR documented Resident 52 was seen 3 times by the physician since their admission-on 10/19/2023, 01/18/2024, and on 04/19/2024. <Resident 60> Resident 60 was admitted on [DATE] and had diagnoses including adult failure to thrive and low thyroid function. A record review documented an admission History and Physical had not been completed by the physician. Resident 60 was seen by the physician on 02/22/2024 but had no other physician visits documented. During an interview on 06/25/2024 at 1:13 PM, Staff A, Executive Director, stated they were not able to locate any other physician visits documentation for the sampled residents. Staff A stated it was their understanding that the physician was responsible for the History and Physical on admission, then was to see the residents at least every 60 days. Staff A stated Staff JJ, Medical Records, sent the provider group a calendar of those residents due for a visit but was unsure what follow-up was done if a resident was not seen. During an interview on 06/26/2024 at 9:19 AM, Staff JJ stated the facility recently switched to a new provider group and they provided the providers with a paper calendar of those residents who were due for a visit. They printed one for the Nurse Practitioners and another for the doctors. Staff JJ stated the new provider group uploaded their own visit documentation into the EMRs, so Staff JJ looked at each resident's record at the end of the month to see what was uploaded. The previous providers crossed the residents off the calendar and initialed that they had seen. Staff JJ stated they had not determined a way to track provider visits with the new provider group yet. Reference: WAC 388-97-1260(4)(c) 46033

