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	04/24/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review, the facility failed to fully inform residents and/or their representatives on admission to the facility of the care to be provided and/or the professional who would furnish that care for 4 of 5 sampled residents (Residents 12, 262, 263 and 313), reviewed for admission. Additionally, the facility failed to provide information of potential risks and/or benefits of psychotropic medications (medications that treat disorders of the mind and emotions) prior to their use for 3 of 5 sampled residents (Residents 79, 313 and 38), reviewed for unecessary medications. These failures placed residents and/or their representatives at risk of not being fully informed of the risks, benefits or alternative treatment options available before decisions were made regarding medications and/or medical care. Findings included . ADMISSION CONSENT TO TREAT <Resident 12> The 03/09/2025 admission assessment documented Resident 12 was admitted to the facility on [DATE] with diagnoses that included muscle weakness and bacterial blood infection. Resident 12 was cognitively intact and able to clearly verbalize their needs. A review of Resident 12's record found no documentation the Admission Agreement and/or supporting documents had been reviewed or discussed with Resident 12 at the time of admission as required. Review of the 03/03/2025 floor nurse Admission Process check list and March 2025 nursing progress notes did not include documentation that Resident 12 signed a consent for routine nursing care, or other care and services to be provided by the facility or providers. <Resident 313> The 03/31/2025 admission assessment documented Resident 313 was admitted to the facility on [DATE] with diagnoses that included dementia and failure to thrive. The assessment further showed Resident 313 had severe cognitive impairment. (continued on next page)

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 - Some	A review of Resident 313's record found no documentation that the Admission Agreement and/or supporting documents had been reviewed or discussed with Resident 313 at the time of admission as required. Review of the 03/25/2025 floor nurse Admission Process check list and March through April 2025 nursing progress notes did not include documentation that Resident 313 or their representative signed a consent for routine nursing care, or other care and services to be provided by the facility or providers. During an interview on 04/18/2025 at 2:47 PM, Resident 313 stated they did not recall if staff informed them of the type of care they were to receive or who was to provide their care when they were admitted to the facility. Resident 313 was unable to recall if they signed a consent for care and treatment when admitted . <Resident 262> The 04/03/2025 admission assessment documented Resident 262 was admitted to the facility on [DATE] with diagnoses that included weakness and wound infection. Resident 262 was cognitively intact and able to clearly verbalize their needs. A review of Resident 262's record found no documentation that the Admission Agreement and/or supporting documents had been reviewed or discussed with Resident 262 at the time of admission as required. Review of the 03/28/2025 floor nurse Admission Process check list and March through April 2025 nursing progress notes did not include documentation that Resident 262 signed a consent for routine nursing care, or other care and services to be provided by the facility or providers. During an interview on 04/18/2025 at 2:49 PM, Resident 262 stated they were not informed of the type of care they were to receive or who was to provide their care when admitted to the facility. Resident 262 further stated they did not recall signing a consent for care and treatment when admitted . <Resident 263> The 04/06/2025 admission assessment documented Resident 263 was admitted to the facility on [DATE] with diagnoses that included hip fracture. Resident 263 was cognitively intact and able to clearly verbalize their needs. A review of Resident 263's record found no documentation that the Admission Agreement and/or supporting documents had been reviewed or discussed with Resident 263 at the time of admission as required. Review of the 03/31/2025 floor nurse Admission Process check list and March through April 2025 nursing progress notes did not include documentation that Resident 263 signed a consent for routine nursing care, or other care and services to be provided by the facility or providers. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/18/2025 at 2:53 PM, Resident 263 stated they were not informed of the type of care they were to receive or who was to provide their care when admitted to the facility. Resident 263 further stated they did not recall signing a consent for care and treatment when admitted . On 04/17/2025 at 10:37 AM, a list of admissions in the past 30 days with full admission packets were requested from Staff A, Administrator. Review of the provided 30-day admissions report documented that from 03/20/2025 through 04/17/2025, the facility had 36 admissions. Only two of the 36 admission packets that contained a consent for routine nursing care, or other care and services to be provided by the facility or providers, were provided. During an interview on 04/21/2025 at 9:45 AM, Staff T, Social Service Assistant, stated they were unsure if admission consents were required to be completed within a certain timeframe. Staff T acknowledged that residents or their representatives would not be fully informed of care and/or services to be provided if admission documents were not reviewed with them timely during the admission process. During an interview on 04/21/2025 at 11:11 AM, Staff U, Director of Business Development, stated admission documents that included consents for routine nursing care, or other care and services to be provided by the facility or providers were completed electronically. Staff U acknowledged they were able to locate only two admission packets for admissions that occurred in the past 30 days. Staff U stated the facility struggled to complete admission documents timely since January of 2025; the Admissions Director/Coordinator position had been vacant. Staff U acknowledged that a lack of reviewing admission documents with residents prevented residents from being informed of and making decisions regarding their care. During an interview on 04/22/2025 at 10:22 AM, Staff A, Administrator, acknowledged the facility had identified admission documents and consents were not completed timely but had been unable to implement corrective action due to staffing vacancies. Staff A stated they expected admission agreements to be reviewed and signed by residents or their representatives within 72 hours of admission. PSYCHOTOPIC MEDICATION CONSENTS <Resident 79> The 02/27/2025 admission assessment documented Resident 79 had diagnoses that included debility (physical weakness, especially from illness) and dementia (a long-term mental decline that involved problems with memory, behavior and muscle control.) Resident 79 had severely impaired cognition and required maximum assistance to stand and transfer between the bed or wheelchair. Resident 79's adult child was the resident's primary decision maker. During a telephone interview on 04/15/25 at 10:28 AM, Resident 79's representative stated they had been notified four or five times since the resident's admission that Resident 79 had fallen. They stated they were then called and told Resident 79 was being started on an antipsychotic medication, quetiapine, because Resident 79 tried to get up unassisted frequently. Resident 79's representative stated they agreed to have the resident started on a medication to stimulate their appetite but was unsure if the quetiapine had been started or not. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility Accident and Incident log documented Resident 79 had fallen frequently since their admission. A 04/12/2025 at 10:29 PM nursing progress note documented Resident 79 had been very impulsive, insistent on standing and attempts to maintain the resident's attention had little effect to maintain the resident's safety. The physician was notified and ordered quetiapine to be given every 12 hours as needed to stabilize the resident's mood. There was no mention of attempts to contact Resident 79's representative for consent and no consent was present in Resident 79's medical record. The April 2025 Medication Administration Record (MAR) documented that quetiapine was administered that evening, on 04/12/2025 at 8:18 PM. A 04/13/2025 at 8:48 AM nursing progress note documented that Resident 79's representative was called and informed about the physician recommendation for quetiapine and because the resident became agitated when staff asked them to not try to stand up without staff assistance. The family member declined the medication because it was indicated for bipolar and schizophrenia and because of possible side effects. The note documented the resident's representative was then asked what they would like staff to do then, to keep the resident safe when the resident was agitated and did not follow instructions. The medication was discontinued. During an interview on 04/24/2025 at 10:20 AM, Staff DD, Medical Records, confirmed there was no consent for quetiapine for Resident 79. <Resident 313> The 03/31/2025 admission assessment documented Resident 313 had diagnoses that included dementia (a disease that caused a decline in memory, thinking and reasoning skills and affected daily life). In addition, Resident 313 received hospice services for end-of-life care. The Order Summary Report dated 03/25/2025 through 04/16/2025 documented Lorazepam and Haloperidol, psychotropic medications, were prescribed on 03/25/2025 and were to be administered on an as needed basis to treat symptoms of anxiety and agitation commonly experienced at the end of one's life. The March 2025 and April 2025 Medication Administration Records (MARs) documented Resident 313 received their first dose of Lorazepam on 03/26/2025, and the first dose of Haloperidol on 03/27/2025. An informed consent regarding risks and benefits of Lorazepam was completed on 03/25/2025, prior to the resident's first dose of the medication. An informed consent regarding the risks and benefits of Haloperidol was completed on 04/06/2025, after the medication had already been administered to Resident 313. During an interview on 04/21/2025 at 9:35 AM, Staff H, Licensed Practice Nurse (LPN), stated informed consents for psychotropic medications needed to be obtained when the medication was ordered by the physician and prior to giving the first dose of the medication to the resident. During an interview on 04/21/2025 at 10:44 AM, Staff C, Assistant Director of Nursing, confirmed Resident 313's consent had not been completed. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 38> The 02/01/2025 quarterly assessment, documented Resident 38 had diagnoses that included anxiety, depression, schizophrenia (disturbances in thoughts that affected a person's ability to think, feel and behave) and post-traumatic stress disorder (PTSD, a mental health disorder that was caused by an extremely stressful or terrifying event). Resident 38 was cognitively intact and received psychotropic medication daily. A review of the provider orders documented venlafaxine was ordered on 10/29/2024 to treat depression, and quetiapine was ordered on 10/30/2024 to treat schizophrenia. The November and December 2024 MARs documented the medications were administered to the resident daily. Further review of Resident 38's record showed the consents, and risks and benefits of the medications were obtained 49 days after the resident had received the medication. The psychotropic consents had not listed the more serious side effects/black box warnings (serious or life-threatening risks) of the medications. During an interview on 04/22/2025 at 9:00 AM, Staff X, LPN, stated informed consents were obtained prior to the first dose of the medication. Staff X added it was the resident's choice to take the medication, and they needed to be aware of the risks. In an interview on 04/22/2025 at 12:07 PM, Staff C, Assistant Director of Nursing, stated informed consents were obtained prior to the first dose of the medication. Staff C stated it was important so the residents could make a decision and acknowledge the side effects. Reference: WAC 388-97-0300 (3)(a) Refer to F572, F578, F579, F582, F620, and F625 for additional information 37544 42802 46115

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 46115 Based on observation, interview and record review, the facility failed to ensure a resident was assessed for their ability to self-administer their medications safely for 1 of 5 sampled residents (Resident 22) reviewed for medication administration. This failure placed the resident at risk for adverse side effects or unintended health consequences if under- or over-medicated. Findings included . The 04/01/2025 significant change in condition assessment documented Resident 22 had diagnoses that included Parkinson's disease (a disorder of the central nervous system that affected movement), and acid reflux (stomach acid irritates the lining of the esophagus). Resident 22 had moderate cognitive impairments and was able to make their needs known. On 04/14/2025 at 1:33 PM, Resident 22 was observed in their room lying in bed. The resident had a bottle of Tums chewable tablets on their overbed table. Resident 22 stated they took the Tums whenever they needed them. Subsequent observations of the Tums chewable tablets on Resident 22's tray table were made on 04/15/2025 at 12:12 PM, 04/16/2025 at 9:11 AM and 12:03 PM, 04/17/2025 at 8:56 AM, and 04/21/2025 at 8:44 AM. A review of the record documented on 11/22/2022, the provider ordered Tums E-X 750 milligram chewable tablets, two tablets twice daily as needed for gastro-intestinal (GI) upset. The resident's record did not include an order for the resident to self-administer their Tums, or an assessment that documented Resident 22 was able to administer their Tums safely and at the frequency ordered. A review of the April 2025 Medication Administration Record had no administrations of Tums documented. In an interview on 04/22/2025 at 2:02 PM, Staff F, Resident Care Manager, stated residents who wanted to self-administer medications needed to be assessed by the provider, have an order obtained, and a self-medication assessment completed. Then if approved, the residents were given a lock box to store their medications in. Staff F stated the assessments were important so staff knew if a resident was able to take their own medications safely, and Resident 22 should have had that assessment completed. Reference: WAC 388-97-0440

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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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review the facility failed to routinely inform cognitively intact residents and/or the legal representatives of cognitively impaired residents of the facility rules, regulations governing resident conduct, resident rights including notice of Medicaid rights and responsibilities for 4 of 5 sampled residents (Resident 12, 313, 262, and 263), reviewed for admission. This failure placed residents at risk of not being fully informed of their rights, facility rules, and resident conduct expectations. Findings included . <Resident 12> According to the 03/09/2025 admission assessment, Resident 12 admitted to the facility on [DATE] with diagnoses including muscle weakness and bacterial blood infection. Resident 12 was cognitively intact and able to clearly verbalize their needs. Review of March 2025 nursing progress notes showed no documentation the admission agreement that included information on all resident rights and