

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 04/03/2025
NAME OF PROVIDER OR SUPPLIER Spokane Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297</p> <p>Based on observation, interview, and record review, the facility failed to provide appropriate care and treatment for 3 of 3 sample residents (Residents 1, 2, and 3), who had surgically inserted devices to provide intravenous (IV) access. Specifically, the facility failed to show adequate monitoring of the IV site, document maintenance flushes, and change site dressings as required. These failures placed the residents at risk for medical complications associated with the use of IV devices.</p> <p>Findings included .</p> <p>Review of a 02/21/2024 Centers for Disease Control (CDC) article showed, a central line (CL) is a catheter (tube) placed in a large vein in the neck, chest or groin to give medication or fluids or to collect blood for medical tests. Central lines accessed a major vein close to the heart, could remain in place for weeks or months, and were much more likely to be a source of serious infection. Types of CL include a peripherally inserted central catheter (PICC, placed into a vein in the arm), a tunneled catheter (passed under the skin and placed into a vein in the chest or neck), and an implanted port (surgically placed under the skin and medicines inserted using a needle placed through the skin into the catheter).</p> <p>Review of a 2017 revised CDC article titled, Guidelines for the Prevention of Intravascular [within a blood vessel] Catheter-Related Infections showed, it recommended to facilities to educate staff regarding proper procedures for the maintenance of CL, establish appropriate infection control measures to prevent catheter-related infections, periodically assess knowledge of and adherence to guidelines for all staff involved in the maintenance of CL, and designate only trained staff who demonstrate competence for the maintenance of CL. The recommendations included instructions to the staff to replace a CL site dressing routinely at least every 7 days for transparent dressings or if it became damp, loosened, or visibly soiled. The article showed the staff should monitor the CL sites visually when changing the dressing or by touch through an intact dressing on a regular basis.</p> <p>Review of an 08/2021 facility policy titled Dressing Change for Vascular Devices showed that to prevent local and extensive infection related to CL, transparent dressings were changed every 7 days and as needed.</p> <p>(continued on next page)</p>

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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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An undated facility policy titled Central Venous and Midline Catheter Flushing showed catheters were flushed before and after intermittent solutions and medication administration. This ensured CL patency, prevented mixing of incompatible medications and solutions, and ensured the entire dose of the solution or medication was administered. Review of an 08/2021 facility policy on IV lines showed a prescriber's order was required for all IV flushes.</p> <p><Resident 1></p> <p>Review of the 03/27/2025 significant change assessment showed Resident 1 readmitted to the facility on [DATE] from the hospital. The assessment showed the staff assessed Resident 1 had severe cognitive impairment and admitted with a diagnosis of pneumonia.</p> <p>Review of 03/21/2025 hospital transfer orders showed, Picc line per protocol. The orders included the administration of two IV antibiotics, cefazolin (administered every 8 hours), and ertapenem (administered every 24 hours) for sepsis (a serious condition in which the body responds improperly to an infection), pneumonia, and bacteremia (the presence of bacteria in the bloodstream). The transfer orders showed Discharge References/Attachments for PICC Line Care but no reference or attachments were located with the transfer orders.</p> <p>Review of the March and April 2025 Medication Administration Records (MARs) and Treatment Administration Record (TARs), showed no instruction to the staff on PICC line protocol for management of Resident 1's CL, to include changing the site dressing, flushing of the line, and monitoring of the CL.</p> <p>Review of the 12/31/2024 comprehensive care plan showed no information to the staff that Resident 1 had a CL, the type of, or interventions related to the care and maintenance of it, to include prevention of CL related complications.</p> <p>Review of progress notes from 03/21/2025 to 04/03/2025 showed, the staff assessed Resident 1 had a PICC line to the right upper arm with a dressing. The staff documented the resident's PICC line was patent and/or flushed (from 03/22/2025 to 3/26/2025) despite no orders for the flush. On 03/29/2025 and 03/30/2025, the staff documented the PICC line was a little sluggish and PICC patent but a little bit of resistance noted. On 04/01/2025 the staff documented, Dressing reinforced to PICC site on right upper inner arm. No documentation showed the staff changed Resident 1's PICC line dressing.</p> <p>An observation and interview on 04/03/2025 (13 days after admission) at 11:04 AM showed, Resident 1 was lying in bed. Observed to the upper, inner right arm was a CL under a transparent dressing. Staff C, Licensed Practical Nurse (LPN), visually confirmed at that time the CL was a PICC and the presence of the initials and date, OUT, OTP and 03/20/2025 on the transparent dressing. When asked what the initials meant, Staff C stated, I have no idea. When asked if the dressing required to be changed, Staff C stated, I don't do that one. I'd have somebody else do it.</p> <p><Resident 2></p> <p>Review of the 03/23/2025 admission assessment showed Resident 2 admitted to the facility on [DATE] from the hospital. The assessment showed the staff assessed Resident 2 was cognitively intact and admitted with medically complex conditions.