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 46115 Based on observation, interview, and record review, the facility failed to provide behavioral health care services for 1 of 1 sampled residents (Resident 80), reviewed for behavioral health. This failure placed the resident at risk for unmet care needs and diminished quality of life. Findings included . According to the 06/06/2024 admission assessment, Resident 80 had diagnoses including bipolar disorder (where moods range from depressive lows to manic highs) and substance abuse in remission. Resident 80 was cognitively intact and able to make decisions regarding their care. During an interview on 06/17/2024 at 10:43 AM, Resident 80 became tearful and began to cry. They stated they had been notified 15 minutes prior to their behavioral health appointment that the facility was unable to provide transportation. Resident 80 stated they were a recovering drug addict, had severe, and they had made the appointment so their medications could be reviewed. Resident 80 stated the appointment had been scheduled for a month and a half and they had no other means to get to there. The resident continued to cry and said they did not know what they were going to do as they really needed counseling. At 2:50 PM, Resident 80 stated they were still upset about missing the appointment because they did not think they would get a new appointment as the clinic was probably booked out for a while. During an interview on 06/20/2024 at 9:04 AM, Resident 80 stated they phoned the behavioral health clinic and were unable to make a new appointment due to being charged a late fee for missing their earlier appointment. Resident 80 repeated that missing the appointment was very upsetting as their medications were supposed to be reviewed and adjusted. During a telephone interview on 06/26/2024 at 9:24 AM, the behavioral health clinic stated Resident 80 had an appointment on 06/17/2024 that was missed, and a no-show fee was charged. The clinic stated the appointment was for medication management; any needed changes to the resident's medications would have been made at that time. During an interview on 06/26/2024 at 10:44 AM, Staff AA, Licensed Practical Nurse, stated Resident 80 had missed an appointment to see their psychiatrist and that they were upset. Staff AA stated Resident 80 was down and out about missing the appointment and it was an appointment they really needed to go to. During an interview on 06/26/2024 at 11:47 AM, Staff L, Social Service Director, stated Resident 80 was depressed upon admission. Staff L stated Resident 80 had missed an appointment for their mental health and sobriety and was not happy about it. Staff A, Administrator was present for the interview and stated the appointment was not placed on the calendar until 06/14/2024 and that would not have allowed the facility enough time to set up transportation. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/26/2024 at 1:30 PM, Resident 80 stated that a week before the 06/17/2024 appointment they told Staff L about the appointment and was reassured the facility would provide transportation. In a follow up interview on 06/26/2023 at 2:37 PM, Staff L stated they did not remember being informed about the appointment but did not dispute Resident 80's assertion that they were notified. Reference: WAC 388-97-1060 (3)(e)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than five percent. Three medication errors were identified for 2 of 5 sampled residents (Resident 9, 78) observed during 32 medication opportunities, that resulted in an error rate of 9.38 percent. The failure to administer medications correctly placed the residents at risk for receiving subtherapeutic effects of their medications and possible adverse side effects. Findings included . Review of a facility policy titled, Medication Administration, revised 12/2022, documented that the facility strived to provide safe administration of all medications, the licensed nurse would administer medications according to State specific regulation, and to document refused or omitted doses. Review of the instructions for use document titled, How to use your Lantus SoloStar pen, (a method of delivery for insulin injections,) dated 08/2022, included the following instructions: 1) Wipe the pen tip (rubber seal) with an alcohol swab, before attaching the needle. 2) Dial up a test dose of two units, press the injection button and check that insulin comes out of the needle. 3) Dial up the ordered amount of medication and insert the needle into the skin. press the injection button until the number in the dose window returns to zero. Slowly count to ten before removing the needle to ensure the full insulin dose was delivered. Review of a document titled, Humalog U-100 KwikPen Instructions for Use, revised 08/2023, documented the same process, but instructed to slowly count to five before removing the needle from the resident's skin. <Resident 9> Review of the medical record showed Resident 9 was readmitted to the facility on [DATE] with diagnoses including diabetes, chronic pain, and anxiety. The 04/09/2024 comprehensive assessment documented that Resident 9 was cognitively intact. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 06/21/2024 at 8:36 AM, Staff Z, Licensed Practical Nurse, obtained Resident 9's Lantus insulin pen from the medication cart and screwed a disposable needle onto the tip (rubber seal) of the pen. Staff Z did not clean the tip of the pen prior to screwing on the disposable needle. Staff Z dialed up the ordered dose of 32 Units on the insulin pen without performing a test dose. Staff Z brought the residents insulin pen, their Flovent inhaler (an inhaled steroid medication) and their pills to Resident 9's bedside. Staff Z administered the ordered injection, (had not wasted a 2 Unit test dose) and waited three seconds before removing the needle from the skin, not the required ten seconds. Staff Z then handed the Flovent HFA inhaler to Resident 9 to use. Staff Z left the inhaler with the resident, turned their back to the resident, and put trash in the trash can, changed the trash bag, and returned to the bedside. Resident 9 handed the inhaler back to Staff Z without using it. During an interview on 06/21/2024 at 9:52 AM, Staff Z stated they were not aware of and had never been trained to perform the safety dose prior to injecting insulin with the insulin pen. They stated they did not wait the right amount of time before removing the needle from the skin. Staff Z stated they did not see Resident 9 use their inhaler. They stated, I usually watch the residents; I thought they took the two puffs. Review of Resident 9's June 2024 Medication Administration Record documented that Resident 9 had received two puffs of the Flovent HFA inhaler, despite Resident 9 not using the inhaler. <Resident 78> Review of the medical record showed Resident 78 was admitted to the facility on [DATE] with diagnoses including a broken right upper arm, diabetes and heart disease. The 05/31/2024 comprehensive assessment documented that Resident 78 was cognitively intact. Review of Resident 78's physician's orders, showed the resident was to receive Lispro (also called Humalog) insulin based on their blood glucose levels. Resident 78's blood glucose level indicated three units of insulin should be administered. During a concurrent observation and interview on 06/21/2024 at 11:33 AM, Staff F, Registered Nurse, obtained Resident 78's Lispro insulin pen and disposable needle from the medication cart and proceeded to the resident's room. They attached the disposable need to the pen tip, without cleaning the tip with alcohol, dialed up the ordered dose of three units of insulin, and administered the dose. Staff F stated they did not know they had to prime the insulin pen before use. During an interview on 06/21/2024 at 11:43 AM, Staff B, Director of Nursing Services, stated the process for using an insulin pen included scrubbing the hub (rubber seal) of the pen with an alcohol swab, attaching the disposable needle to the hub, and priming the pen with two units of insulin. Staff B agreed that Staff Z and Staff F did not follow the proper process for administration of insulin using an insulin pen. Reference: WAC 388-97-1060(3)(k)(ii)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 46033 Based on observation, interview and record review, the facility failed to ensure residents were given their medications as ordered for 3 of 9 sampled residents (Residents 36, 42 and 80) reviewed for medication management. This failure placed residents at risk of exacerbations of their chronic health conditions, and unintended consequences when doses of their medications were omitted. Findings included . <Resident 42> A06/09/2024 quarterly assessment documented Resident 42 had diagnoses including end-stage kidney disease, seizures (sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements, feelings, and consciousness), and diabetes (a group of diseases that result in too much sugar in the blood). Resident 42 was cognitively intact and required dialysis (a way of ridding the body of waste when the kidneys do not function.) The 12/01/2023 care plan documented Resident 42 received dialysis every Monday, Wednesday and Friday at 2:00 PM. Staff were instructed to administer medications according to the dialysis center recommendations, coordinate care with the dialysis center and physician, and ensure medication and eating times were adjusted to accommodate dialysis sessions. A review of the June 2024 Medication Administration Record (MAR) documented medication orders and omissions: -Levetiracetam 250 milligrams (mg) in the morning for seizures. Entries on the MAR on 06/04/2024, 06/10/2024, and 06/13/2024 had a code 8 entered. The code key documented a code 8 instructed one to see progress notes. The corresponding progress notes showed the levetiracetam was waiting for delivery, or unavailable. -Levetiracetam 250mg by mouth in the evening every Monday, Wednesday and Friday for seizures, give after dialysis. The entries on the MAR for 06/03/2024, 06/10/2024, 06/12/2024, 06/14/2024, 06/17/2024, 06/21/2024, and 06/24/2024 were not given and had a code 3 entered. The code key documented a code 3 indicated the resident was absent from the facility without their medications. The dates and times of the omissions corresponded with times Resident 42 was at their dialysis appointment. -On 06/20/2024, a new order was entered to change the levetiracetam administration times to every 12 hours, at 9:00 AM and 9:00 PM. On 06/21/2024, 06/22/2024, 06/23/2024 for the PM dose, and the 06/23/2024 AM dose, a code 8 was entered on the MAR. The corresponding progress notes documented the medication was on order from the pharmacy and not available. -Advair discus 500-50 micrograms (mcg) per dose, one puff inhaled twice a day for asthma. On 06/12/2024, 06/13/2024 and 06/26/2024, the morning doses had a code 8 entered; the medication was unavailable. On 06/12/2024, 06/14/2024, and 06/21/2024, the evening doses had code 3, out of facility without medications. These doses corresponded with the dates and times Resident 42 was their dialysis treatment. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Erythromycin 250mg twice a day at 12:00 PM and 5:00 PM before meals for gastroparesis (delayed stomach emptying). Resident 42 missed the 5:00 PM doses 06/03/2024, 06/10/2024, 06/12/2024, 06/14/2024, 06/17/2024, and 06/21/2024. A code 3 was entered on the MAR. The missed doses corresponded with dates and times Resident 42 was at their dialysis appointment. -Guaifenesin extended release 600mg (helps clear chest congestion) twice daily at 6:00 AM and 4:00 PM. Resident 42 missed 4:00 PM doses on 06/03/2024, 06/05/2024, 06/10/2024, 06/12/2024, 06/14/2024, 06/17/2024, 06/19/2024, 06/21/2024, and 06/24/2024. A code 3 was entered on the MAR. The missed doses corresponded with dates and times Resident 42 was at their dialysis appointment. On the same dates, 06/03/2024, 06/05/2024, 06/10/2024, 06/12/2024, 06/14/2024, 06/17/2024, 06/19/2024, 06/21/2024, and 06/24/2024, Resident 42 missed evening doses of the following medications: -Probiotic supplement, one capsule at dinner, -hydralazine 25mg for high blood pressure, -sevelamer 1600mg to prevent phosphorous build-up in the blood, and -calcium carbonate 1000mg for indigestion. A code 3 was entered on the MAR. The missed doses corresponded with dates and times Resident 42 was at their dialysis appointment. During an interview on 06/26/2024 at 2:08 PM, Staff CC, Medication Technician, stated when a resident's medications were not present in the resident's section of the medication cart, Staff CC checked the bottom drawer of the cart. This drawer contained overflow of medications. If not in the overflow, they notified the nurse and the nurse checked to see if the medication was in the pyxis (a locked cart in the medication room that contained extra doses of commonly prescribed medications). If not in the pyxis, they checked to see if the medicine had been ordered from the pharmacy. At times, they would have to order the medication three times before it was received, or they would attempt to call the pharmacy, but the pharmacy did not answer. On 06/26/2024 at 2:26 PM, the pyxis was observed with Staff I, Resident Care Manager. A list of medications contained in the pyxis was also observed. The list was undated, and Staff I stated they were not certain when the pyxis inventory had been reviewed and updated by the pharmacy. The levetiracetam was on the list of medications contained in the pyxis. Staff I stated it was possible the pyxis had run out of the levetiracetam for Resident 42. The pharmacy was called almost daily regarding the resident's levetiracetam. Staff I also stated when residents were gone to dialysis, medications were not sent with them. They just missed a dose. Staff I stated they had never thought about talking with the providers about changing the administration times. Staff I stated if residents missed doses of their medications, they could possibly have a bad outcome. <Resident 36> A 06/15/2024 quarterly assessment documented Resident 36 had diagnoses including end-stage kidney disease, high blood pressure and diabetes. Resident 36 was cognitively intact and required dialysis. (continued on next page)

