| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505322 | A. Building<br>B. Wing | 10/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Spokane Health & Rehabilitation | North 6025 Assembly<br>Spokane, WA 99205 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>45433<br><br>Based on interview and record review, the facility failed to protect the residents' right to be free from neglect for 2 of 5 residents (Resident 7 and 8). The failure to provide incontinence care to residents who were identified by nursing staff to have been incontinent, and required staff assistance for toileting and incontinence care, resulted in a possible diminished quality of life. Findings included .<br><br><Resident 7><br><br>Record review showed Resident 7 had admitted to the facility in April of 2024 with diagnoses of Parkinson's Disease (a brain disorder that causes unintended or uncontrolled movements) and dementia (a loss of thinking, remembering and reasoning skills).<br><br>Review of Resident 7's care plan, dated 04/20/2024, showed that Resident 7 required assistance from one staff with toilet use and was incontinent.<br><br><Resident 8><br><br>Record review showed Resident 8 had admitted to the facility in April of 2024 with diagnoses of Parkinson's Disease, and a need for assistance with personal care.<br><br>Review of Resident 8's care plan, dated 04/03/2024 and revised on 11/10/2023, showed that Resident 8 was dependent on staff for toileting and was incontinent.<br><br>Review of a facility incident report, dated 09/05/2024, stated that at shift exchange between evening shift and night shift, of 09/05/2024, Staff I, Nursing Assistant, found Resident 7 and 8 with dried feces in their incontinence briefs.<br><br>Per a witness statement, dated 09/06/2024, evening shift Staff J, Nursing Assistant, stated that about 3:30 pm on 09/05/2024 they had found Resident 8 crawling out of bed and that they and their bed were soiled. Staff J helped clean the resident up but was not assigned to that section of residents and did no further cares for this resident. Staff J further stated that when the night shift Nursing Assistant, Staff I, started work just before 11:00 PM they told them that Resident 8 was a mess.<br><br>(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: 505322 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
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| Spokane Health & Rehabilitation | North 6025 Assembly<br>Spokane, WA 99205 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Per a witness statement, dated 09/06/2024, Staff G, Licensed Practical Nurse, said that about 4:00 PM on 09/05/2024, Staff M, Nursing Assistant had been asked by Staff L, Nursing Assistant, to watch their section of residents. Staff L had told Staff M that their section of residents was all changed and fine. Staff M then came and got Staff G to show them that Resident 7 had dried feces and brown urine on their bed, and they were lying in their bed and appeared to have not been changed. They further stated that at shift exchange between evening and night shift, just before 11:00 PM, Staff I came and got them, and they both observed Resident 7 and 8 not in bed. Resident 8 was then helped into bed where they found dried feces on them and Staff G stated that they appeared to have not been changed. Resident 7 was observed as being soaked.<br><br>Per a witness statement, dated 09/06/2024, Staff I started night shift and found Resident 7 with BM coming out of the top of the pants of [the Resident]. It looked old and some fresh. They then went to ask Staff L what had happened and found them on their phone at the nurse's station. Staff L then stated, [they had] been like that all night, I am not doing it again. Staff M stated that they had asked Staff L to change Resident 7 and 8, and that Staff G had also asked Staff L to change Resident 7 and 8.<br><br>Staff C, Resident Care Manager, was interviewed on 09/17/2024 at 1:09 PM. They stated that Staff I had texted them the night of 09/05/2024, to tell them that Residents 7 and 8 were both found soiled and looked like they had not had incontinence care for a while. Staff C stated they completed part of the investigation and documented that the allegation of neglect of Resident 7 and 8 had been substantiated by the facility and that Staff L, an agency nursing assistant, had been banned from the facility.<br><br>Staff A, Administrator, was interviewed on 10/08/2024 at 2:00PM and stated that the neglect allegations for Resident 7 and 8 had been substantiated by the facility. They further stated that it was the duty of the Licensed Nurse on shift to make sure all care was provided to residents they were responsible for.<br><br>Reference (WAC) 388-97-0640(1) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45433<br><br>Based on interview, and record review, the facility failed to ensure physician ordered medications were available as ordered for 4 of 5 residents (Resident 1, 4, 5 and 6) and that medications were administered per the direction of the physician order for 2 of 5 (Resident 1 and 4) residents reviewed for quality of care. This failure placed residents at risk of not receiving necessary care and a diminished quality of life. Findings included .