services, facility rules governing resident conduct, State-developed notice of Medicaid rights and obligations, and written acknowledgement of understanding was reviewed and/or discussed with Resident 12 upon admission, as required. Additional review of the resident's record found no documentation the admission agreement and/or included paperwork had been reviewed or discussed with Resident 12 upon admission, as required. <Resident 313> According to the 03/31/2025 admission assessment, Resident 313 admitted to the facility on [DATE] with diagnoses including dementia and failure to thrive. The assessment further showed Resident 313 had severe cognitive impairment. Review of March 2025 nursing progress notes showed no documentation the admission agreement that included information on all resident rights and services, facility rules governing resident conduct, State-developed notice of Medicaid rights and obligations, and written acknowledgement of understanding was reviewed and/or discussed with Resident 313 and/or their representative upon admission, as required. Additional review of the resident's record found no documentation the admission agreement and/or included paperwork had been reviewed or discussed with Resident 313 and/or their representative upon admission, as required. In an interview on 04/18/2025 at 2:47 PM, Resident 313 stated they did not recall if staff reviewed the facility rules, resident rights including Medicare/Medicaid rights, resident conduct expectations and responsibilities with them, upon admission to the facility. <Resident 262> (continued on next page)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 04/03/2025 admission assessment, Resident 262 admitted to the facility on [DATE] with diagnoses including weakness and wound infection. The assessment further showed Resident 262 was cognitively intact and able to clearly verbalize their needs. Review of March 2025 through April 2025 nursing progress notes showed no documentation the admission agreement that included information on all resident rights and services, facility rules governing resident conduct, State-developed notice of Medicaid rights and obligations, and written acknowledgement of understanding was reviewed and/or discussed with Resident 262 upon admission, as required. Additional review of the resident's record found no documentation the admission agreement and/or included paperwork had been reviewed or discussed with Resident 262 upon admission, as required. In an interview on 04/18/2025 at 2:49 PM, Resident 262 stated they did not recall if staff reviewed the facility rules, resident rights including Medicare/Medicaid rights, resident conduct expectations and responsibilities with them, upon admission to the facility. <Resident 263> According to the 04/06/2025 admission assessment, Resident 263 admitted to the facility on [DATE] with diagnoses including hip fracture. The assessment further showed Resident 263 was cognitively intact and able to clearly verbalize their needs. Review of March 2025 through April 2025 nursing progress notes showed no documentation the admission agreement that included information on all resident rights and services, facility rules governing resident conduct, State-developed notice of Medicaid rights and obligations, and written acknowledgement of understanding was reviewed and/or discussed with Resident 263 upon admission, as required. Additional review of the resident's record found no documentation the admission agreement and/or included paperwork had been reviewed or discussed with Resident 263 upon admission, as required. In an interview on 04/17/2025 at 10:37 AM, a list of admissions in the past 30 days with full admission packets were requested from Staff A, Administrator. Review of the admissions report from 03/20/2025 through 04/17/2025 showed the facility had 36 admissions. Only two out of 36 admission packets that contained information on the facility rules, resident rights including Medicare/Medicaid rights, resident conduct and responsibilities were received. In an interview on 04/18/2025 at 2:53 PM, Resident 263 stated staff did not review or inform them of the facility rules, resident rights including Medicare/Medicaid rights, resident conduct expectations and responsibilities, upon admission to the facility. In an interview on 04/21/2025 at 9:45 AM, Staff T, Social Service Assistant, stated they were unsure of the time frame the admission packets and the asssociated paperwork were to be completed by. Staff T acknowledged residents and/or their representatives would not be fully informed of facility rules, rights, and responsibilities if admission paperwork and the associated paperwork was not reviewed with them timely. Staff T stated admission related paperwork should be reviewed and filled out timely upon admission. (continued on next page)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/21/2025 at 11:11 AM, Staff U, Director of Business Development, explained admission packets and the associated admission paperwork were completed electronically. Staff U was informed the survey team requested admission packets for all admits in the past 30 days but only received two packets. Staff U acknowledged that was correct, they were only able to locate two admission packets for admits in the past 30 days. Staff U