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F 0760

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

The 03/11/2024 care plan documented Resident 36 received dialysis every Tuesday, Thursday and Saturday at 4:30 PM. Staff were instructed to administer medications according to the dialysis center recommendations, coordinate care with the dialysis center and physician, and ensure medication and eating times were adjusted to accommodate dialysis sessions.

A review of the June 2024 MAR showed Resident 36 missed evening doses of the following medications on 06/01/2024, 06/04/2024, 06/06/2024, 06/11/2024, 06/15/2024, and 06/25/2025:

-Acetaminophen 650mg for pain

-atorvastatin 60mg for high cholesterol

-apixaban 2.5mg for a blood thinner

-ferrous gluconate 324mg for iron supplement

-gabapentin 300mg for amputation pain

-sevelamer 1600mg to prevent phosphorous build-up in the blood, and

-hydralazine 75mg for high blood pressure.

Additional doses of hydralazine were also missed on 06/08/2024, 06/13/2024, 06/18/2024, 06/20/2024 and 06/22/2024. A code 3 was entered on the MAR: the resident was out of the facility without their medications. The missed doses corresponded to dates and times Resident 36 was at their dialysis appointment.

<Resident 80>

A 05/30/2024 admission assessment documented Resident 80 had diagnoses including low back pain and bipolar depression (mental health condition that causes extreme mood swings). Resident 80 was cognitively intact.

A review of the June 2024 nursing progress notes documented that on 06/04/2024 at 4:21 PM, Resident 80 returned from an appointment with an oral surgeon after having all of their teeth removed. The Resident Care Manager (RCM) called the oral surgeon's clinic and requested any follow-up instructions and that the clinic physician order any medications through the facility's pharmacy. On 06/07/2024 at 9:22 AM, the facility had not received amoxicillin, an antibiotic to prevent infection, ordered after the teeth were removed. At 10:04 AM, the order for amoxicillin was received and the initial dose was obtained from the facility's emergency kit while waiting for the remaining tablets to be delivered from the pharmacy.

A review of the June 2024 MAR documented Resident 80 received the first dose of amoxicillin on 06/07/2024 at 3:00 PM, three days after the oral surgery was completed.

During an interview on 06/17/2024 at 10:43 AM, Resident 80 stated they had recently been to the dentist and had all their teeth pulled. They were supposed to start an antibiotic after, and it took the facility 3-4 days to get the antibiotic. The procedure was painful according to Resident 80.