<br><br><Resident 1><br><br>Record review showed that Resident 1 readmitted to the facility from the hospital on 09/09/2024 with diagnosis including Enterocolitis due to Clostridium difficile (a bacteria that causes an infection of the bowel causing abdominal pain, nausea and diarrhea), Diabetes (a chronic disease that happens when the body cannot process sugar) and End Stage Renal Disease requiring dialysis (the kidneys have stopped working and a process for cleaning waste products from the blood (dialysis) is required to live).<br><br>Review of the hospital discharge summary dated 09/09/2024 at 11:25 AM, stated that Resident 1 had completed 8 of 10 days of an antibiotic to treat their Clostridium difficile infection (Fidaxomicin) and required the facility to finish the administration of the drug (five doses). The discharge instructions also specified for the resident to continue their dose of an anti-nausea drug (Scopolamine), given in patch form, administered every 72 hours, their two times daily injection of a diabetes medication (Tresiba) used to treat high blood glucose (high level of sugar in the blood) and two different daily bowel medications (Gavilax powder and Senna tablets) used to treat constipation (difficulty having a bowel movement).<br><br>Review of Resident 1's September 2024 Medication Administration Record (MAR) showed that the antibiotic used to treat their bowel infection (Fidaxomicin) was to be given twice daily (8:00 AM and 4:00 PM) for six doses. MAR entries for 09/09/2024 4:00 PM through 09/12/2024 at 8:00 AM showed the medication was not given.<br><br>Further review of Resident1's September MAR showed that their anti-nausea patch, to be applied every three days, was not given on 09/10/2024, 09/13/2024, 09/16/2024 and 09/19/2024.<br><br>Further review of Resident 1's MAR showed that their two times daily diabetes medication was not given on 09/09/2024 at 8:00 PM and again not given on 09/10/2024 at 8:00 AM and then was placed on hold (not given) from 09/10/2024 at 8:00 PM through 09/17/2024 at 8:00AM.<br><br>Further review of Resident 1's MAR showed that their Gavilax powder, directed to be given two times daily for bowel care, hold for loose stools, was given at 8:00 AM and 4:00 PM on 09/10/2024, 09/11/2024, 09/12/2024, 09/16/2024 and 09/17/2024.<br><br>Further review of Resident 1's MAR showed that their Senna tablets, directed to be given as two tabs twice daily for bowel care, hold for loose stools, was given on 09/09/2024 at 4:00 PM, on 09/10/2024, 09/11/2024 twice, given one time on 09/12/2024, 09/13/2024, 09/14/2024, 09/15/2024, and then was given twice daily on 09/16/2024 and one time on 09/17/2024.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of a progress note written by Staff H, Physician Assistant, on 09/10/2024, stated that Resident 1 was still complaining of recurrent diarrhea and that they could not go to dialysis while they were having diarrhea because they would have to sit in the diarrhea for four hours.<br><br>Review of a progress note written by Staff H on 09/11/2024, stated that patient reports to have a lot of diarrhea, [they] are unable to attend dialysis today due to the fact [they are] constantly soiling [themselves]. [They] are almost done with Fidaxomicin, which will end tomorrow.<br><br>Review of a progress note written by Staff H on 09/12/2024, stated that patient continues to complain of abdominal pain cramping with diarrhea. Patient is currently on Fidaxomicin and Imodium (a drug used to stop loose stools). As a result of persistent diarrhea patent has been unable to attend dialysis.<br><br>Review of a progress note written by Staff H on 09/13/2024, stated continues with liquid diarrhea . An addendum to this note stated that Resident 1 had not been on Fidaxomicin due to unavailability and the medication was to restart in 24 hours.<br><br>Review of a progress note written by Staff H on 09/17/2024, stated Patient is being seen today because [they] refused to go to dialysis yesterday because [they were] quote not feeling well. Patient has a repeated issues with this and is always making up reason why [they] can't go to [dialysis]. Normally [they] refuse to go to dialysis because of diarrhea and loose stools. [They] did recently have [clostridium difficile] and is still completing treatment for it. Patient says that [they] didn't feel well because [their] blood sugars have been elevated. Patient's blood sugar was over 400 yesterday and we treated [them] with [their] normal 22 units plus [sliding] scale plus an additional 10 units. [They also] receive Tresiba 42 units at bedtime. Further on in the same note Staff H wrote Changed [their] MiraLAX and Senna to [as needed]. [They] should not have been receiving these with [their] recent C-diff (Clostridium difficile) an[d] diarrhea issues. Further on in the same note Staff H continues It was discovered that the patient Tresiba has been on hold since arrival due to confusion with [their] insulin on arrival. Restarted to Tresiba 42 units twice daily. Will continue to monitor and adjust if needed. Previously planned insulin changes were discounted once it was discovered [they] had not been receiving [their] Tresiba correctly.