explained the facility had been struggling since January 2025 to complete admission packets timely because of the admissions director/coordinator position vacancy. Staff U acknowledged residents and/or their representatives would not be fully informed of facility rules, rights, resident conduct and responsibilities, if admission paperwork was not reviewed with them timely. In an interview on 04/22/2025 at 10:22 AM, Staff A, Administrator, stated the admissions director/coordinator and/or Staff U reviewed and completed the admission agreement packets and the associated paperwork with residents and/or their representatives. Staff A acknowledged the facility had identified admission packets were not being completed timely but were unable to implement corrective action due to staffing. Staff A stated they expected admission agreements to be reviewed and signed within 72 hours of an admission. Reference WAC 388-97-0300 (1)(a), (7)(b) Refer to F552, F578, F579, F582, F620, and F625 for additional information.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46115 Based on record review and interview, the facility failed to routinely inform and provide written information regarding the right to formulate an advance directive (legal document that oulined wishes for medical care if a person was unable to make decisions for themselves) for 4 of 19 sampled residents (Resident 3, 15, 69, and 263), reviewed for advanced directives. This failure placed residents at risk of not being able to exercise their rights, not having their wishes honored, and a diminished quality of life. Findings included . Review of the facility policy titled Advance Directives dated March 2023, showed residents would be provided with written information concerning the right to formulate an advanced directive if they chose to do so. If the resident was incapacitated and unable to receive information about their right to formulate an advanced directive, the information may be provided to the resident's legal representative. Upon admission, the Social Service Director or designee would inquire of the resident, their family, and/or legal representative about the existence of any written advanced directives. <Resident 3> A review of the record showed Resident 3 had diagnoses which included chronic obstructive pulmonary disease (COPD, inflammation in the lungs that made it difficult to breathe) and chronic pain. The record did not contain documentation that Resident 3 had been informed of their right to form an advance directive or if they had accepted assistance in forming one. <Resident 15> A review of the record showed Resident 15 had diagnoses which included COPD and high blood pressure. The record did not contain documentation that Resident 15 had been informed of their right to form an advanced directive or if they had accepted assistance in forming one. <Resident 69> A review of the record showed Resident 69 had diagnoses which included high blood pressure and anxiety. The record did not contain documentation that Resident 69 had been informed of their right to form an advance directive or if they had accepted assistance in forming one. In an interview on 04/22/2025 at 9:55 AM, Staff C, Assistant Director of Nursing, stated advance directives were completed upon admission and it was important so they would know how to care for the residents. Staff C stated they believed Social Services were responsible for completing the advance directives. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/22/2025 at 9:59 AM, Staff V, Social Service Director, stated advance directives were discussed in the care conferences which were held within 48 to 72 hours of admission. Staff V stated the discussion about advanced directives were placed in the progress notes. Staff V was unable to provide information that advanced directives were offered to the residents listed above. <Resident 263> According to the 04/06/2025 admission assessment, Resident 263 admitted to the facility on [DATE] with diagnoses which included a hip fracture. The assessment further showed Resident 263 was cognitively intact and able to clearly verbalize their needs. Review of March 2025 nursing progress notes showed no documentation the admission agreement that included information on the right to formulate advanced directives was reviewed and/or discussed with Resident 263 upon admission, as required. Additional review of the resident's record found no documentation the admission agreement and/or included paperwork had been reviewed or discussed with Resident 263 upon admission, as required. In an interview on 04/17/2025 at 10:37 AM, a list of admissions in the past 30 days with full admission packets that included information on the right to formulate advanced directives was requested from Staff A, Administrator. Review of the admissions report from 03/20/2025 through 04/17/2025 showed the facility had 36 admissions. Only two out of 36 admission packets were received. In an interview on 04/18/2025 at 2:53 PM, Resident 263 stated staff did not review and/or discuss the right to formulate advanced directives with them when they admitted to the facility. In an interview on 04/21/2025 at 9:45 AM, Staff T, Social Service Assistant, stated they were unsure of the time frame the admission packets that contained information on the right to