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/26/2024 at 10:44 AM, Staff AA, Licensed Practical Nurse, stated if a resident came back from an appointment outside of the facility and had printed, signed orders, they would enter the orders to the electronic medical record to be carried out. If none were returned from the appointment, the RCM called the clinic to obtain the orders or a visit summary. If the providers did not return calls, they would continue to reach out to get the orders. Staff AA stated they played phone tag with Resident 80's oral surgeon office, and the antibiotic was eventually prescribed. Staff AA stated the antibiotics should have been started immediately after the teeth were extracted to prevent an infection and they could have reached out to the facility's provider for an order. During an interview on 06/26/2024 at 12:16 PM, Staff B, Director of Nursing, stated it was important for Resident 80's antibiotic to be started right away to prevent infection. Staff B stated staff had attempted to get the necessary paperwork from the dental clinic but were also able to reach out to the facility providers if orders were needed right away. Reference: WAC 388-97-1060(3)(k)(iii)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45117 Based on observation and interview, the facility failed to ensure controlled medications were properly stored in 1 of 2 medication storage rooms (North Medication Room), and expired medications were removed from 1 of 2 medication rooms (South Medication Room) and 1 of 2 medication carts (North Medication Cart), reviewed for medication storage. These failures placed the residents at risk for receiving medications with decreased efficacy and increased the risk for diversion of controlled substances. Findings included . Review of a facility policy titled, Controlled Medication Storage, dated 01/2023, showed that medications included in the Drug Enforcement Administration classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility in accordance with federal, state, and other applicable laws and regulations. Only authorized licensed nursing and pharmacy personnel have access to controlled medications. Controlled medication requiring refrigeration are stored within a locked, permanently affixed box within the refrigerator. During an observation on 06/21/2024 at 8:05 AM, the South Medication Room medication storage refrigerator contained a Levemir (long acting) Flex Touch insulin pen that had a yellow pharmacy label with an expiration date of 03/08/2025. The manufacturer label showed an expiration date of 11/2023. During an observation on 06/21/2024 at 10:59 AM, the medication refrigerator in the North Medication Room had a lock that was not engaged. There was an emergency kit in the refrigerator that had a red tag lock that had been broken and was partially removed. The emergency kit contained four vials of Lorazepam (a schedule IV-controlled substance used to treat anxiety and seizure disorders), and two 30 milliliter bottles of Lorazepam oral solution. The schedule IV-controlled substances were not secured as required. During an observation on 06/21/2024 at 11:08 AM, the North Medication Cart contained a bottle of Acetaminophen (a pain reliever and fever reducer) Rapid Release Gel capsules that contained half of the capsules and had an expiration date of 04/2024. There was a bottle of Vitamin B-12 tablets, two thirds full, that had an expiration dated of 05/2024. There was an oblong, white tablet in an unlabeled medication cup in the top drawer of the medication cart, and a round, white tablet in the bottom of the drawer of the medication cart. During an interview on 06/21/2024 at 11:06 AM, Staff Z, Licensed Practical Nurse, stated the emergency kit was normally locked with the red tag and the refrigerator was also normally locked. They stated staff checked expiration dates on the insulin in the emergency kit on 06/20/2024 and probably didn't put a lock back on. Staff Z stated all of the medication nurses were responsible for looking at expiration dates on the medications and removing them from the cart when they were expired. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/21/2024 at 11:47 AM, Staff B, Director of Nursing Services, stated if the staff broke into the emergency kit, either the red tag lock should have been replaced or the refrigerator should have been locked to properly secure the controlled substances. Staff B stated the process was to ensure the emergency kit was double locked. Additionally, Staff B stated the expired medications should have been taken off the medication cart. Reference: WAC 388-97-1300(2), 388-97-2340

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F 0791 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide or obtain dental services for each resident. 46115 Based on interview, and record review, the facility failed to schedule a dental appointment for 1 of 1 sampled resident (Resident 59), reviewed for dental services. Resident experienced on-going mouth pain when there was a delay in coordination of a dental extractions appointment. This failed practice placed residents at risk of diminished quality of life. Findings included . Review of 03/20/2024 quarterly assessment, Resident 59 was cognitively intact, able to make decisions regarding their care, and had diagnoses which included cavities. Review of dental care plan, dated 01/02/2024, documented Resident 59 had broken teeth and instructed nursing staff to coordinate arrangements for dental care. Review of a dental visit note, dated 05/15/2024, documented Resident 59 requested to have all their teeth extracted because they experienced pain. In addition, the dentist documented the resident had several teeth extracted during that visit due to the pain and a referral was made to have the remaining teeth extracted. Further review of the resident's record found no documentation that the referral had been done, nor was there any documentation to show the resident's remaining teeth had been extracted. Review of a progress note, dated 06/05/2024 at 4:18 PM, documented Resident 59's bottom row of their teeth were breaking and causing pain. During an interview on 06/18/2024 at 2:15 PM, Resident 59 stated they had mentioned to Staff I, Resident Care Manager, and Staff J, Transportation Staff, about a month ago they needed a dental appointment set up to have their teeth extracted by a surgeon. During a follow up interview on 06/20/2024 at 9:41 AM, Resident 59 stated their teeth caused them constant pain. The resident rated their pain a 10 on a scale of 1-10 (1 being mild and 10 being severe pain). During an interview on 06/21/2024 at 9:48 AM, Resident 59 stated their pain was a 10 the night before and was currently a 6. In a subsequent interview at 1:53 PM, Resident 59 stated their pain remained a six and a dental appointment still had not been made. In an interview on 06/25/2024 at 2:20 PM, Staff J stated they were responsible to make appointments and arrange the transportation when a resident had an outside provider appointment. When asked if an appointment had been made for Resident 59 to have their teeth extracted, Staff J stated they had been notified by Staff I that the resident had dental pain and an appointment needed to be made, but it appeared to have been missed. In an interview on 06/25/2024 at 2:26 PM, Staff I stated if an appointment had been made for Resident 59 to have had their teeth extracted, they would not have had the mouth pain and Staff I acknowledged that Resident 59 the pain. (continued on next page)