<br><br>In an interview on 10/08/2024 at 12:10 PM Staff C, Resident Care Manager, stated that they were not sure why the Fidaxomicin was ordered for six doses and not five per the hospital discharge orders. They further stated that Resident 1's Fidaxomicin, Tresiba and Scopolamine were not available because they were not sent from the pharmacy. They further stated that it appeared from review of Resident 1's September 2024 MAR that they had been receiving several constipation medications while they had been having diarrhea.<br><br>In an interview on 10/08/2024 at 12:06 PM Staff H, Physician Assistant, stated that they had not been aware that Resident 1 did not have their ordered doses of Fidaxomicin, Scopolamine, and Tresiba. They also had not been aware that the resident was being administered constipation medications when they had been complaining of diarrhea. When they became aware, they had restarted the medications and changed the constipation medications to as needed for constipation, but the resident had gone out to the hospital shortly after for an issue with wounds. They stated that giving constipation medications when a resident had loose stools, and a Clostridium difficile infection, was contraindicated.<br><br><Resident 4><br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident 4's hospital discharge summary dated 09/06/2024 at 11:10 AM showed that they were admitting to the facility with diagnoses including diverticulitis (inflammation in the bowel), asthma (a condition where airways narrow and swell), Chronic Obstructive Pulmonary Disease (COPD) (an ongoing lung condition caused by damage to the lungs) and schizophrenia (a serious mental disorder characterized by distortions in thinking, perception, emotions, language, sense of self, and behavior). They were ordered by the discharging Physician to start taking an antibiotic three times a day for four days (12 doses). They were also ordered to continue their home doses of a medication to treat symptoms of schizophrenia, a topical (applied on the skin) medication to treat pain, and two different inhaled medications to treat asthma and/or COPD.<br><br>Review of Resident 4's September 2024 MAR showed that the ordered antibiotic was not given at 2:00 PM on 09/06/2024 and then was given at 10:00 PM and then was given for an additional 12 doses (13 doses total).<br><br>Further review of Resident 4's September MAR showed that they did not receive one of their ordered medications, to treat their diagnosis of Schizophrenia, on 09/06/2024 at 4:00 PM and again on 09/07/2024 at 8:00 AM.<br><br>Further review of Resident 4's September MAR showed that they did not receive their ordered dose of their topical pain medication on 09/06/2024 at 4:00 PM and 8:00 PM, and again on 09/07/2024 at 8:00 AM and 12:00 PM.<br><br>Further review of resident 4's September MAR showed that they did not receive their ordered inhaled medication for asthma on 09/06/2024 at 4:00 pm nor on 09/07/2024 at 8:00 AM. They also did not receive their COPD inhaled medication on 09/07/2024 at 8:00 AM.<br><br>In an interview with a collateral contact on 10/01/2024 at 11:40 AM, they stated that they received a call from a facility nurse on 09/07/2024. The nurse stated that they did not have one of Resident 4's prescribed medications used to treat their diagnosis of schizophrenia. The facility requested the collateral contact to bring the residents home medication to the facility to administer, which the collateral contact did the same day.<br><br>In an interview on 10/08/2024 at 12:10 PM Staff D, Resident Care Manager, stated that they had called Resident 4's collateral contact to let them know that they did not have one of Resident 4's medications to treat Schizophrenia and asked them to bring in the home medication. They further stated that when Resident 4 was sent from the hospital there was not a written prescription for one of Resident 4's schizophrenia medications, which the pharmacy required because it was a controlled medication, and so it was not immediately available.<br><br>In the same interview, Staff D stated that there had been problems getting medication in a timely manner from the facility pharmacy.<br><br><Resident 5><br><br>Review of Resident 5's MAR showed that they admitted to the facility on [DATE] with diagnoses including COPD. During their stay at the facility, in August 2024, they were diagnosed with a shingles infection (a viral infection causing a painful rash with blisters).