

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  07/25/2025
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, interview, and record review, the facility failed to ensure available staff provided the necessary care and services in a timely manner for 8 of 10 sampled residents (Resident 1, 2, 3, 4, 5, 6, 7, and 8), reviewed for call light response. This failure placed the residents at risk for unmet care needs and a diminished quality of life. Findings included. &amp;lt;Resident 1&amp;gt;A facility assessment, dated 06/16/2025, showed Resident 1 was admitted with diagnoses to include both arms fractured. The resident was able to make their needs known and was dependent on most Activities of Daily Living (ADL's). During an interview on 07/22/2025 at 1:18 PM, Resident 1 stated the call light response time was not good at the facility. Resident 1 said sometimes staff came in, told them they had to get help, and took a long time to return. On 07/22/2025 at 3:30 PM, Resident 1's call light was on and sounded at the nurses' station. Staff seen in the nurses' station and several staff walked past the resident's room. The call light system at the nurses' station read the call light had been on 45 minutes. At 3:32 PM, the surveyor went into Resident 1's room and Resident 1 stated they needed to have their brief changed. At 3:35 PM, a staff member entered Resident 1's room to assist them. The call light had been on for 50 minutes before Resident 1 received help. &amp;lt;Resident 2&amp;gt;A facility assessment, dated 06/19/2025, showed Resident 2 was admitted with diagnoses of a prior stroke. The resident had difficulty making their needs known and was dependent with toileting. On 07/22/2025 at 1:13 PM, Resident 2's call light was on. The call light system at the nurses' station showed it had been on 26 minutes before being answered. On 07/25/2025 at 10:00 AM, Resident 2 was lying in bed with their call light within reach. The resident was asked about what the response was when they used the call light, the resident lifted up their call light and did not answer the question. &amp;lt;Resident 3&amp;gt;A facility assessment, dated 07/01/2025, showed Resident 3 was admitted with diagnoses to include a narrowing of their spine in the neck. The resident was able to make their needs known and required partial/moderate assistance with most ADL's. On 07/11/2025 at 1:07 PM, Resident 3's call light was turned on. It lit outside of the resident's room and sounded at the nurses' station. At 1:29 PM, Resident 3's call light remained on. Several staff walked past the resident's room and a nurse was at their cart just outside the resident's room. The call light had been on for 22 minutes. The resident's call light was answered at 1:34 PM, 27 minutes after the call light had been pushed. On 07/18/2025 at 11:25 AM, Resident 3 was in their wheelchair in their room. The resident had a collar on their neck. When asked about call light response times, the resident stated sometimes it took a long time to be answered. The surveyor told the resident the prior day their call light had been on for 27 minutes and Resident 3 stated that was not as bad as other times. Resident 3 stated they felt their call light was ignored because someone had told them they were a difficult patient. &amp;lt;Resident 4&amp;gt;A facility assessment, dated 06/21/2025, showed Resident 4 was admitted with diagnoses to include a stroke. The resident was able to make their needs known, required substantial/moderate assistance with most ADL's and dependent with toileting. On 07/22/2025 at 2:03 PM, Resident 4's call light came on in the hall. At 2:22 PM Resident 4 was laying in their bed. When asked what they had their call light on for, the resident stated they didn't know it was on. Resident 4 stated the facility was very slow on everything, which included the call lights. At 2:43 PM, the call light remained on. The call light system sounded in the nurses' station and showed the resident's call light had been on for 40 minutes. Staff were seen at the nurses' station and walked by the resident's room. At 2:55 PM, the call light was answered after being on for 52 minutes. &amp;lt;Resident 5&amp;gt;A facility assessment, dated 06/27/2025, showed Resident 5 was admitted with diagnoses to include a fractured leg. The resident was able to make their needs known, required substantial/maximum assistance with most ADL's, and partial/moderate assistance with toileting. On 07/22/2025 at 3:33 PM, Resident 5's call light was on. The call light system at the nurses station showed it had been on for 29 minutes. The light was answered at 3:34 PM, after 30 minutes on. On 07/25/2025 at 10:13 AM, Resident 5 was sitting in their wheelchair in their room. The resident stated the care at the facility was slow and they needed more help. The resident stated when they pushed their call light it would take a long time for someone to answer it. At 12:55 PM, Resident 7, Resident 5's roommate, stated they had to wait for an hour at times to get help. Resident 7 stated they couldn't stand or walk by themselves and required a sit to stand lift to get to the commode. &amp;lt;Resident 6&amp;gt;A facility assessment, dated 07/25/2025, showed Resident 6 was admitted with diagnoses to include a fractured arm and pelvic bone. The resident had some difficulty making their needs known and required substantial/maximum assistance for ADL's which included toileting. On 07/25/2025 at 9:06 AM Resident 6's call light was on. Several staff walked by the resident's room and did</p>		