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F 0791 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 06/25/2024 at 2:37 PM, Staff B, Director of Nursing, confirmed Resident 59 should have had a dental appointment made. Reference: WAC 388-97-1060 (3)(j)(vii)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 42802 Based on interview and record review, the facility failed to ensure the Dietary Manager had the required credentials. This failure placed all resident at risk for receiving dietary services that did not provide the necesary nutritional requirements and foods prepared according to industry standards. Findings included . During an interview on 06/26/2024 at 3:42 PM, Staff H, Dietary Manager, stated that they did not have a Food Service Manager certification, and had planned to take the class. During an interview on 06/27/2024 at 10:00 AM, Staff K, Registered Dietician (RD), stated that they were at this facility only part-time. During an interview on 06 27/2024 at 3:19 PM, Staff A, Executive Director and Staff B, Director of Nursing acknowledged that since the RD was not full-time, Staff H did not have the required certification to meet the regulation. Reference: WAC 388-97-1160(1)

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F 0804

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.

45117

Based on observation, interview, and record review, the facility failed to provide palatable, attractive meals at a safe and appetizing temperature for 6 of 8 sampled residents (1, 9, 26, 42, 47, 338) reviewed for food. These failures placed the residents at risk for unplanned weight loss and dissatisfaction with their dining experiences.

Findings included .

Review of a policy titled, Food Preferences, dated 08/2023, showed upon admission, quarterly and as needed, the food and nutrition services manager, or designee, will interview the resident for the following information using a Food Preferences Interview form:

Likes/dislikes, intolerances, food allergies;

Cultural and/or religious preferences;

Preferred dining location;

Preferred mealtime;

Beverage preferences.

The food preferences information would be kept on file in the food and nutrition department for six months and would be used to ensure each resident's needs and desires for food were met.

<Resident 1>

Review of the medical record showed Resident 1 had diagnoses including rheumatoid arthritis (inflammation affecting small joints in the hands and feet), fibromyalgia (involves widespread body pain and fatigue), and depression. The 06/14/2024 comprehensive assessment showed Resident 1 was cognitively intact and required no assistance with eating.

<Resident 9>

Review of the medical record showed Resident 9 had diagnoses including Parkinsonism (a movement disorder that can occur as a side effect of certain types of medication), chronic pain, and anxiety. The 04/09/2024 comprehensive assessment showed Resident 9 was cognitively intact and required setup/clean-up assistance of one staff member for eating.

