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	02/10/2025

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

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to ensure psychotropic medication consents were accurate and obtained prior to their administration for 2 of 7 sampled residents (Residents 1 and 2) whose medications were reviewed. This failure placed the residents or their representative at risk of not being fully informed of the potential risks and benefits of taking the medications. Findings included . <Resident 1> Record review showed Resident 1 admitted to the facility on [DATE] with orders for the staff to administer sertraline, a psychotropic. Review of the December 2024 and January 2025 Medication Administration Records (MAR) showed the staff administered sertraline daily, starting 12/12/2024 through 01/16/2025. Review of a medication consent for sertraline showed the facility discussed the risks, benefits, purpose, and side effects of the medication with Resident 1's Power of Attorney for healthcare on 01/01/2025, 21 days after the resident's admission to the facility. <Resident 2> Review of an undated consent for Lexapro (a psychotropic) and a 01/13/2025 consent for mirtazapine (a psychotropic) showed Resident 2's signature to the consents. The consents provided the resident the opportunity to choose whether they agreed to the use of the psychotropics. The consents showed no documentation Resident 2 made any choice to the use of the psychotropics. Review of the January and February 2025 MAR showed orders for the administration of mirtazapine and Lexapro since 01/10/2025 and 01/11/2025 respectively. The MAR showed the staff administered the psychotropics daily through 02/06/2025, a total of 28 days, despite the consent not showing the resident's choice to use the medications. The above information was shared with Staff B, Assistant Director of Nursing, on 02/07/2025 at 9:29 AM. Staff B acknowledged the inadequate consents for the use of the psychotropics. Staff B stated that the consents should be signed and completed prior to the staff giving the medication. No further information was provided. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97-0300(3)(a), -0260, -1020(4)(a-b).

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to notify the resident representative of a significant weight loss experienced by 1 of 7 sampled residents (Resident 1) reviewed for nutrition. This failure placed the resident at risk for delayed decisions for treatment by the legal representative. <Resident 1> In an interview on 02/04/2025 at 12:06 PM, a Collateral Contact stated that on a visit with Resident 1, they observed the resident, looked terrible, skinny. In an interview on 02/05/2025 at 2:47 PM, another Collateral Contact stated that when they visited Resident 1, they were, not touching food when food was in front of [them]. Review of a 12/17/2024 comprehensive assessment showed Resident 1 admitted to the facility on [DATE], had severe cognitive impairment, and required assistance for eating. Record review also showed Resident 1 had a Power of Attorney (POA) for medical decision-making. Review of a 12/11/2024 hospital discharge summary showed Resident 1's weight at 178.9 pounds. Review of the facility's electronic medical records showed the staff obtained a weight on 12/18/2024 of 161.6 pounds, a significant weight loss of 17.3 pounds or 9.67% in one week. Review of Resident 1's medical record showed no documentation the facility notified Resident 1's POA of the significant weight loss. The above information was shared with Staff B, Assistant Director of Nursing, on 02/07/2025 at 9:49 AM. Staff B stated that the staff should notify resident representatives of a significant weight loss. Staff B acknowledged the medical record showed no documentation the staff notified Resident 1's POA of the significant weight loss. Reference WAC 388-97-0320.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 45433 Based on interview and record review, the facility failed to implement written abuse policies and procedures related to monitoring for psychosocial harm after abuse and/or neglect allegations for 4 of 6 residents (Residents 7,8, 9 and 10). This failure placed residents at risk for unmet care needs related to possible psychosocial harm. Findings included . Review of the facility policy titled, Abuse revised 10/20/2022, showed the facility would maintain and implement policies and procedures to prohibit and prevent abuse that would include: in the event of an allegation or observation of abuse, the facility will immediately assess the resident . The policy further states that the resident's plan of care will be revised to reflect interventions to minimize recurrence and to treat any injury or harm identified through assessment of the resident. <Resident 7> Review of Resident 7's medical record showed they were admitted to the facility with diagnoses including Chronic Obstructive Pulmonary Disease (ongoing lung disease caused by damage to the lungs) and heart failure (failure of the heart to pump blood efficiently throughout the body). Their