

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2024
NAME OF PROVIDER OR SUPPLIER  Alderwood Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  3600 East Hartson Avenue Spokane, WA 99202	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>27590</p> <p>Based on observation, interview, and record review, the facility failed to ensure prompt efforts were made to resolve grievances for 8 out of 9 residents (Resident 1, 2, 3, 4, 5, 6, 8, and 9) related to not honoring residents food choices and not following resident meal cards (cards that show likes, dislikes, allergies, and fluids to be served). Failure to promptly resolve grievances resulted in on-going dietary complaints from residents and a diminished quality of life.</p> <p>Findings included .</p> <p>&lt;Resident interviews&gt;</p> <p>On 05/29/2024 at 1:00 PM, Resident 1 stated they attended the food committee monthly and residents had been told they don't fill out menus correctly and that was why they didn't get the food they ordered. Resident 1 stated they were served food they hadn't circled on the menu and was often served their dislikes. The resident stated kitchen management told the committee changes would be made and it didn't happen.</p> <p>On 05/29/2024 at 1:14 PM, Resident 8 stated the food wasn't good. The resident stated it didn't matter what was filled out on the menu, the kitchen didn't serve it and would argue with you. Resident 8 went to the food committee meetings and they were told how the menu should be filled out and it would be correct going forward, it didn't get fixed. Resident 8 stated the committee had a meeting with Staff D, Administrator. The kitchen doesn't go off [Resident] preferences. Nothing is getting done. Resident 8 stated they resorted to buying their own food.</p> <p>On 06/12/2024 at 10:25 AM, Resident 4 stated the taste of the food had gotten better. The resident stated they didn't fill out a menu and was just served the meal for the day. Resident 4 stated if they rejected the food served, staff would get rude. Resident 4 stated they would become ill if they ate cucumbers and on a couple of occasions received them. I just pick them out of the food. The resident's food card was on their bedside table and reviewed. Under allergies it had cucumbers.</p> <p>On 06/12/2024 at 11:30 AM, Resident 6 stated they ate soft food because they had no top teeth. Most meals are terrible. Resident 6 stated they would fill out a menu sometimes but the kitchen didn't go by what they wrote down.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 06/12/2024 at 12:35 PM, Resident 9 was laying in bed eating a packaged protein bar. Resident 9 stated the food had too many carbohydrates and not enough protein, so they ate the food they bought. Resident 9 stated the facility had menus you filled out but you don't always get the items you circled.</p> <p>On 06/12/2024 at 1:25 PM, Resident 5 was in their room in a wheel chair. Resident 5 stated they went to the food committee monthly but the suggestions the residents made didn't happen or if it did happen it took forever. Resident 5 received menus and they would chose their meal but you don't get it. Resident 5 stated they were told the cooks didn't read the menus.</p> <p>On 06/12/2024 at 12:10 PM, Resident 3 was in their wheel chair in their room. Resident 3 stated the items they circled on the menu was not served. Resident 3 stated they required protein drinks and they were to be served from the kitchen for two of their meals. Resident 3 stated they maybe got it once a week. When Resident 3 asked the kitchen staff, they told the resident it was back ordered. At 12:25 PM, Resident 3 had been served their meal. The resident's meal card had sugar free health shake and ice tea under liquids, neither were on the tray.</p> <p>&lt;Resident Grievances&gt;</p> <p>Review of the facility grievances showed the following grievances related to food:</p> <p>On 04/05/2024 an anonymous reporter wrote a concern the residents were not getting the food they requested from their menu. The reporter felt the kitchen was not reading the menus and many residents felt the same as them. The response by Staff E, Dietary Manager, was residents that had orders for easy to chew food couldn't get salads. Staff E had educated cooks to talk with residents to find out what foods they wanted.</p> <p>On 04/30/2024 Resident 2 reported they did not get the items they had ordered. Resident 2 wrote it was an ongoing issue, not getting what they ordered, and when the resident called the kitchen, they would get the food after their tray had sat and was cold. The written response to the grievance, by Staff E, was staff were educated to pay more attention to the meal tickets.</p> <p>On 05/07/2024 during resident council, Staff F, Activities Director, had filled out a grievance that stated residents were frustrated that topics discussed in food committee did not result in any resolution. Staff D wrote under investigation steps things were not fixed, residents and staff were still confused about filling out menus. The response was to educate staff to pay attention to everyone's tickets.</p> <p>&lt;Food Committee&gt;</p> <p>The following were notes from the food committee:</p> <p>On 03/05/2024, only those that attended the meeting was documented.