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	01/23/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 27590 Based on observation, interview, and record review, the facility failed to ensure 5 of 12 dependent residents (Residents 1, 2, 3, 6, and 7), reviewed for activities of daily living (ADL's), received the appropriate number of showers per week. This failure placed residents at risk for poor hygiene and a diminished quality of life. Findings included . <Resident 1> A facility assessment, dated 01/06/2025, showed Resident 1 was admitted on [DATE] with diagnoses which included a recent stroke with left sided weakness and colon perforation with a new ileostomy (surgical procedure where a diversion from the intestine to the outside of the abdomen is made to divert stool from the body). The Resident was not able to make their needs known and was dependent on staff for showers. Review of the Resident's shower record from 12/30/2024 to 01/21/2025 showed Resident 1 was scheduled for showers on Monday and Friday evenings. The record showed that the Resident received a shower on 12/31/2024 at 2:43 AM and on 01/13/2025 at 5:27 PM. The dates of 01/02/2025, 01/03/2025 and 01/12/2025 had NA (not applicable) marked. During an observation on 01/13/2025, at 12:05 PM, Resident 1 was observed to be sitting up in bed, with the head of their bed elevated, they were wearing a hospital gown and their hair appeared very oily. During this observation Resident 1 was observed to inadvertently put their left hand into their plate of pureed food that was on the bedside table in front of them, appear confused with what to do with the pureed food on their hand and several times run their left hand through their hair on the left side of their head, leaving green and white pureed food in their hair. <Resident 2> A facility assessment, dated 12/31/2024, showed Resident 2, was admitted on [DATE] with diagnoses including right hip and elbow fractures. The Resident was able to make their needs known and was dependent on staff for showers. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident's shower record from 12/24/2024 to 01/22/2025 showed the resident was scheduled for showers on Monday and Thursday evenings. The record showed that the Resident received a shower on 01/03/2025 at 5:19 PM and on 01/06/2025 at 9:59 PM. The dates of 12/30/2024, 12/31/2024, 01/02/2025, 01/02/2025, 01/16/2025 were marked with NA. The record showed the resident refused a shower on 01/20/2025. During an interview on 01/21/2025 at 11:20 AM, Resident 2 was observed lying in their bed with the head of the bed elevated at about 45 degrees. The resident was dressed, and their hair was combed but oily. The resident answered all orientation questions correctly and stated they had a couple showers during their stay. They further stated that they would like to have more showers, but they didn't like to complain and they knew the girls were busy. <Resident 3> A facility care plan, dated 01/01/2025, showed Resident 3 was admitted on [DATE] with diagnoses which included heart failure and after care following a leg amputation. The Resident was able to make their needs known and was dependent on staff for showers. Review of the Resident's shower record from 12/27/2024 to 01/08/2025 (date of discharge) showed the Resident was scheduled for showers on Wednesday and Sunday days. The record showed that the Resident received a shower on 01/05/2025 at 1:59 PM and on 01/08/2025 at 1:59 PM. All other documented days were marked as NA. <Resident 6> According to a facility assessment, dated 01/16/2025, showed Resident 6 was admitted on [DATE] with diagnoses to include kidney disease and an infection of the skin. The resident was able to make their needs known and was dependent on staff for showers. Review of the resident's shower record from 01/10/2025 to 01/23/2025 showed the resident refused a shower on 01/14/2025 and had a bed bath on 01/17/2025. The resident received one bath in 13 days. During an interview on 01/23/2025 at 2:40 PM, Resident 6 was sitting on the side of the bed. The resident was dressed and hair was combed but appeared oily. The resident stated they only had one bed bath since they admitted and would like to have another I don't care if it is a shower or bed bath, I just want something. <Resident 7> According to a facility assessment, dated 01/15/2025, showed Resident 7 was admitted on [DATE] with diagnoses to include an arm and leg fracture. The resident was able to make their needs known and was dependent on staff for showers and hygiene. Review of the resident's shower record from 01/09/2025 to 01/23/2025 showed the resident had a shower on 01/12/2025 and refused a shower on 01/19/2025. The resident received one shower in 15 days. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/23/2025 at 2:30 PM, Resident 7 was laying in bed. The resident was in isolation for COVID. Resident 7 had a sling on their right arm and stated they had broken their arm and leg from a fall. Resident 7 stated they had one bed bath they knew of and would like more. On 01/21/2025 at 12:40 PM, Staff B, Certified Nursing Assistant (CNA), stated the aides did their own showers and thought there was a shower aide on evenings. Staff B stated if a resident refused a shower, the resident would be reapproached and if continued to refuse, a sheet would be filled out and given to the nurse. Staff B stated the residents in isolation received bed baths. On 01/23/2025 at 2:45 PM, Staff C, CNA, stated they had a shower list to show what showers they were responsible for. Staff C stated if a resident refused a shower, a bed bath would be offered. If they refused a bed bath the nurse would be notified. Staff C said they did have make up days for the residents that refused. On 01/23/2025 at 2:52 PM, Staff D, Director of Nursing (DNS), stated residents were to receive two showers a week and as needed. There was shower lists for staff and the showers were spread out between days and evenings. If a resident refused, staff were to try and offer one the next day. Reference: (WAC) 388-97-1060(2)(c)

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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 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** 45433 Based on interview and record review, the facility failed to provide care according to the medical provider orders for 2 of 12 sampled residents (Resident 1 and 3) reviewed for quality of care. Specifically, Resident 1 did not have their vital signs monitored per the medical provider orders and Resident 3 was on a fluid restriction but did not have evidence that the restriction was monitored. These failures placed residents at risk for unintended health consequences and decreased quality of life. Findings included . <Resident 1> Resident 1's care plan dated 12/30/2024, showed they were admitted on [DATE] with diagnoses which included a recent stroke with left sided weakness, colon perforation with a new ileostomy (surgical procedure where a diversion from the intestine to the outside of the abdomen is made to divert stool from the body) and need for enteral nutrition (nutrition provide in liquid form through a tube inserted through the nose and then into the stomach). The same care plan had a focus for enteral feedings that stated the resident was at risk for complications related to the need for enteral feeding. The interventions associated with this focus stated, observe for signs and symptoms of aspiration or aspiration pneumonia. Review of Resident 1's order recapitulation for 12/01/2024 through 01/31/2025 showed a medical provider order for vitals BID (two times per day) every day and evening shift for monitoring, with a start date of 12/30/2024 and end date of 01/14/2025. Review of Resident 1's Electronic Medication Administration Record (EMAR) showed blood pressure and pulse being monitored daily related to a medication the resident was being administered. An additional scheduled vital sign section on the EMAR which included a space to enter values for blood pressure, temperature, pulse, respirations and oxygen saturation were blank from 01/01/2025 through 01/13/2025. Review of the vitals section of the Resident's EMAR showed one temperature value entered on 12/31/2025 of 99.3 degrees Fahrenheit. No other documentation could be located. Further review showed one respiration value entered on 12/31/2024 of 21 breaths per minute. No other documentation could be located. Further review showed one oxygen saturation value, dated 12/31/2024 of 90% saturation. No other documentation could be located. During an interview on 01/13/2025 at 12:10 PM, Staff G, Registered Nurse, stated that full sets of vitals are important for Resident's with enteral nutrition because the first signs of aspiration are usually an elevated temperature, decreased oxygen and increased respirations. Upon review of Resident 1's EMAR Staff G stated that they didn't know why just the blood pressure and pulse were being collected and recorded, but not the other vital signs. <Resident 3> (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 3's care plan dated 12/28/2024, showed they were admitted on [DATE] with diagnoses which included acute on chronic combined systolic and diastolic heart failure (a new worsening of an old condition with the heart not able to pump an adequate volume of blood throughout the body to meet demand, with fluid buildup occurring in the lungs and/or extremities). The same care plan had a focus for the resident being at risk for cardiac (heart) complications secondary to heart failure. A focus or intervention for a fluid restriction was not found. Review of Resident 3's order recapitulation for 12/01/2024 through 01/31/2025 showed a dietary order for an 1800 milliliter (ml) fluid restriction that began on 12/27/2024 and was discontinued on 12/31/2024. No orders to record the Resident's fluid intake were found. Review of Resident 3's Electronic Medication Administration Record (EMAR) showed no order to monitor fluid intake and/or record the intake for the resident. Hospital discharge orders for Resident 3, dated 12/27/2024, showed a recommendation for an 1800 ml fluid restriction. In an interview on 01/21/2025 at 12:45 PM, with Staff E, Resident Care Manager, they stated that when a resident admits there is an order put in automatically for 14 days of vital signs to be completed two times per day. Upon review of Resident 1s EMAR they stated that it looked like full sets of vital signs had not been documented, that there should have been full sets of vital signs