STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505257	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alderwood Manor	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)
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. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to monitor a surgical wound for 1 of 3 sampled residents (Resident 1), reviewed for non-pressure wounds. This failure placed residents with surgical incisions at risk of potential worsening skin conditions and complications. Findings included .A facility document titled Documentation and Assessment of Wounds, revised 06/12/2025, showed the facility Policy was to guide nurses in the assessment of wounds to include pressure ulcer/injuries (damage to the skin and underlying tissue caused by unrelieved pressure that restricts blood flow), venous (open sore on the lower leg from impaired circulation), arterial (painful wounds caused by poor circulation), diabetic (sores, ulcers, or chronic conditions that develop in people with diabetes, often on the feet, due to poor circulation, nerve damage), and dehisced surgical wounds (surgical wound that split open or separate), and other wounds not otherwise specified. A wound observation was to be made with each dressing change. The provider would be notified of changes and updated with a treatment plan if applicable. The nurse that performed the treatment would do an as needed assessment and document if a change had occurred (if wound appeared to be infected or appeared to have declined).Review of a facility assessment, dated 06/10/2025, showed Resident 1 was admitted with diagnoses to include Peripheral Vascular Disease (PVD, a circulation disorder that affected the peripheral arteries and veins, most commonly in the legs and arms, due to a narrowing or blockage), below knee amputation on both legs, and Diabetes. The resident was able to make their needs known.Per record review, the resident had dry gangrene (caused by insufficient blood flow leading to tissue death) to their right fingertips and had them amputated on 06/19/2025. The resident arrived at the facility with a dressing on their right hand which was not to be removed until their follow up with the surgeon on 06/24/2025.Review of a surgical follow up visit on 06/24/2025 showed the resident had their dressing removed in the office and wound care was ordered to be done daily. Resident 1's next follow up was on 07/01/2025.Review of the resident's Treatment Administration Record (TAR) for June 2025 showed the resident's wound care included cleansing the wound, covering the wound with an ointment type gauze, and to secure it with self-adherent wrap. The wound care was marked as done daily from 06/24/2025 to 06/29/2025, on 06/30/2025 there was no signature. Nurse progress notes were reviewed from 06/24/2025 thru 06/30/2025 and no documentation was found about the resident's surgical wound on their right hand. Review of a surgical follow up on 07/01/2025, Resident 1 had their dressing removed and the surgeon noted the fingertips were healing but the resident had developed a large blister over the palm of their hand. The surgeon debrided (removal of dead skin) the blister. The surgeon documented there appeared to be a soft tissue infection. New wound care was ordered, the resident was to start on antibiotics, and the area was to be monitored for increased redness. The resident's next follow up appointment was 07/11/2025.The TAR for July 2025 showed the resident's new wound care orders were to wash the hand with water or normal saline, apply bacitracin (antibiotic ointment) to a non-adherent dressing, and cover with gauze. The dressings were marked as done from 07/02/2025 through 07/13/2025 daily. There was nothing on the TAR to show the resident's right hand was monitored for increased redness or signs of worsening infection. Review of nurses notes from 07/01/2025 to 07/11/2025 showed a note written by Staff D, Registered Nurse (RN), on 07/04/2025. It was documented the resident's right-hand wound infection had mild redness and odor which was resolving with antibiotics. Staff D had written a note on 07/05/2025 which showed the wound appeared less inflamed (red, swollen, hot) and redness appeared to have lessened. Review of a surgical follow up note on 07/11/2025 showed the resident rated their pain a 7 out of 10 (0 being no pain, 10 being the worst pain) and described the pain in the hand and into the wrist. It was noted the resident's hand was red and the resident had wound cellulitis (bacterial infection of the skin and underlying tissues, characterized by red, swollen, warm, and painful skin). The surgeon discussed going to the hospital for a CT scan (a scan that created a detailed image of the inside of the body to help in diagnoses such as an infection), but the resident wanted to wait and do the CT scan as outpatient. The resident was instructed to report to the hospital if symptoms worsened. The wound care remained the same. Review of nursing progress notes from 07/11/2025 to 07/13/2025 showed no documentation the resident's hand was monitored by staff which would include a description of the wound on the right hand or if the wound infection had worsened. A nurses note on 07/14/2025 showed the resident was sent to the hospital for a worsened infection of their right hand. There was no documentation to show the assessment of the wound and how the infection had worsened. Review of hospital notes on 07/14/2025 showed the resident arrived at the hospital with redness that had