care plan dated 12/18/2024 and revised on 01/14/2025 showed the resident had a history of trauma. Record review of a facility investigation dated 12/31/2025 showed that on that date Resident 7 reported a staff member looking through the drawers in their room and taking photos of them. The investigation stated that the resident was placed on alert. Record review did not show evidence that the resident was monitored or assessed after the incident for any signs or symptoms of psychosocial harm. <Resident 8> Review of Resident 8's medical record showed they were admitted to the facility with diagnoses including vascular dementia (lack of blood flow to the brain causing impaired reasoning, judgement and memory) and right sided weakness after a stroke. Their care plan dated 12/17/2024 showed the resident was dependent on staff for toileting. Record review of a facility investigation dated 01/02/2025 showed that on that date Resident 8 was found to have not been changed during a specified shift. The investigation stated that the resident reports no impaired psycho-social wellbeing from incident. Record review did not show evidence that the resident was monitored or assessed after the incident for any signs or symptoms of psychosocial harm. <Resident 9> Review of Resident 9's medical record showed they were admitted to the facility with diagnoses including high blood pressure and difficulty walking. Their care plan dated 02/05/2025 showed the resident had a history of trauma. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a facility investigation dated 01/23/2025 showed that the resident reported that there had been a call light response delay resulting in having to sit in a wet bed. The investigation stated that the resident was placed on alert. Record review did not show evidence that the resident was monitored or assessed after the incident for any signs or symptoms of psychosocial harm. <Resident 10> Review of Resident 10's medical record showed they were admitted to the facility with diagnoses including Chronic Obstructive Pulmonary Disease (ongoing lung disease caused by damage to the lungs) and dementia (damage to the brain causing impaired reasoning, judgement and memory). Daily nurse documentation on 12/23/2024 at 8:58 PM noted that the resident was incontinent of bladder and required assistance to use the toilet. Record review of a facility investigation dated 01/01/2025 showed that Resident 10's roommate had reported that a nursing assistant had declined to assist the resident to the bathroom. The investigation stated that the resident was placed on alert. Record review showed no evidence that the resident was monitored or assessed after the incident for any signs or symptoms of psychosocial harm. During an interview on 02/10/2025 at 10:32 AM, Staff C, Director of Nursing, stated that after an allegation of abuse or neglect the facility process was to place the resident on alert, typically for 72 hours, during which time the nursing staff would complete a progress note each shift indicating they had monitored and assessed the resident for any signs or symptoms of psychosocial harm related to the specific incident the resident had been involved in. If psychosocial harm was found the resident would have care plan updates and follow-up as needed. During an interview on 02/10/2025 at 10:48 AM, Staff A, Administrator, stated that the alert charting order was in place for each resident, but that nursing was not consistently completing the charting in each resident's progress notes. Reference: WAC 388-97-0640(1)(6)(b)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 45433 Based on interview and record review, the facility failed to complete a thorough investigation into allegations of neglect, to include a skin assessment, for 1 of 5 residents (Resident 11) reviewed for abuse and/or neglect. Failure to complete a skin assessment placed the resident at risk for unmet care needs and diminished quality of life. Findings included . Review of a 01/10/2025 facility investigation noted that Resident 11 was found soaking wet, with brown urine rings soaked through [their] bedding and stool stuck to [their] bottom. The facility investigation noted that a skin check was completed and no skin issues noted. Record review on 02/06/2025 did not find a skin check for that date in Resident 11's medical record or in the facility investigation. A skin assessment was found for 01/08/2025 at 3:56 PM with no skin concerns in the groin region noted. On 01/12/2025 Resident 11 received assistance with a shower and no skin concerns were noted at that time. In an interview with Staff C, Director of Nursing, on 02/10/2025 at 10:32 AM, they stated that a skin check needed to be completed after an allegation of neglect or abuse. They further stated that the skin check had been done after the allegation on 01/10/2025. In email correspondence with Staff A, Administrator, on 02/11/2025 at 9:44 AM, they wrote that the nurse who worked with Resident 11 on 01/10/2025 worked for an agency and had not been allowed to return to the facility. No skin assessment after the substantiated neglect