for at least 14 days. During the same interview Staff E stated that Resident 3 had a diet order for a fluid restriction, but there were no orders to record the amount of fluid the resident drank each day, and so no place to record the volume of fluids on the EMAR. They further stated that recording the amount of fluid a person drinks when they are on a fluid restriction and have heart failure is important because they can fill up with fluid. Reference WAC 388-97-1060 (1)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27590 Based on observation, interview, and record review, the facility failed to ensure staff obtained accurate and timely weights, to include weights on admission and/or ongoing weights per the medical provider order, for 6 of 12 sampled residents (Residents 1, 2, 3, 5, 6, and 7), reviewed for nutrition. Further findings included failure to provide required assistance with meals for 1 of 12 sampled residents (Resident 1). These failures placed the residents at risk for unrecognized, unplanned, weight loss and nutritional complications. Findings included . <Resident 1> A facility assessment, dated 01/06/2025, showed Resident 1 was admitted on [DATE] with diagnoses which included a recent stroke with left sided weakness, colon perforation with a new ileostomy (surgical procedure where a diversion from the intestine to the outside of the abdomen is made to divert stool from the body) and need for enteral nutrition (nutrition provide in liquid form through a tube inserted through the nose and then into the stomach). The resident was not able to make their needs known. The assessment identified the resident was at risk for weight loss and an updated weight was needed. Review of Resident 1's admission paperwork, dated 12/30/2024, showed hand-written documentation of their admission weight of 169 lb. (pound) 2 oz (ounces), which was then lined out with a red pen and above was written 120 lb. 2 oz. Upon review of the Resident's weights in their facility medical record, 120 lbs. was entered on 12/31/2024. The next weight entered in their facility medical record under weights was on 01/14/2025 and was recorded as 147 lbs., 15 days after the resident was admitted . Review of Resident 1's meal monitors for 01/01/2025 through 01/22/2025 showed Resident 1 had intake of 75 -100 percent (%) of their meal on two occasions, otherwise their intake was 51-77% on three occasions, 26 to 50% on eight occasions, and 0-25% on 15 occasions. Refusals were recorded on 15 occasions. Review of Resident 1's January 2025 Electronic Medication Administration Record (EMAR) and medical orders from 12/30/2024 through 01/21/2025 showed that they had an order for enteral nutrition that started on 12/30/2024. The January EMAR showed five different enteral feed orders, none of the documentation showed the actual amount of nutrition that was administered. Further review showed an undated order for daily weights to be done at 8:00 AM daily, with no weights entered. Review of the Resident's initial weight change nutrition note, for loss/gain, dated 01/09/2025, showed the resident had an intake of 0 - 50%, and had one weight taken at that time of 120 lbs. At that time a by mouth nutrition supplement was added and their enteral nutrition timing was modified. Review of Resident 1's care plan, dated 12/31/2024, showed weights to be collected as ordered. A care plan intervention was added on 01/01/2025 for feeding assistance with meals. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Collateral Contact 1, 2 and 3, on 01/13/2025, they all stated that they were concerned their family member was losing weight and that they were not being offered feeding assistance by staff and that the tube placed for their enteral nutrition had been inadvertently dislodged by Resident 1 or had become plugged and had to be replaced (at the time of these interviews record review showed the tube had been replaced three times, with each replacement requiring a trip to the hospital and possibly time without their enteral nutrition administered). They further stated that while they were in the facility on 01/01/2025, 01/04/2025 and 01/07/2025 no feeding assistance was provided by staff for Resident 1. During an observation on 01/13/2025, at 12:05 PM through 12:26 PM, Resident 1 was observed to be sitting up in bed, with the head of their bed elevated, with a tray of pureed food and five different cups, one standard coffee cup with a plastic lid, one plastic cup with juice with a plastic cover, a nutritional shake in a cardboard container that was open, and two double handled cups with clear liquid in them. During this observation, Staff F, Nursing Assistant came into the room to assist the other Resident in the room back into bed but made no attempt to assist Resident 1 with eating. Resident 1 was observed to lift the double handled cup to their mouth multiple times but did not drink. Resident 1 was also observed to inadvertently put their left hand into their plate of pureed food on multiple occasions and then appeared to be confused, lifting their hand toward their eyes, shaking their head and then going back to lifting their cup and putting it down. Several times the Resident was observed to run their left hand through their hair, on the left side of their head, after