<Resident 26>

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record showed Resident 26 had diagnoses including peripheral vascular disease (PVD, narrowed blood vessels that reduce blood flow to the extremities), diabetes and depression. The 04/08/2024 comprehensive assessment showed Resident 26 was cognitively intact and required maximum assistance/dependent on one to two staff members for activities of daily living (ADLs); setup/clean-up assistance for eating. <Resident 42> Review of the medical record showed Resident 42 had diagnoses including end stage renal disease (loss of kidney function), diabetes, and heart disease. The 06/09/2024 comprehensive assessment showed Resident 42 was cognitively intact and required no staff assistance for ADLs. <Resident 47> Review of the medical record showed Resident 47 had diagnoses including Crohn's disease (inflammatory bowel disease that affects the lining of the digestive tract) and adult failure to thrive. The 04/12/2024 comprehensive assessment showed Resident 47 was cognitively intact and was independent with ADLs. <Resident 338> Review of the medical record showed Resident 338 had diagnoses including kidney failure and adult failure to thrive. The 06/19/2024 comprehensive assessment showed Resident 338 was cognitively intact and required supervision of one staff member for ADLs. During an interview on 06/18/2024 at 10:05 AM, Resident 26 stated fresh fruits and vegetables were rare, canned fruits and vegetables were all they were served, and the food was lukewarm. Resident 26 stated the kitchen no longer served bananas. During an interview on 06/18/2024 at 9:47 AM, Resident 47 stated they were not happy with their meals. They stated the menu did not always reflect what was served and the food was not hot. During a Resident Council (a group of residents that met regularly to improve the quality of life and care in the nursing home) meeting on 06/25/2024 from 2:00 PM until 3:00 PM, the residents voiced the following concerns in regard to the food at the facility: Resident 1 stated the food was cold. They stated the plate warmer was broken. Resident 42 stated they did not get regularly scheduled dinner meals and the facility would not hold a tray for them. They stated the food was always cold. Resident 47 stated the kitchen served cold food and would not reheat it. Resident 338 stated they were served a cold hamburger on 06/24/2024, had asked for spaghetti and was told they ran out and was offered a peanut butter and jelly sandwich for dinner. They stated the food was served cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/26/2024 at 10:16 AM, Resident 9 stated the facility served the same food all the time and the food was not always hot. During an interview on 06/25/2024 at 3:40 PM, Resident 42 stated they were recently served a burger that was congealed grease. They stated the facility would not heat up food for the residents. Resident 42 stated they were told reheating food was against the law. During an interview on 06/26/2024 at 10:20 AM, Resident 1 stated the food had been served cold since May when the plate warmer broke. They stated the kitchen staff would not reheat the food, the residents just have to eat the cold food and that makes me not very happy. Resident 1 stated they did not have substitutions for meals unless the substitution was requested the day before. They stated there was no flavor to the food and they had been eating a peanut butter and jelly sandwich for every lunch and dinner meal since the plate warmer broke. Resident 1 stated they had to practically beg for fresh fruit. They stated they attended monthly food committee meetings, made suggestions on what they would like to have, but no changes were made. They stated they were rarely served salads, the last salad had slimy lettuce with vegetables on top. Resident 1 stated they were gaining weight because of all of the sandwiches they were eating. During an interview on 06/24/2024 at 10:35 AM, Staff H, Dietary Manager, stated the plate warmer broke, and they were having issues getting the pellets for the new warmer from the supplier. Staff H stated they were not allowed to reheat food for the residents. They stated once food left the kitchen, they could not reheat it due to cross contamination issues. Staff H stated they were unable to order all of the ingredients necessary to make the recipes on the menus. They stated they were locked out of ordering some of food items on the supplier's website for budgetary reasons. During an interview on 06/25/2024 at 2:28 PM, Staff A, Executive Director, stated they were not aware of the resident's food concerns. They stated they had a few complaints that the food was cold and that was because the pellet warmer was no longer working. Staff A stated the menus were based off the food supplier rotation and they made edits to the menu here and there. They stated they did have the ability to buy local and could get fresh fruits in an emergency. During a follow up interview on 06/26/2024 at 2:21 PM, Staff A stated they had fruit now and would get it weekly. Reference: WAC 388-97-1100(1)(2)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 45117 Based on interview and record review, the facility failed to provide at least three meals daily for 1 of 1 sampled residents (42), reviewed for frequency of meals. Specifically, Resident 42 attended outside medical appointments every Monday, Wednesday and Friday and did not return to the facility for the regularly scheduled evening meal. This failure placed the resident at risk for unplanned weight loss, and nutritional deficits. Findings included . <Resident 42> Review of the medical record showed Resident 42 had diagnoses including end stage renal disease (loss of kidneys function), diabetes, and heart disease. The 06/09/2024 comprehensive assessment showed Resident 42 was cognitively intact and required no staff assistance for ADLs. During an interview on 06/25/2024 at 3:40 PM, Resident 42 stated they had repeatedly asked the facility to hold their evening meal on Mondays, Wednesdays and Fridays because they did not return from their dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) appointments until 6:45 to 7:00 PM. Resident 42 stated since their admission to the facility, the kitchen staff had only held their meal one time. Resident 42 stated that if there was no food waiting for them when they returned from dialysis I just go hungry. Resident 42 stated the facility sent a sack lunch with them to their dialysis appointments that consisted of a cheese sandwich, a graham cracker, and a small container of juice. They stated they did not always get to eat a hot lunch before leaving for dialysis at 12:00 PM (on their dialysis days) and usually ate the sack lunch when they got to the dialysis center. They stated once they ate the sack lunch, they did not receive another meal until breakfast the next morning. During an interview on 06/26/2024 at 10:35 AM, Staff H, Dietary Manager, stated the process for meals when a resident was going to be out of the building at normal mealtimes included sending a sack lunch with the resident. They stated for Resident 42, they typically returned to the facility at 7:00 PM on Mondays, Wednesdays and Fridays. Staff H stated they sent a sack lunch with Resident 42 on their dialysis days and were not holding an evening meal for them as they should. Staff H stated, I think it was my fault, I didn't communicate with the kitchen staff to hold a meal (for Resident 42). During an interview on 06/27/2024 at 9:27 AM, Staff A, Executive Director, stated Resident 42 usually took a meal with them to dialysis. They stated they were unsure if the kitchen staff were holding a meal for Resident 42, but the process would be that the kitchen staff held a hot meal for residents that were not in the facility at the regularly scheduled mealtimes. Reference: WAC 388-97-1120(1)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42802 Based on observation, interview and record review, the facility failed to communicate with the hospice provider about bathing services for 1 of 1 sampled residents (Resident 15), reviewed for Hospice services. Specifically, Resident 15 did not receive a shower or sponge bath from either the Hospice or facility staff for over 7 weeks, due to a scheduling error. This failed practice placed the resident at risk for skin breakdown and decreased quality of life. Findings included . According to a quarterly assessment dated [DATE], Resident 15 had diagnoses that included dementia, failure to thrive (a syndrome of overall decline) and had severe cognitive impairment. The resident required maximum assistance with repositioning and personal hygiene and was was totally dependent on staff for bathing and toileting. Brief observations of the resident in bed were made on 06/17/2024 at 3:17 PM, 06/18/2024 at 2:38 PM and 06/20/2024 at 8:44 AM and 3:36 PM. Resident 15 was resting quietly without distress and/or odor. According to the Electronic Medical Record (EMR), Resident 15 was discharged on [DATE]. A review of the residents record showed that a change of condition assessment was completed on 03/18/2024, when hospice services were added. The undated North Hall Shower book documented the resident was scheduled for showers on Tuesdays and Fridays by hospice. According to Hospice Interdisciplinary Team Meeting Notes, dated 04/04/2024, 05/16/2024 and 05/30/2024, the Hospice Nursing Assistant (HNA) was scheduled for bathing assistance twice a week. The most recent bathing note from the hospice was dated 05/06/2024. According to the facility (paper) shower log from 04/06/2024 through 06/21/2022, Resident 15 did not have a shower documented. According to the EMR, from 04/26/2024 to 05/25/2024 there were no showers documented. During an interview on 06/25/2024 at 10:18 AM, Staff Q, Nursing Assistant (NA), stated that resident showers were documented in the computer and in the shower book. They further stated that if there were gaps in the computer, the paper shower log would be the most complete. During an interview on 06/26/2024 at 1:58 PM, Staff R, NA, stated that hospice was giving Resident 15 their bath. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note from hospice, dated 06/26/2024, documented that they had mistakenly cancelled Resident 15's bath aide, due to another resident with a similar name. The note confirmed that the last bath from hospice staff was given on 05/06/2024. During an interview on 06/26/2024 at 2:41 PM, Staff S, Resident Care Manager, stated they had confirmed with hospice that the resident's last visit for a bath was on 05/06/2024, over 7 weeks earlier, and that the facility had not bathed the resident during that time either. Staff S further stated that the failure was on the facility because they were ultimately responsible for Resident 15's care. During an interview on 06/27/20 at 3:19 PM, Staff A, Executive Director and Staff B, Director of Nursing, acknowledged that the facility had not ensured that Resident 15 received adequate bathing and grooming. No associated WAC