</p> <p>On 04/09/2024, less eggs was written.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/8/2024, residents were concerned with menus and wanted to know why residents needed to write their dislikes on the menu when the kitchen had that information. In addition, residents had issues with not getting food items they ordered. Staff E documented it was explained to residents cooks don't have time to look everyone's dislikes up, when residents ordered specialized food, and it would be helpful for residents to write their dislikes on the menu.</p> <p>During an interview on 06/12/2024 at 1:44 PM, Staff E stated when a resident admitted to the facility, activities staff asked resident likes/dislikes. Staff E stated residents would fill out a menu each week. If a resident didn't fill one out, the cooks would go off their likes/dislikes list for that meal. Staff E stated the process to serve food was for the kitchen aides to call off the residents diet, which was on a meal card, and the cook would plate the food. Staff E stated there was a food committee that met monthly. In March and April Staff E was not able to attend and their assistant was not very detailed on the notes. Residents had concerns related to the menu process. Residents didn't understand if an item was ordered that wasn't on the menu, such as chef salad, the resident needed to write on the menu what they didn't like and that item would be left off. Staff E stated the cooks shouldn't have to search for each residents dislikes. Staff E stated the cooks were more familiar with residents food allergies rather than resident dislikes. For Resident 4, being served food they were allergic to, it was looked into because it happened on two different occasions. They found the resident was served the wrong meal tray and that was why the food they were allergic to was on it.</p> <p>During an interview on 06/12/2024 at 2:24 PM, Staff E, Activities Director (AD), stated they attended the resident council meetings and the food committee, which was immediately after. Staff E stated if there was a concern brought up, they would fill out grievance cards and give them to Social Services. Staff E stated the residents don't feel the food issue had been resolved. The residents had concerns with not getting what they wanted and the kitchen not paying attention to their dislikes.</p> <p>On 06/12/2024 at 3:00 PM, Staff D stated they had been brought into the food committee in May. The residents were frustrated about the menus and filling them out. Residents felt the staff were not reading their meal cards. Staff D confirmed the food concerns had not been resolved.</p> <p>Reference: WAC 388-97-0460</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>27590</p> <p>Based on interview and record review, the facility failed to thoroughly investigate allegations of abuse and/or neglect for 4 of 6 residents (Resident 4, 5, 6, and 7), reviewed for abuse and/or neglect. This failure placed residents at risk for further abuse and/or neglect and a diminished quality of life.</p> <p>Findings included .</p> <p>&lt;Resident 4&gt;</p> <p>According to the facility assessment, dated 06/03/2024, Resident 4 had diagnoses to include heart disease. Resident 4 was able to make their needs known.</p> <p>On 06/12/2024 at 10:25 AM, Resident 4 was sitting in a wheel chair in their room. The resident was asked if they had any concerns with staff and replied not that they could recall. Resident 4 stated if they did, it was probably one of the agency people that worked weekends, because they didn't know the residents very well.</p> <p>Review of the facility grievance log showed Resident 4 had filed a nursing concern on 05/14/2024.</p> <p>Review of the grievance form, dated 05/14/2024, showed Resident 4 had a concern about Staff A, Licensed Practical Nurse (LPN), who was rough and rude to them. Under Facility investigation and response Staff B, Director of Nursing (DNS) documented they spoke with the resident, abuse/neglect was ruled out, and education was done. There was no documentation to show a thorough investigation had been done to include resident and staff interviews and how it was concluded abuse/neglect was ruled out.</p> <p>&lt;Resident 5&gt;</p> <p>According to the facility assessment, dated 05/22/2024, Resident 5 had diagnoses to include Diabetes and paraplegia (unable to move the lower extremities). Resident 5 was able to make their needs known.</p> <p>During an interview on 06/12/2024 at 1:35 PM, Resident 5 was in their room sitting in a wheel chair. Resident 5 stated they had filled out a grievance card about two different nurses at the facility. Resident 5 stated one was rude and the other made them feel hesitant to ask for medication because of how they treated them. Resident 5 stated another grievance they filled out had to do with not getting out of bed for three days. The resident stated a staff member told them they didn't have time to get them up and some staff stated they didn't know how to work the Hoyer lift (mechanical lift used to transfer the resident).</p> <p>Review of the facility grievance log showed Resident 5 had filed a nursing concern on 03/26/2024 and 03/29/2024.