having placed their left hand in their tray of food. During this observation Resident 1 would look at the investigator from time to time but did not answer questions or appear to understand the situation. During this observation the Resident's right hand rested at the level of their mid abdomen with their hand closed into a fist (admission diagnosis of left sided weakness, not right sided). During an interview with Staff F on 01/13/2025 at 12:25 PM, they stated that they knew they needed to assist Resident 1 with eating, but they had not had time to help them. During an interview on 01/13/2025 at 12:10 PM with Staff G, Registered Nurse, they stated that there was an active order to weigh Resident 1 daily, but that all they could see was one weight entered in their medical record. <Resident 2> A facility assessment, dated 12/31/2024, showed Resident 2, was admitted on [DATE] with diagnoses including right hip and elbow fractures and severe protein-calorie malnutrition (obvious significant muscle wasting with loss of fat). The Resident was able to make their needs known. The assessment identified the Resident was at risk for weight loss and an updated weight was needed. Review of the Resident's weights showed the Resident did not have an admission weight, the first weight was taken on 01/14/2025, 21 days after admission. Review of the Resident's initial weight change nutrition note, dated 12/31/2024, showed the Resident had an intake of 51 - 100%, had no facility weights available, and there was no admission weight. The assessment noted the need for updated weight to determine recent weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 3> A facility care plan, dated 01/01/2025, showed Resident 3 was admitted on [DATE] with diagnoses which included heart failure and after care following a leg amputation. The Resident was able to make their needs known. The care plan included a focus for being at risk for weight loss, malnutrition or poor hydration status related to chronic disease as well as a focus to weigh the resident as ordered. Review of the Resident's weights showed the resident did not have an admission weight, the first weight was taken on 01/05/2025, 10 days after admission. Review of the Resident's hospital discharge paperwork, dated 12/27/2025, showed the order for daily weights related to their heart failure. Review of Resident 3's order recapitulation from 12/01/2024 through 01/31/2025 showed no orders for weights to be completed. <Resident 5> A facility assessment, dated 01/15/2025, showed Resident 5 was admitted on [DATE] with diagnoses which included a fractured arm and leg. The Resident was able to make their needs known. The assessment identified the Resident was at risk for weight loss. Review of the Resident's weights showed the resident did not have an admission weight, the first weight was taken on 01/14/2025, almost a week later. Review of the Resident's meal monitor from 01/09/2025 through 01/23/2025 showed the Resident had 1 day of at least one meal they ate 0 - 25% and 7 days they ate 26-50%. Review of the Resident's initial weight change nutrition note, dated 01/16/2025, showed the Resident had an intake of 0 - 100%, had only 1 weight at the time of the note, and there was no admission weight or height for the resident. Staff were to continue to monitor the resident. <Resident 6> A facility assessment, dated 01/09/2025, showed Resident 6 was admitted on [DATE] with diagnoses which included Diabetes. The Resident was able to make their needs known. Review of the Residents weight record showed there was no weight on admission, the first weight was taken on 01/09/2025, almost a week later. Review of a weight change nutrition note, dated 01/09/2025, showed the Resident did not have a height documented and did not have an initial admission weight. The summary noted the Resident's intake was adequate and the resident would be reviewed in a week. <Resident 7> (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility assessment, dated 01/16/2025, showed Resident 7 was admitted on [DATE] with diagnoses which included an infection of the skin. The Resident was able to make their needs known. Review of Resident's weight record showed there was no weight on admission, the first weight was dated 01/19/2025, nine days later. There was no documentation the Resident had an initial weight change nutrition note. During an interview on 01/21/2025 at 12:45 PM, Staff E, Resident Care Manager, stated the nurse managers entered the orders for weights at admission. They stated that they were new to the position and that they would have to verify what weight orders to enter when resdent's were admitted as the information was not on their cheat sheet. During an interview on 01/23/2025 at 2:52 PM, Staff D, Director of Nursing, stated the residents were to all be weighed on admission, weekly for 4 weeks, and if stable monthly. If an admission weight was not taken, staff could use the hospital weight if it was clearly dated and within the last 30 days, stating it was not ideal. Staff D stated they did weight change nutrition meetings at admission and then if needed, and weights were reviewed at that time. Staff D confirmed the above residents did not have admission weights completed. Reference: WAC 388-97-1060(3)(h)