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on observation, interview and record review, the facility failed to ensure hand hygiene was performed when indicated for 1 of 1 residents (Resident 78) during a medication pass observation, and enhanced barrier precautions (EBP) were implemented for 2 of 4 sampled residents (Residents 12 and 17) reviewed for infection control. Specifically, Resident 12 had a history of antibiotic resistance and had weeping leg wounds and was not on EBP, and staff did not implement EBP during wound care of a pressure ulcer for Resident 17. Also, the facility failed to develop, implement and review a water management plan. These failures placed residents at risk for transmission of disease, antibiotic resistance, water-borne infections, and unintended health consequences. Findings included . Per the CDC (Center for Disease Control), Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Review of the policy titled, Handwashing/Hand Hygiene, revised 08/2019, showed staff would follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Staff would perform hand hygiene before preparing or handling medications and after contact with a resident's skin. Further review showed staff would wear single-use disposable gloves when anticipating contact with blood or bodily fluids. <Resident 78> Review of the 05/31/2024 comprehensive admission assessment showed Resident 78 had a diagnosis of diabetes (a group of diseases that result in too much sugar in the blood) and required moderate to substantial assistance of one staff member for ADLs. During an observation on 06/21/2024 at 11:33 AM, Staff F, Infection Preventionist/Registered Nurse approached the South Medication cart. Staff F, without performing hand hygiene, obtained an insulin pen, alcohol swab, and disposable needle from the medication cart. They placed the disposable needle on the tip of the insulin pen. They proceeded to Resident 78's room, and without performing hand hygiene or putting on gloves, raised Resident 78's shirt to expose their abdomen, wiped the injection site with the alcohol swab, injected the insulin into their abdomen, and pulled their shirt back down. Staff F removed the disposable needle from the insulin pen and carried it to the South Nurse's station. Staff F stated there was no place to dispose of the sharps in the resident room, then crossed the hall and disposed of the needle in the sharp's container on the South Medication cart. Staff F used hand sanitizer at the medication cart. During an interview on 06/26/2024 at 2:12 PM, Staff B, Director of Nursing Services, stated they expected staff to wear gloves and perform hand hygiene when administering insulin to a resident. 46033 (continued on next page)