allegation on 01/10/2025 was produced for review. Reference: WAC 388-97-0640 (6)(a)(b)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to maintain complete and accurate records for 9 of 10 sampled residents (Residents 1, 2, 3, 4, 5, 6, 12, 13 and 14) whose medical records were reviewed. Failure to ensure completed consents for psychotropics (drugs that affect a person's mental state), signed nutrition documents, accurate documentation in progress notes, complete discharge paperwork, complete assessment and monitoring, accurate code status within a resident chart, and an accurate weight record, placed the residents at risk for unmet needs. Findings included . <Incomplete Psychotropic Consents> <Resident 2> Review of Resident 2's medical record showed an undated consent for Lexapro (a psychotropic) signed by Resident 2. The form showed no documentation who reviewed the form with the resident, and the areas to be addressed by staff with the resident were left blank. Similar findings were identified with a [DATE] consent for mirtazapine (a psychotropic). <Resident 3> Review of Resident 3's medical record showed [DATE] informed consents for Xanax (a psychotropic) and mirtazapine, but no resident signature. <Unsigned Nutrition Assessments> Review of Nutrition Assessments showed no documentation on who completed the assessments for the following residents: Resident 1 - [DATE], [DATE], [DATE], and [DATE] Resident 2 - [DATE] and [DATE] Resident 3 - [DATE] and [DATE] Resident 4 - [DATE] and [DATE] Resident 5 - [DATE] and [DATE] Resident 6 - [DATE] Resident 14 - [DATE], [DATE], and [DATE] Resident 15 - [DATE] (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Inaccurate Progress Notes> <Resident 1> Record review showed Resident 1 had severe cognitive impairment. Review of a [DATE] Care Conference Note showed the staff gave Resident 1 a NOMNC (Notice of Medicare Non-Coverage, a document informing them that their Medicare covered services were ending and explained how they could appeal the decision if they disagreed with it). Review of a [DATE] NOMNC showed it was signed by Resident 1's representative, contrary to the [DATE] progress note. <Incomplete Discharge Paperwork> <Resident 1> Review of Notice of Transfer of Discharge and Discharge Transition Plan and Acknowledgement forms showed the facility obtained a verbal consent from Resident 1's representative on [DATE]. The forms served to show the facility discussed specifics about Resident 1's discharge. Review of the forms showed all areas of discussion were left unchecked, to include Comments for items not checked. The forms showed no documentation which staff obtained the verbal consent from the representative to discharge or transfer the resident. <Incomplete assessment and/or monitoring> <Resident 12> Record review showed that on [DATE] Resident 12 may have received their roommate's medication. The facility investigation noted the medical provider told nursing staff to monitor for any possible adverse effects for the possibility of receiving the wrong medications. Further record review found no evidence of Resident 12 being monitored after the reported incident. <Resident 13> Record review of a facility investigation showed that on [DATE] it was alleged that Resident 13 had not had a surgical dressing change in six days. The investigation noted the wound was healing within normal limits. Further record review found no skin assessment conducted and no progress notes indicating the state of the incision or if/when dressing changes had occurred between [DATE] and [DATE]. A handwritten statement dated [DATE] of a nurse assessment of Resident 13's wound was provided to the investigator on [DATE] at 9:44 AM. <Incorrect code status> <Resident 14> Record review of Resident 14's medical chart showed a Physician Order for Life-sustaining Treatment (POLST) document signed on [DATE] with direction to not administer cardiopulmonary resuscitation (CPR). During record review on [DATE] it was observed that Resident 14's banner area of their medical chart, containing quick access to code status, allergies, contacts as well as other information, indicated Resident was a full code (wished to have CPR if it was indicated). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Inaccurate weight record> <Resident 14> Review of weights for Resident 14 found weight documentation that widely fluctuated with indication from nutrition notes on [DATE] that weights weresuspect on [DATE] and [DATE]. No re-weighs on these dates were found to determine accuracy. Thus the facility staff were unable to determine if the resident had gained or lost weight over time. The above findings were shared in a joint conversation with Staff A, Administrator, and Staff B, Assistant Director of Nursing, on [DATE] at 9:49 AM. Staff B stated that the [DATE] Care Conference Note in Resident 1's medical record was erroneous and should have shown it was given to the representative. Staff A and Staff B acknowledged the incomplete and inaccurate medical records and that dates, signatures, and completed forms were required. Reference WAC [DATE] (1)(a)(i-iv)(b).