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	03/25/2025

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 0684 Level of Harm - 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 order labs on admission, to act timely in accordance with professional standards for critical lab results and medical provider orders for 1 of 3 residents (Resident 1) reviewed for quality of care. Resident 1 experienced harm when they had the change in condition that required transfer to the hospital for treatment and were diagnoised with acute kidney failure. These failures placed residents at risk for unintended health consequences and decreased quality of life. Findings included . Record review showed that on [DATE] Resident 1 admitted from the hospital to the facility. Review of their hospital discharge documentation showed that the resident had been at the hospital for treatment of heart failure (the heart cannot pump enough blood to meet the body's needs) with pulmonary hypertension (high blood pressure in the arteries in the lungs) and fluid overload (occurs when the body cannot get rid of excess fluid). They were discharged to the facility with normal kidney function (glomerular filtration rate (eGFR) of 91 (above 90 is considered normal) on [DATE])) on oral diuretic medication (torsemide) with an order to monitor the resident's kidney function twice weekly. The same record indicated the resident was a full code (wanted all treatment possible to sustain life). Record review showed that on [DATE], Staff D, Medical Doctor, saw the resident and ordered labs to be completed on [DATE]. They further reviewed the resident's history and most recent labs and wrote that the resident was medically stable. Record review of progress notes for Resident 1 found that on [DATE] at 6:52 AM, Staff B, Licensed Practical Nurse (LPN) wrote, Resident was worried last night about [their] fluid overload. [They] feel as if [they] [are] filling up again. [They] [have] not had any urination since [their] dose of torsemide evening shift .[their]diuretic was given early .per [their] request. Day shift nurse to monitor for results. Placed in provider book so [they] can speak to them about the issue. Lung sounds are diminished in the bases with upper field wheezing (indicates possible fluid in the lungs). Record review found that Resident 1 was not seen by a medical provider on [DATE] and no nursing progress notes were written for the resident. Further review of the Resident's Medication Administration Record (MAR) showed the lab scheduled for that day was signed off by the nurse, indicating it was completed. (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 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident 1's resulted labs showed that on [DATE] at 8:11 PM the ordered labs were collected, and the labs resulted the same day at 10:15 PM. The lab results showed an eGFR of 12 (indicated kidney failure-kidneys can no longer filter fluids and waste products and they build up in the body), a creatinine (a measure of how well the kidneys are filtering waste products from the blood) of 4.74 mg/dL (normal is between 0.7 to 1.5, with higher levels indicating waste is not being filtered) and a Blood Urea Nitrogen (levels above normal indicate kidney damage) of 71 mg/dL (normal is between ,d+[DATE]). Record review of the Resident 1's facility medical record did not documentations that the resident was refusing hospital care. During an interview on [DATE] at 10:03 AM, Resident 1's spouse stated that they woke on the morning of [DATE] to find a voicemail from Resident 1 asking them if they thought they should go to the hospital. They further stated that they didn't know what [Resident 1] was thinking, of course [they] should have gone to the hospital, I did not get the voicemail until morning because I were so exhausted. They further stated that Resident 1 had possibly not been thinking clearly as they had a medical background and should have understood what the lab values meant. They stated that if they had spoken to their spouse, they would have told [them] [they] had to go to the hospital and that no one else from the facility called. Resident 1's spouse further stated that they had met Resident 1 at the hospital on [DATE] and there had been an attempt to try dialysis (a medical procedure that removes waste products from the bloodstream when the kidneys are unable to function) but that it had not worked, and Resident 1 had died of kidney failure on [DATE]. During an interview on [DATE] at 1:40 PM, Staff F, Advanced Registered Nurse Practitioner (ARNP), stated that they saw Resident 1 on [DATE] and during the visit the resident expressed concern that they were filling up with fluid, also that labs had not been done. They stated that they then ordered STAT (to be completed as soon as possible) labs. At that time, Staff F stated that the resident did not want to go to the hospital, that they wanted to see their labs and decide after that if they needed to go to the hospital. During an interview on [DATE] at 11:53 AM, Staff B, stated they worked with Resident 1 on the night shift of [DATE] into [DATE] and again on [DATE] into [DATE]. They stated that the resident was concerned they were filling up with fluid on both nights. They indicated that on the night of [DATE] into [DATE] they had written the resident's concerns in the doctor book so that the resident could be seen by the medical provider that day. They further stated that on the night of [DATE] they had received the resulted labs for Resident 1 after 10:00 PM, showing that the resident was in kidney failure. They stated that they then gave a copy of the labs to the resident per their request and told them they were going to call the on-call medical provider. They stated that they called the on-call medical provider, Staff E, ARNP, with the critical lab values between , d+[DATE] AM. They stated that the ARNP they spoke to did not give any orders but stated that the facility medical provider would see the resident on [DATE]. They stated that they could not remember if they went back and talked to the resident after speaking to Staff E, I had 55 patients that night, I can't remember if I went back or not. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 11:56 AM, Staff C, Registered Nurse, stated that they were told by the night shift nurse that during the night of [DATE] into [DATE] Resident 1 had complained of decreased urine output and trouble breathing. Staff C then worked for 16 hours on [DATE], during which time the Resident had one wet incontinence brief, had diminished lung sounds and was short of breath when they got up to have their weight taken. Staff C further stated that they thought that the labs scheduled to be completed that day had already been completed. Record review of the medical provider on-call log showed that at 1:00 AM on [DATE], Staff E, ARNP, took a call related to Resident 1. The note stated that STAT labs had been completed with an elevated creatinine. The note further stated alert and oriented at baseline, no complaints reported. Nurse reports resident is very anxious about condition. The recommendations section of the note state, in house to follow up to discuss results and goal of care and notify provider of any change in condition. Record review showed a note from Staff F, on [DATE], that indicated Resident 1 needed hospital treatment related to the lab values that had resulted the night before. Record review showed Staff G, LPN, wrote a progress note on [DATE] at 10:22 AM that stated the staff F ordered Resident 1 to go to the hospital for evaluation and an ambulance was called. Staff G wrote another note at 10:56 AM that the resident had left in the ambulance, about 12 hours after the critical lab results had been available and about three days since Resident 1 had started complaining of decreased urination and feeling like they were filling up with fluid. During an interview with Staff A, Resident Care Manager, on [DATE] at 12:33 PM, they stated that the lab orders for Resident 1, that came from the hospital, should have been entered upon admit and were not. They further stated that the labs ordered to be completed on [DATE] had also not been completed. They further stated that if a resident is having trouble breathing or had concerns for filling up with fluid, that the nurse working with the resident should not write in the medical provider book, the book is for non-urgent needs, but should have called the medical provider. They further stated that when the critical labs for Resident 1 had resulted that the nurse could have called the on-call nurse manager for consult. They stated that if they had received a call with the lab values reported they would have told the resident they needed to go to the hospital, that there was nothing that could be done for them at the facility. Reference (WAC) [DATE](1)