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 06/27/2024
NAME OF PROVIDER OR SUPPLIER: Aurora Valley Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 414 S University Rd Spokane, WA 99206	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 12> A 04/08/2024 comprehensive admission assessment documented Resident 12 had diagnoses including prediabetes and stroke. The resident was mildly impaired cognitively, required partial assistance with most activities of daily living (ADLs), and had no diagnosis of having a multi-drug resistant organism (MDRO, bacteria that no longer respond to antibiotics.) The 04/01/2024 care plan documented Resident 12 was colonized with MRSA (methicillin-resistant Staphylococcus aureus, a staph infection not killed by many commonly used antibiotics. When colonized, one has MRSA on their skin or mucous membranes, but no active infection.) Staff were instructed to educate regarding importance of handwashing, wash hands immediately after ADLs, care tasks and activities, and monitor/report/notify the provider of signs of infection-inflammation around wound, or drainage. A skin assessment completed on 04/01/2024 on admission documented Resident 12 had areas on both upper arms and lower legs described as red and dry with self-scratching. A 04/02/2024 Nurse Practitioner progress note documented that the skin on both lower legs had wounds and scratches that appeared to be caused by the resident scratching with their nails and these appeared to be healing well. The skin had mild swelling and redness and the resident stated they had MRSA on both lower legs. During an interview on 06/17/2024 at 2:11 PM, Resident 12 stated they had MRSA and wondered what was being done for it. They stated they were going to have surgery in the future on their hip but were told they would not have the surgery until the MRSA was gone. The entrance to the resident's room did not have any signage to indicate the resident required enhanced barrier precautions to be implemented, nor a bin that contained personal protective equipment such as disposable gowns or gloves to don. On 06/20/2024 at 3:19 PM, Resident 12 was observed lying nude on their bed, which was their preference. Their midsection was covered with the corner of their sheet and their lower legs were exposed. Resident 12 was wearing two pairs of stockings. The first pair was white and went to the knee. Over those was a second pair of yellow non-skid socks that went up to the ankles. Both pairs were soiled and the white socks had rings of dried brownish/pink stains and other rings that were a straw yellow color. Resident 12 asked again about the status of their MRSA and stated their legs bled from it. The resident appeared to be wearing the same stockings or similar stockings that were also stained with drainage on 06/21/2024 at 9:19 AM and on 06/24/2024 at 9:44 AM. During an interview on 06/25/24 at 3:09 PM, Staff J, Transportation/Central Supply, stated Resident 12 had an appointment with the Infectious Disease provider on 05/03/2024. A copy of the visit progress note was requested. On 06/26/2024 at 8:46 AM, Staff B, Director of Nursing, stated there was no Infectious Disease progress note. Resident 12 had not gone to the appointment on 05/03/2024, and Staff B was uncertain why. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/27/2024 at 4:54 PM, Staff B stated the Infection Control nurse determined which residents were to be placed on enhanced barrier precautions. Resident 12 had draining wounds so should have been on EBP. 47728 <Resident 17> Per the assessment dated [DATE], Resident 17 was cognitively impaired, was dependent on staff for all activities of daily living such as positioning and personal care, and had diagnoses including pressure sores (injuries to the skin and the tissue below the skin that are due to pressure on the skin for a long time), and dementia. Review of Resident 17's record, documented the resident was on enhanced barrier precautions related to having wounds. Enhanced barrier precautions (EBP) required staff to wear PPE (personal protective equipment, such as gowns and gloves) when providing cares such as positioning, personal care, and wound care for the resident. On the wall beside the door going into the resident's room, an enhanced barrier precaution sign was present that instructed staff what PPE was required. During an observation and interview on 06/27/2024 at 11:01AM, Staff EE, Registered Nurse and Staff FF, nursing assistant (NA), provided personal care for Resident 17 including perineal care (cleaning of the area of the body that surrounds a person's genitals and anal area), wound care, and repositioned the resident multiple times in the bed. Neither Staff EE nor Staff FF were wearing the required PPE as instructed on the sign. When asked if the resident was on EBP Staff FF stated they were not aware of the resident's EBP status. When asked when EBP are needed, Staff EE stated when a resident had a urinary catheter, IV, or had bacterial infection resistant to many antibiotics. Staff EE stated Resident 17 didn't have any of those things and didn't need to be on EBP. In an interview on 06/27/2024 at 11:38AM when asked why Resident 17 had an EBP sign outside their room door, Staff GG and Staff FF, NAs, both stated they were not sure. When asked if EBP were supposed to be followed during wound care, Staff FF stated probably. In an interview on 06/27/2024 at 11:40AM Staff I, Resident Care Manager, stated the EBP sign was because of Resident 17's wounds and staff should have been using PPE during personal care and wound care for Resident 17, and they had received previous training regarding when to use EBP. <WaterManagement Plan> A review of the facility's undated Water Management Plan (in a white binder) had a signature page that was signed by an Administrator, Director of Nursing and Maintenance Assistant that were no longer employed at the facility. The plan documented the facility used a water test kit to test different parts of the building monthly. Water temperatures were logged, but the specific rooms, pipes, and locations the temperatures were monitored were not listed. (continued on next page)

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	505114	A. Building B. Wing	06/27/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/26/2024 at 3:32 PM, Staff HH, Director of Maintenance, was asked for the monthly water testing results. Staff HH pointed to boxes of test kits on a shelf. He was unable to locate the test results log and asked Staff II, Maintenance Assistant to join the interview. When asked who was on their Water Management team, Staff HH stated it used to be him, the Administrator, Staff II, the Food Service Manager and the Housekeeping Manager. Staff HH stated the plan was about to be reviewed and was uncertain when it had been reviewed last. When asked how they would know if a resident was ill with Legionella, Staff HH stated, Believe me, it would be known. But it will never happen. This is all just a bunch of [NAME] anyhow. During an interview on 06/26/2024 at 3:40 PM, Staff II stated they did not keep a log of their water test results. They stated they kept the actual test in the test kit box and dated the box. Staff II stated one would not be able to tell what the results of the test were because they were not valid after sitting for 24 hours. They stated if they had a positive result, they were to notify the Administrator. Staff II stated if there was a positive water test result, they would just give the local health department (LHD) the actual positive test kit. When observed, the water test kit boxes that were saved did not list where in the facility the water test sample was collected. The water test kit manufacturer's instruction/information insert reviewed on 06/26/2024 at 4:00 PM documented in the first paragraph that the kit was a convenient screening test but did not replace water testing through an accredited laboratory. During an interview on 06/27/2024 at 5:07 PM, Staff A, Administrator, stated Staff HH was responsible for maintaining the facility's Water Management Plan, and expected them to manage that plan according to the guidelines. Reference: WAC 388-97-1320 (2)(a)