formulate advanced directives, were to be completed by. Staff T acknowledged residents and/or their representatives would not be fully informed of the right to formulate advanced directives if admission paperwork was not reviewed with them timely. Staff T stated admission paperwork should be reviewed and filled out timely upon admission. In an interview on 04/21/2025 at 11:11 AM, Staff U, Director of Business Development, explained admission packets and the information on the right to formulate advanced directives, were completed electronically. Staff U was informed the survey team requested admission packets for all admits in the past 30 days but only received two packets. Staff U acknowledged that was correct, they were only able to locate two admission packets for admits in the past 30 days. Staff U explained the facility had been struggling since January 2025 to complete admission packets timely because of the admissions director/coordinator position vacancy. Staff U acknowledged residents and/or their representatives would not be fully informed of the right to formulate advanced directives if admission paperwork was not reviewed with them timely. In a follow-up interview on 04/22/2025 at 10:11 AM, Staff V explained they asked residents if they had advanced directives when their care conferences were held and requested copies of paperwork if they had advanced directives. Staff V further stated they did not offer or provide information on the right to formulate advanced directives if and/or when a resident stated they did not have any. (continued on next page)

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	505322	A. Building B. Wing	04/24/2025

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/22/2025 at 10:22 AM, Staff A stated admission agreement packets that contained information on the right to formulate advanced directives was to be reviewed and completed with residents and/or their representatives by the admissions director/coordinator or Staff U but information on advanced directives was also reviewed during care conferences. Staff A acknowledged the facility had identified admission packets were not being completed timely but were unable to implement corrective action due to staffing. Staff A stated they expected admission agreements to be reviewed and signed within 72 hours of admission. Reference: WAC 388-97-0300(1)(b), (3)(a-c) Refer to F552, F579, F572, F582, F620, and F625 for additional information.

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F 0579 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide information about how to apply for and use Medicare and Medicaid benefits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review, the facility failed to routinely provide residents and/or their representatives oral and written information on how to apply for and use Medicare and/or Medicaid benefits for 4 of 5 sampled residents (Resident 12, 313, 262, and 263), reviewed for admission. This failure placed residents and/or their representatives at risk of not being fully informed of their Medicare/Medicaid rights, unmet care needs, and a diminished quality of life. Findings included . <Resident 12> According to the 03/09/2025 admission assessment, Resident 12 admitted to the facility on [DATE] with diagnoses which included muscle weakness and bacterial blood infection. Resident 12 was cognitively intact and able to clearly verbalize their needs. Review of the March 2025 nursing progress notes showed no documentation the admission agreement that included information on how to apply for and use Medicare and/or Medicaid benefits, Denial of Medicare and Medicaid, discontinuation of Medicaid or Medicare was reviewed and/or discussed with Resident 12 upon admission, as required. Additional review of the resident's record found no documentation the admission agreement and/or included paperwork had been reviewed or discussed with Resident 12 upon admission, as required. <Resident 313> According to the 03/31/2025 admission assessment, Resident 313 admitted to the facility on [DATE] with diagnoses which included dementia and failure to thrive. The assessment further showed Resident 313 had severe cognitive impairment. Review of March 2025 nursing progress notes showed no documentation the admission agreement that included information on how to apply for and use Medicare and/or Medicaid benefits, Denial of Medicare and Medicaid, discontinuation of Medicaid or Medicare was reviewed and/or discussed with Resident 313 and/or their representative upon admission, as required. Additional review of the resident's record found no documentation the admission agreement and/or included paperwork had been reviewed or discussed with Resident 313 and/or their representative upon admission, as required. In an interview on 04/18/2025 at 2:47 PM, Resident 313 stated they did not recall if staff orally reviewed or provided them written information on how to apply for and use Medicare and/or Medicaid benefits, Denial of Medicare and Medicaid, discontinuation of Medicaid or Medicare, when they admitted to the facility. <Resident 262> According to the 04/03/2025 admission assessment, Resident 262 admitted to the facility on [DATE] with diagnoses which included weakness and wound infection. The assessment further showed Resident 262 was cognitively intact and able to clearly verbalize their needs. (continued on next page)

