STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505322	A. Building B. Wing	11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spokane Health & Rehabilitation	North 6025 Assembly 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45433 Based on observation, interview, and record review, the facility failed to ensure 2 of 9 residents (Resident 7 and 8) reviewed for range of motion/mobility, received monitoring and consistent treatment for identified range of motion limitations. This failure placed the residents at risk for avoidable range of motion declines. Findings included . <Resident 7> Review of Resident 7's medical record showed they admitted to the facility on [DATE] with diagnosis of Parkinsonism (clinical syndrome characterized by tremor, rigidity and postural instability) and generalized muscle weakness. A quarterly assessment, dated November 8, 2024, showed the resident had no functional limitation in range of motion for their upper extremities, but had functional limitation for both of their lower extremities. Review of Resident 7's care plan, dated 11/10/2023, showed that they required total assistance from two staff for transfers using a mechanical lift (a hydraulic lift used to move residents who have a medical condition that does not allow them to stand or assist with moving). The Resident's kardex (short summary of care needs for a resident mostly used by nursing assistant staff) showed that they used a sit-to-stand lift (a device that helps lift a resident into a supported, standing position to allow movement between surfaces) for transfers with two staff to assist. Neither care plan or kardex indicated the resident had any functional limitation in their upper or lower extremities. Neither care plan or kardex indicated if the resident was on a facility program to prevent a decrease in their range of motion in their upper and/or lower extremities. Record review of facility assessments for Resident 7 showed that there was not a range of motion assessment conducted within the last year. Further review showed a referal for therapy services on 11/18/2024 indicating the resident required therapy services for flexion contractures (inability to fully straighten or extend the knee or elbow) of both upper and lower extremities. (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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 7's medical provider notes showed that on 10/02/2024, Staff F, Physician Assistant, wrote that they had seen the resident because of concerns from family that patient developing contractures of [their] extremities. Staff F also entered an order on 10/24/2024, at 7:00 PM, for physical therapy services to start for range of motion exercises to minimize flexion contractures of upper and lower extremities. Recommended by neurology. On 11/13/2024 at 10:00 AM Resident 7 was observed seated in their tilt-in-space wheelchair (a specialized wheelchair designed to enhance postural support, comfort and decrease areas of pressure by tilting back, allowing the resident to sit comfortably in a reclined position) near the nurses' station. Resident 7 had their eyes closed, the trunk of their body was leaning forward in their reclined wheelchair with their chin resting on their chest, both of their arms were bent at the elbow and tucked in toward their chest, both of their knees were flexed in a seated position. On 11/18/2024 at 10:58 AM Resident 7 was observed seated in their tilt-in-space wheelchair near the nurses' station. Resident 7 had their eyes closed, the trunk of their body was leaning forward in the wheelchair with their chin resting on their chest, both of their arms were bent at the elbow and tucked in toward their chest, both of their knees were flexed in a seated position. During an interview on 11/18/2024 at 10:22 AM, Staff D, Rehabilitation Director, stated that physical therapy had last worked with Resident 7 in August of 2024. They further stated that they had not received a referal for Resident 7 to work with therapy services related to a decrease in their range of motion. They reviewed their computer system and showed that there were not any referrals or completed referrals for therapy services for Resident 7, and they did not know why they did not receive a referal if the medical provider had ordered one to be completed. On 11/18/2024 at 11:33 AM Staff C, Resident Care Manager, was interviewed and stated that they could see the order written by Staff F, Physician Assistant on 10/24/2024, for Resident 7 to have a referal to physical therapy related to contractures in their arms and legs. They stated that the order had been confirmed by nursing staff but had not been forwarded to the therapy department for follow-up. <Resident 8> Review of Resident 8's medical record showed they admitted to the facility on [DATE] with diagnosis of Cerebral Palsy (a group of conditions that affect movement and posture) and quadriplegia (a symptom of paralysis that affects movement and sensation in both arms and legs). A quarterly assessment, dated September 2, 2024, showed the Resident was cognitively intact, and had functional limitation in range of motion for their upper and lower extremities. The same assessment showed Resident 8 was dependent on staff for all of their care. The same assessment showed the Resident was not receiving passive range of motion (movement of a joint applied entirely by another person meant to help prevent decline) or active range of motion (movement of a joint by the person with assistance or guidance from another person), nor any other restorative programs (programs meant to prevent decline in a resident's abilities). Review of Resident 8's care plan, dated 03/11/2024 and revised on 09/23/2024, showed that they had contractures of upper and lower extremities, but did not show any interventions to prevent a decline in their range of motion. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility assessments for Resident 8 did not show a baseline range of motion assessment at admission for staff to reference when determining if the Resident's range of motion had gotten better or worse. Record review of Resident 8's medical provider notes showed that on 11/07/2024, Staff G, Nurse Practitioner, wrote that the Resident was mostly bedbound [with] contractures upper and lower extremities impacting mobility issues. On 11/13/2024 at 11:40 AM Resident 8 was observed being helped back into bed by Staff H, Physical Therapist, who stated they had assessed the resident for safety using their motorized wheelchair and that the assessment was not successful. On 11/13/2024 at 11:50 AM Resident 8 was observed lying in bed on their right side in a fetal position (lying on one side of the body with arms and legs pulled in toward the center of the body). At that time Resident 8 stated that the contractures in their arms had gotten worse, that they could not reach the control on their motorized wheelchair during the physical therapy assessment. On 11/13/2024 at 1:00 PM, Staff I, Community Engagement Specialist, was interviewed while they visited with Resident 8. Staff I, stated that when they worked with the resident in their prior facility, they were able to reach the controls on their wheelchair and would zip around. Record review of a progress note written by Staff H, Physical Therapist, dated 11/13/2024 at 12:11PM and revised on the same date at 3:39 PM, stated that the patient feels [their] left arm is not moving well enough. The note further states that the resident will start working with therapy to give [them] more motion in the left upper extremity. Right now [their] biceps (the large muscle that lies on the front of the upper arm between the shoulder and the elbow) has a lot of tone (the resistance of muscles to passive stretch or elongation) that limits [their] ability to reach out to the joystick (standard driving control found on motorized wheelchairs). Reference: WAC [PHONE NUMBER](3)(d)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 45433 Based on observation and interview the facility failed to consistently implement infection control standards related to handling of contaminated laundry (laundry which has been soiled with blood/body fluids or other potentially infectious materials), for 5 of 13 residents. This failure placed residents at risk for exposure to an infectious disease. Findings included . During general facility observations on 11/13/2024 at 11:58 AM, Resident 1 was observed to have a collateral contact with them in their room. When both were asked how things were going at the facility the collateral contact displayed a white plastic bag with dirty laundry in it and stated that they had brought a bag from home to pick up Resident 1's dirty laundry. They stated that they thought the facility was washing Resident 1's laundry but had noticed on previous visits, Resident 1's room had been messy. They further stated that they had just collected dirty laundry from Resident 1's wheelchair and out of the bottom of their closet. They stated that one pair of sweatpants in the wheelchair had been wet, and the other clothing was dirty. During an observation on 11/18/2024 at 10:05 AM, Resident 2 was observed to have visibly soiled linen in a clear plastic bag on the floor outside the bathroom door. During an observation on 11/18/2024 at 10:07 AM, Resident 3 was observed to have a clear plastic bag with visibly soiled linen on the floor against the far wall of their room under the window. During an observation on 11/18/2024 at 10:46 AM, Resident 4 was observed to have a clear plastic bag on the floor under their sink with what appeared to be a nightgown inside. During an observation on 11/18/2024 at 11:00 AM, Resident 5 was observed to have a clear plastic bag with soiled linen under the sink in the main area of their room. In an interview on 11/18/2024 at 10:12 AM, Staff E, Nursing Assistant, stated that they had been trained that it was not okay to leave soiled clothing or bed linens on beds, chairs, wheelchairs or anywhere in the room. They further stated that the nursing staff were supposed to take soiled linen directly from the resident rooms to the dirty utility room, where it was kept, until it could be washed. They stated that they had been taught to never leave dirty linen on the floor or room surfaces because it could spread germs. In an interview on 11/18/2024 at 11:50 AM, Staff B, Director of Nursing, stated that it was not acceptable infection control practice to leave soiled linen in bags on the floors of resident rooms or on room surfaces, and that soiled linen needed to be put directly into bags and be taken to the soiled utility room to prevent any possible spread of infection. Reference: WAC 388-97-1320(3)