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the grievance dated 03/26/2024 showed Resident 5 wrote the resident was told they couldn't get out of bed for three days because staff did not have time. Under Facility investigation and response Staff B wrote they spoke to Resident 5 about the concerns. The action was to educate staff and adjust staffing on the weekends.</p> <p>The grievance dated 03/29/2024 showed Resident 5 filed a grievance about a staff member who was rude and when Resident 5 filled out a blue card (the facility's grievance form) the staff member was confrontational with them.</p> <p>There was no documentation to show the allegations of abuse and/or neglect had been thoroughly investigated, to include resident and staff interviews.</p> <p>&lt;Resident 6&gt;</p> <p>According to the facility assessment, dated 03/29/2024, Resident 6 had diagnoses to include respiratory disease. Resident 6 was able to make their needs known.</p> <p>On 06/12/2024 at 11:30 AM, Resident 6 was observed sitting in a recliner in their room. Resident 6 stated they had written up care givers three different times. Resident 6 stated the facility did not have enough staff and one time they filled out a card because they couldn't find any staff to help them when they were sick and throwing up. Resident 6 stated they didn't get follow up after filling out the cards.</p> <p>Review of the facility grievance log showed on 04/12/2024 Resident 6 had filed concerns about nursing.</p> <p>Review of the grievance, dated 04/12/2024, showed Resident 6 reported there wasn't any aides or nurses to be found on their side of the building. The resident ended up finding one aide that told them they were new and couldn't handle everyone. The staff member assisting the resident to fill out the card wrote they tried looking for an aide or nurse and couldn't find them either. The staff member was not able to do direct care. Under Facility investigation and Response Staff B wrote they spoke with staff. Staffing was good, nurses were doing medication pass, and the nursing assistants were providing care.</p> <p>There was no documentation to show a thorough investigation had been done to include resident and staff interviews, and a conclusion if abuse and/or neglect had been ruled out.</p> <p>&lt;Resident 7&gt;</p> <p>According to the facility assessment, dated 03/28/2024, Resident 7 had a disease of the central nervous system. Resident 7 was able to make their needs known.</p> <p>During an interview on 05/29/2024 at 12:30 PM, Resident 7 was sitting in their wheel chair at the side of their bed. Resident 7 stated some care was good, some bad. Resident 7 stated staff had some trouble knowing who took care of what.</p> <p>Review of the facility grievance form showed Resident 7 filed a grievance on 04/12/2024.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the grievance, dated 04/12/2024, showed Resident 7 was upset because there was only one nursing assistant in the hallway and their call light had been on for 50 minutes. A staff member helped Resident 7 fill out the card and the resident told them they didn't think they had a nursing aide or nurse assigned to them. The staff member who helped fill it out the grievance wrote they could only find one aide on the floor at the time of the incident. Under Facility investigation and Response Staff B wrote they spoke with staff and staffing was good, nurses were doing medication pass, and nursing aides were caring for residents.</p> <p>There was no documentation to show a thorough investigation had been done to include resident and staff interviews, and a conclusion if abuse and/or neglect had been ruled out.</p> <p>During an interview on 05/29/2024 at 12:53 PM, Staff C, Social Services Director (SSD), stated when a grievance came in for nursing, they would log it and give it to nursing. Nursing would then address the concern, the Administrator would sign off, and a copy would be placed in the grievance book.</p> <p>On 06/12/2024 at 2:37 PM, Staff G, Resident Care Manager, stated if a grievance came in for nursing, social services would bring it to them and it would be discussed in the morning meeting. The issue would be looked into and determined how to handle the concern. Staff D stated if they received a grievance about concerns related to a staff member being rude or rough, they would talk to the nurse and resident, and then the DNS would come and take care of it from there.</p> <p>On 06/12/2024 at 3:00 PM, Staff D, Administrator and Staff B were interviewed. They stated when a resident had a grievance, they would fill out a blue card, or a staff member could assist them if needed. The card would be given to Social Services, there was also a drop box in the hall they could put it in, or sometimes it would be slipped under their door. It was logged and then looked at to determine what department it would go to. If it was a nursing issue, it would go to staff B. If it was an allegation of abuse and/or neglect then the process would be followed which would be to log it in the state log, call it to the State Survey Agency, and conduct an investigation to rule out abuse and/or neglect. Staff B confirmed the grievances above were not investigated as allegations of abuse and/or neglect.</p> <p>Reference WAC: 388-97-0640 (6)(a)(b)</p>		