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F 0579 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of March 2025 nursing progress notes showed no documentation the admission agreement that included information on how to apply for and use Medicare and/or Medicaid benefits, Denial of Medicare and Medicaid, discontinuation of Medicaid or Medicare was reviewed and/or discussed with Resident 262 upon admission, as required. Additional review of the resident's record found no documentation the admission agreement and/or included paperwork had been reviewed or discussed with Resident 262 upon admission, as required. In an interview on 04/18/2025 at 2:49 PM, Resident 262 stated staff did not orally review or provided them written information on how to apply for and use Medicare and/or Medicaid benefits, Denial of Medicare and Medicaid, discontinuation of Medicaid or Medicare when they admitted to the facility. <Resident 263> According to the 04/06/2025 admission assessment, Resident 263 admitted to the facility on [DATE] with diagnoses which included a hip fracture. The assessment further showed Resident 263 was cognitively intact and able to clearly verbalize their needs. Review of March 2025 through April 2025 nursing progress notes showed no documentation the admission agreement that included information on how to apply for and use Medicare and/or Medicaid benefits, Denial of Medicare and Medicaid, discontinuation of Medicaid or Medicare was reviewed and/or discussed with Resident 263 upon admission, as required. Additional review of the resident's record found no documentation the admission agreement and/or included paperwork had been reviewed or discussed with Resident 263 upon admission, as required. In an interview on 04/17/2025 at 10:37 AM, a list of admissions in the past 30 days and full admission packets were requested from Staff A, Administrator. Review of the Admissions Report from 03/20/2025 through 04/17/2025 showed the facility had 36 admissions. Only two out of 36 admission packets that included information on how to apply for and use Medicare and/or Medicaid benefits, Denial of Medicare and Medicaid, discontinuation of Medicaid or Medicare were received. In an interview on 04/18/2025 at 2:53 PM, Resident 263 stated staff did not orally review or provided them written information on how to apply for and use Medicare and/or Medicaid benefits, Denial of Medicare and Medicaid, discontinuation of Medicaid or Medicare when they admitted to the facility. In an interview on 04/21/2025 at 9:45 AM, Staff T, Social Service Assistant, stated they were unsure of the time frame the admission packets that included information on how to apply for and use Medicare and/or Medicaid benefits, Denial of Medicare and Medicaid, discontinuation of Medicaid or Medicare were to be completed by. Staff T acknowledged residents and/or their representatives would not be fully informed on how to apply or use Medicare and/or Medicaid benefits if admission paperwork was not reviewed with them timely. Staff T stated admission paperwork should be reviewed and filled out timely upon admission. (continued on next page)

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F 0579 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/21/2025 at 11:11 AM, Staff U, Director of Business Development, explained admission packets that included information on how to apply for and use Medicare and/or Medicaid benefits, Denial of Medicare and Medicaid, discontinuation of Medicaid or Medicare were completed electronically. Staff U was informed the survey team requested admission packets for all admits in the past 30 days but only received two packets. Staff U acknowledged that was correct, they were only able to locate two admission packets for admits in the past 30 days. Staff U explained the facility had been struggling since January 2025 to complete admission packets timely because of the admissions director/coordinator position vacancy. Staff U acknowledged residents and/or their representatives on would not be fully informed on how to apply for and use Medicare and/or Medicaid benefits if admission paperwork was not reviewed with them timely. In an interview on 04/22/2025 at 10:22 AM, Staff A, Administrator, stated admission agreement packets that contained included information on how to apply for and use Medicare and/or Medicaid benefits, Denial of Medicare and Medicaid, discontinuation of Medicaid or Medicare were reviewed and completed with residents and/or their representatives by the admissions director/coordinator or Staff U. Staff A acknowledged the facility had identified admission packets were not being completed timely but were unable to implement corrective action due to staffing. Staff A stated they expected admission agreements to be reviewed and signed within 72 hours of an admission. Reference WAC 388-97-0300 (9) Refer to F552, F578, F572, F582, F620, and F625 for additional information.