<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the July 2024 MAR showed that Resident 5 was ordered a medication on 07/10/2024 at 8:00 AM, for five days, to treat a cough related to their diagnosis of COPD. The MAR showed that on 07/10/2024 and 07/11/2024 the medication was not administered.<br><br>Review of Resident 5's medical record showed that they developed a shingles rash on 09/18/2024. The Physician Assistant, Staff H, placed an order the same day to start an antiviral medication to treat the rash. A second medical provider, Staff K, Medical Doctor, was noted to stop the medication the same day, at 11:14 PM and wrote as the reason time change due to just now being confirmed so there are no missed doses. The order was then written to start on 09/19/2024 at 4:00 PM.<br><br>Review of the August 2024 MAR showed that Resident 5 was ordered, by Staff H, to start five days (given four times per day at 7:00 AM, 12:00 PM, 4:00 PM and 9:00 PM) of an antiviral medication used to treat shingles to start on 09/18/2024 at 12:00 PM (noon). It then showed the order was discontinued at 11:14 PM the same day. The order then was written again to start on 09/19/2024 at 4:00PM. At 4:00 PM the medication was not available and was not given. At 9:00 PM the second prescribed dose was also marked as not available and was not given. The medication was then started on 09/20/2024 at 7:00 AM, a delay of five doses.<br><br>In an interview on 10/08/2024 at 12:10 PM Staff C stated that Resident 5's antiviral medication had not come from the pharmacy and so was not available until 09/20/2024.<br><br><Resident 6><br><br>Review of Resident 6's MAR showed that they admitted to the facility in October of 2022 with diagnoses including Congestive Heart Failure (the heart fails to pump efficiently). During their stay at the facility, in September 2024, they were diagnosed with a bacterial infection (an infection caused by bacteria that are normally outside the body) and prescribed an antibiotic to be given one time per day for five days to start on 09/25/2024 at 4:00 PM and finish on 09/29/2024 at 4:00 PM.<br><br>Review of Resident 6's September 2024 MAR showed that they did not receive their prescribed dose of antibiotic on 09/25/2024.<br><br>Review of nursing and medical provider progress notes for September did not find evidence that the fifth dose of the prescribed antibiotic was given nor that the provider was notified or aware of the missing dose.<br><br>In an interview on 10/08/2024 at 1:05 PM Staff E, Infection Control Nurse, stated that they keep track on a spreadsheet of which residents are taking antibiotics or antivirals and when they start and stop the medications to make sure the resident gets the full course as ordered. They further stated that they were off work when Resident 6 was prescribed their antibiotic medication and they did not have them, or their course of antibiotic on their tracking spreadsheet.<br><br>In an interview on 10/08/2024 at 2:00 PM Staff B, Director of Nursing stated that they were aware of the problem with pharmacy not delivering medication for residents in a timely manner and that they had called the pharmacy multiple times. They further stated that it was not a standard of care to give constipation medication to residents who have diarrhea and that receiving a full course of antibiotics, as ordered, was important to prevent residents from developing resistant bacteria that are hard to treat.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 10/08/2024 at 2:00 PM Staff A, Administrator, stated that they were aware of the issue with pharmacy, and when a problem with a medication had been identified by nursing, they had been calling the pharmacy to try and get the medication in a timely manner. They also stated that there had not been a backup staff for Staff E identified as there had been several recent changes in the Director of Nursing for the facility.<br><br>See related F 698 dated 10/08/2024<br><br>Reference: (WAC) 388-97-1060 (1) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45433<br><br>Based on observation, interview, and record review, the facility failed to provide dialysis services consistent with professional standards, and ensure consistent, ongoing communication and collaboration with the dialysis facility for 3 of 3 sampled resident (Residents 1,2 and 3), reviewed for dialysis. These failures placed the residents at risk for unmet care needs and medical complications. Findings included .<br><br>The facility policy, End Stage Renal Disease - Care of Resident, undated, stated that Agreements between this facility and the contracted ESRD (end stage renal disease) facility will include all aspects of how the resident's care will be managed including but not limited to: .the communication process between the nursing facility and the dialysis center that will reflect ongoing communication, coordination and collaboration. The policy further states that the nursing facility staff will provide immediate monitoring and documentation of the status of the resident's condition and resident's access site(s) upon return from dialysis treatment to observe for bleeding or other complications.