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	03/05/2026

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 - 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** Based on interview and record review, the facility failed to assess, evaluate and monitor non-pressure skin conditions for 1 of 3 sampled residents (Resident 1). Resident 1 developed an inflammatory skin rash while in the facility between the folds of skin under their stomach and in the groin area. In addition, the resident was sent to the hospital on [DATE] where it was discovered their staples remained in place from a 12/18/2025 surgery. These failures placed residents at risk of not receiving timely treatment and services to prevent worsening skin conditions. Findings included . The undated facility policy Non-Pressure injury/Ulcer management documented the nursing facility would ensure systems and processes were in place to assist in the identification, investigation, treatment and care of residents with non-pressure injury related wounds. Staff would report any observation of a change in the resident's skin integrity, which would include surgical wounds. Weekly skin observations would be conducted by a licensed nurse and findings documented in the resident's medical record. Documentation may include location of ulcer/injury, date ulcer/injury acquired, description to include measurements, type of tissue, presence/absence of drainage, surrounding tissue description, and presence/absence of pain with the wound.The 01/09/2026 facility admission assessment documented Resident 1 was admitted on [DATE] with diagnoses to include a hip fracture with a surgical wound on the right hip. Resident 1 was able to make their needs known. The 01/02/2026 hospital transfer orders documented the resident had a wound to their right hip with staples. Wound care was to include the surgical dressing be changed daily or as needed. The orthopedic (specialty in medicine dealing with conditions that affect bones) discharge instructions documented the resident had surgery on 12/18/2025 and a follow-up appointment with the surgeon was to be made 12-14 days after surgery for an incision check and x-rays. The documentation did not show a follow up appointment had been made at the time the resident was discharged from the hospital. The resident's care plan, dated 01/02/2026, documented the resident had skin impairment to the right hip related to a surgical incision. The interventions included to not apply any heat, ointments, or lotions to the incision, do weekly skin observations, notify the wound physician when needed, and treatments were as ordered. The 01/02/2026 admission nursing skin assessment documented the resident had bruises and a surgical incision. The 01/23/2026 nursing skin assessment documented the resident had staples to the right hip and thigh. The facility shower sheets for the resident were reviewed. The shower sheets instructed staff who give showers to notify the nurse of any skin conditions and the nurse was to open a risk management for any new areas, complete a skin assessment and notify the provider for wound care orders. The document was to be signed by the staff giving the shower and the nurse. The 01/06/2026 shower sheet showed the area between the resident's buttocks was circled and the groin was marked redness and chapped. There was no signature from a nurse.The 01/13/2026 shower sheet showed the area of the resident's groin circled and documented redness. There was no signature from a nurse. The 01/18/2026 shower sheet showed circled areas on both arms, the groin, and both lower legs that documented redness. A nurse had signed the shower sheet. The Medication Administration Record (MAR) and Treatment Administration Record (TAR) for January 2026 had no documentation related to the resident's incision with staples and no documentation for (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 - Minimal harm or potential for actual harm Residents Affected - Few	the resident's reddened areas which had been identified on 01/06/2026, 01/13/2026, and 01/18/2026. From 01/02/2026 to 02/07/2026 the nursing skin assessment sheets and progress notes were reviewed and there was no documentation or assessment of the resident's reddened areas in the groin or the rest of the identified reddened areas on the body.The hospital records, dated 02/07/2026, showed the resident was sent to the hospital with altered mental status. It was documented the resident had surgical staples in place since surgery on 12/18/2025, and the skin had redness with tissue that begun to overgrow on the staples. The staples were removed, 51 days after surgery, and the resident's incision was noted to have mild irritation. The document also showed the resident had intertrigo (a common inflammatory skin rash occurring in body folds caused by skin-on-skin friction, moisture, heat, and lack of ventilation). Staff cleansed the area and the skin was noted to be inflamed and irritated with maceration (the softening and breakdown of the skin as a result of prolonged exposure to moisture).In an interview on 03/05/2026 at 12:26 PM, Staff F, Licensed Practical Nurse (LPN), stated residents had weekly skin assessments. If a resident had a new skin issue, the nurse would assess the area and it would be documented in the resident's record. In an interview on 03/05/2026 at 12:30 PM, Staff A, Certified Nursing Assistant (CNA), stated if a new skin issue was identified they would immediately tell the nurse. Staff A stated during the resident's shower there was a skin check done which would be documented on a shower sheet. Staff A stated when a skin issue was found, the CNA and nurse would both sign the form. In an interview on 03/05/2026 at 1:00 PM, Staff B, Resident Care Manager (RCM), stated when a resident was admitted from the hospital, the RCM's would review the orders, put the medications and/or treatments in the electronic record and a second nurse would review to ensure they were transferred accurately. For non-pressure skin issues, the nurse was to complete risk management and then the facility's treatment nurse would be notified. Orders for wound care would be placed in the TAR's if needed. Staff B stated they did not work at the facility when Resident 1 resided in the facility.In an interview on 03/05/2026 at 2:30 PM, Staff C, Director of Nursing (DNS) stated if a resident had an order for a follow up appointment on admission, the DNS or Assistant Director of Nursing would make the appointments. For a resident with a non-pressure skin issue, the facility had risk management packets for skin the nurses would refer to. The provider would be notified if needed, and the area would be placed on the TAR and assessed weekly until resolved. After review of documentation, Staff C confirmed a follow-up had not been scheduled with orthopedics for an incision check and x-rays. Reference: WAC 388-97-1080(1)-(3)