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of 03/17/2025 hospital transfer orders showed Resident 2 experienced an infection to the left ankle and required weekly blood draws for infectious disease management. The orders instructed the staff to administer meropenem (an antibiotic) into the vein every eight hours. The transfer orders showed Resident 2 had a Medi-port (a surgically implanted device under the skin that provided long-term access to a major vein for administering medications, fluids, and blood products, or for drawing blood samples) to the right chest.</p> <p>Review of a 03/17/2025 handoff report showed, the hospital communicated to the facility Resident 2 had an IV Port Rt [right] chest].</p> <p>Review of the March and April 2025 MARs and TARs showed no instruction to the staff for the management of Resident 2's CL, to include changing the site dressing, flushing of the line, and monitoring of the CL.</p> <p>Review of the 03/17/2025 comprehensive care plan showed no information to the staff Resident 2 had a CL, the type of, or interventions related to the care and maintenance of it, to include prevention of CL related complications.</p> <p>Review of progress notes from 03/17/2025 to 04/03/2025 showed the staff documented on 3/17/2025, Resident has midline port in place. A midline port is not a medical term. Review of 03/19/2025 and 03/31/2025 notes showed the staff assessed, PICC line noted. Right Chest. A 04/02/2025 note showed the staff assessed Resident 2 had, No intravenous, infusion or dialysis sites present.</p> <p>An observation and interview on 04/03/2025 at 11:59 AM showed, Resident 2 was sitting up in front of an over-the-bed table. Observed to the upper right chest was a CL catheter under an undated transparent dressing. Resident 2 stated that the last time their dressing was changed was, Last Monday, and previously had concerns with, One nurse wasn't scrubbing the port [where the needle entered the skin] when giving the medication and I reported it, and they took care of it. Scrubbing helps to remove surface bacteria and other microorganisms that could potentially enter the bloodstream through the access point, leading to infection.</p> <p><Resident 3></p> <p>Review of the 03/26/2025 admission assessment showed Resident 3 admitted to the facility on [DATE] from the hospital with medically complex conditions, to include an abscess to the spine. The assessment showed the staff assessed Resident 3 had moderately impaired cognition.</p> <p>Review of 03/19/2025 hospital transfer orders showed Resident 3 had a PICC line and required weekly blood draws. The orders instructed the staff to administer two antibiotics into the vein once a day.</p> <p>Review of the March 2025 TAR showed the staff documented they changed Resident 3's CL dressing on 03/27/2025.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation and interview on 04/03/2025 at 12:14 PM showed, Resident 3 was sitting up in front of an over-the-bed table. Staff D, LPN, and the resident representative were also present during the observation. Observed to the upper, inner right arm was a CL catheter under a transparent dressing dated 03/19/2025 and was acknowledged by Staff D. Resident 3 stated, They haven't changed this dressing since I came here. Staff D reviewed the resident's March 2025 TARs and acknowledged the dressing did not reflect the date of 03/27/2025. Staff D stated Resident 3, missed a dressing on that particular day [03/27/2025]. Staff D stated that to ensure the CL functioned adequately and to prevent complications, the staff must flush the CL before and after the antibiotic administration, and determine the presence of a dressing and how long since its last change. Staff D stated that CL dressings should be changed weekly or within the week.</p> <p>The above findings were shared with Staff B, Assistant Director of Nursing on 04/03/2025 at 11:34 AM. Staff B stated that CL dressings were changed, Every 5 days. Staff B stated that the nurses knew when a CL dressing change was due by referring to orders in the MAR and by looking at the date on the CL dressing. Staff B said that to prevent CL related complications, the nurses should monitor the site for infection and get a flush order for before and after medication administration and as needed to prevent clotting. Staff B acknowledged Residents 1 and 2 medical records showed no orders or instructions to the staff that the residents had a CL, the type of, or interventions related to the care and maintenance of it, to include prevention of CL related complications.</p> <p>Reference WAC 388-97-1060 3(j)(i).</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>40297</p> <p>Based on observation and interview, the facility failed to ensure the staff secured topical (applied on the skin) medications for 1 of 4 units observed. This failure placed residents at risk for medication errors and accidental ingestion.</p> <p>Findings included .</p> <p>An observation on 04/04/2025 at 10:17 AM showed Staff C, Licensed Practical Nurse, walked out of a room in the back end of the Northwest Unit (Rooms 130 to 135) and head to the medication cart parked in the hall near those rooms. Observed about two rooms down from the medication cart and towards an exit door was a treatment cart. On top of the treatment cart were four food boats (disposable food packaging designed to hold a variety of foods), each identified with a forename. One boat had a medication cup with white powder inside, another had a medication cup with a white cream inside. Another boat had two medication cups, one with green cream and the other with white powder inside. Yet another boat had a medication cup with green cream inside.</p> <p>On 04/04/2025 at 10:18 AM, the above findings were shared with Staff C who was still standing at the medication cart. Staff C stated, Oh, that's me. I forgot to put them [medications] in the drawer, because they got distracted.</p> <p>The above findings were shared with Staff B, Assistant Director of Nursing, on 04/03/2025 at 11:45 AM. Staff B stated that all topical medications should be locked in the treatment or medication cart. Staff B stated that Staff C, Stepped away [from the treatment cart and] forgot about them and got busted.</p> <p>Reference WAC 388-97-1300(2).</p>