<br><br><Resident 1><br><br>Record review showed Resident 1 had admitted to the facility on [DATE] with diagnoses of a lower leg fracture, diabetes (a chronic disease that happens when the body cannot process sugar) and ESRD requiring dialysis (the kidneys have stopped working and a process for cleaning waste products from the blood (dialysis) is required to live).<br><br>Review of Resident 1's July, August and September Medication Administration Record (MAR) showed an order for the licensed nurse to complete Pre/Post Dialysis Review Assessment that includes vital signs. Place the vital signs on the dialysis communication form every evening shift every Mon, Wed, Fri for dialysis.<br><br>Review of dialysis communication forms in the assessment portion of Resident 1's electronic health record and their dialysis book download showed assessment forms for 08/02/2024, 08/07/2024, 08/16/2024, 08/19/2024, 09/14/2024 and 09/18/2024. Forms on 08/07/2024 and 09/18/2024 were partially completed. Review of Resident1's dialysis schedule showed that they had 15 opportunities during July, August and September 2024 to attend dialysis. The resident was noted to have some refusals, but it was difficult to determine from their record and interviews when they did or did not attend dialysis.<br><br><Resident 2><br><br>Record review showed Resident 2 had admitted to the facility in 05/15/2024 with diagnoses of a lower leg fracture, diabetes and ESRD requiring dialysis.<br><br>Review of Resident 1's July, August and September Medication Administration Record (MAR) showed an order for the licensed nurse to complete Pre/Post Dialysis Review Assessment that includes vital signs. Place the vital signs on the dialysis communication form two times a day every Tue, Thurs, Sat for dialysis.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident 2's dialysis communication book showed documentation for 24 dialysis sessions, 22 of the assessment sheets were not complete. Review of Resident 2's assessment tab in their electronic health record showed 39 dialysis sessions, 19 of the assessment sheets were not complete.<br><br><Resident 3><br><br>Record review showed Resident 3 admitted to the facility 10/01/2024 with diagnoses of a bone infection of their ankle, diabetes and ESRD requiring dialysis.<br><br>Review of the Medication Administration Record for October of 2024 showed an order for the licensed nurse to complete Pre/Post Dialysis Review Assessment that includes vital signs. Place the vital signs on the dialysis communication form one time a day every Mon, Wed, Fri and one time a day.<br><br>In an observation during an interview with Staff F, Registered Nurse, Resident 3's dialysis binder was reviewed at the nurses' station. Staff F explained that the book goes with the resident each time they go to dialysis and the nurse working with the resident that day puts their completed and then printed pre-dialysis assessment in the book, the book goes to dialysis with the resident, dialysis puts weights, vital signs and any other pertinent information on the sheet and then the resident brings the binder back, gives it to the nurse and the nurse fills out the post dialysis assessment and leaves it in the book. When the book was opened, one dialysis communication sheet was visualized for 10/01/202. Staff F stated that that was the only sheet they had because Resident 3 had lost their dialysis binder.<br><br>During an interview on 10/08/2024 at 12:10 PM, Staff C, Resident Care Manager, stated that the pre and post dialysis forms were how the facility nurse and the staff at the dialysis center communicated and included and assessment done by the facility nurse prior to the resident leaving for dialysis and when they came back. They stated that to fill them out correctly the form would be completed in its entirety, all boxes completed, with pre and post weights, collected by the dialysis center staff and written on the form. This document showed nursing staff was monitoring the resident for complications of dialysis before they went to dialysis and when they came back.<br><br>During an interview on 10/08/2024 at 2:00 PM Staff B, Director of Nursing stated that the facility process for communication with the dialysis center was to send a binder with the facility completed assessment with the resident to their dialysis appointment. At the appointment the dialysis center would enter the resident's weight before dialysis and then after dialysis and note anything out of the ordinary. When the resident returned to the facility the licensed nurse working with the resident would get the book and fill out the second part of the assessment and leave it in the book. This process would happen each day a Resident had dialysis. They further stated that all available dialysis forms had been downloaded into Resident 1, 2 and 3's electronic medical record.<br><br>See related F 684 dated 10/08/2024<br><br>Reference: WAC 388-97-1900 (1), (6)(a-c) |