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review, the facility failed to routinely inform cognitively intact residents and/or their legal representatives, of items and services included in nursing services which the resident may and may not be charged for and amount of potential costs for services not covered under Medicare and/or Medicaid or by the facility's per diem rate for 4 of 5 sampled residents (Resident 12, 313, 262, and 263), reviewed for admission. Additionally, the facility failed to provide the required beneficiary notices for 2 of 3 sampled residents (Residents 19 and 85), reviewed for required notices and associated choices related to Medicare services ending. These failures placed residents at risk of not being fully informed of their rights and/or financial responsibilities, unmet care needs, and diminished quality of life. Findings included . Review of the Skilled Nursing Facility (SNF) Advanced Beneficiary Notice (ABN) form showed it provided information to Medicare beneficiaries so that they could decide if they wished to continue receiving the skilled services that might not be paid for by Medicare and assume financial responsibility. The form was required when a resident had skilled benefit days remaining, was being discharged from Medicare Part A services, and continued living in the facility. ADMISSION INFORMATION <Resident 12> According to the 03/09/2025 admission assessment, Resident 12 admitted to the facility on [DATE] with diagnoses which included muscle weakness and bacterial blood infection. Resident 12 was cognitively intact and able to clearly verbalize their needs. Review of March 2025 nursing progress notes showed no documentation the admission agreement which included information on basic charges, payments, interest on late payments, and the facility discharge check out time of 11:00 AM. No documentation was found that showed the facility policy of charging a fee of 660 dollars, the private daily room rate, for going past the 11:00 AM discharge time was provided to the resident and/or their representative. Additional review of the resident's record found no documentation the admission agreement and/or included paperwork had been reviewed or discussed with Resident 12 upon admission, as required. <Resident 313> According to the 03/31/2025 admission assessment, Resident 313 admitted to the facility on [DATE] with diagnoses which included dementia and failure to thrive. The assessment further showed Resident 313 had severe cognitive impairment. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of March 2025 nursing progress notes showed no documentation the admission agreement which included information on basic charges, payments, interest on late payments, and the facility discharge check out time of 11:00 AM. No documentation was found that showed the facility policy of charging a fee of 660 dollars, the private daily room rate, for going past the 11:00 AM discharge time was provided to the resident and/or their representative. Additional review of the resident's record found no documentation the admission agreement and/or included paperwork had been reviewed or discussed with Resident 313 upon admission, as required. In an interview on 04/18/2025 at 2:47 PM, Resident 313 stated they did not recall if staff reviewed items and services included in nursing services which the resident may and may not be charged for and costs of potential charges for services not covered under Medicare and/or Medicaid or by the facility's per diem rate with them, upon admission to the facility. <Resident 262> According to the 04/03/2025 admission assessment, Resident 262 admitted to the facility on [DATE] with diagnoses which included weakness and wound infection. The assessment further showed Resident 262 was cognitively intact and able to clearly verbalize their needs. Review of March and April 2025 nursing progress notes showed no documentation the admission agreement which included information on basic charges, payments, interest on late payments, and the facility discharge check out time of 11:00 AM. No documentation was found that showed the facility policy of charging a fee of 660 dollars, the private daily room rate, for going past the 11:00 AM discharge time was provided to the resident and/or their representative. Additional review of the resident's record found no documentation the admission agreement and/or included paperwork had been reviewed or discussed with Resident 262 upon admission, as required. In an interview on 04/18/2025 at 2:49 PM, Resident 262 stated they did not recall if staff reviewed items and services included in nursing services which the resident may and may not be charged for and costs of potential charges for services not covered under Medicare and/or Medicaid or by the facility's per diem rate with them, upon admission to the facility. <Resident 263> According to the 04/06/2025 admission assessment, Resident 263 admitted to the facility on [DATE] with diagnoses which included a hip fracture. The assessment further showed Resident 263 was cognitively intact and able to clearly verbalize their needs. Review of March 2025 nursing progress notes showed no documentation the admission agreement which included information on basic charges, payments, interest on late payments, and the facility discharge check out time of 11:00 AM. No documentation was found that showed the facility policy of charging a fee of 660 dollars, the private daily room rate, for going past the 11:00 AM discharge time was provided to the resident and/or their representative. Additional review of the resident's record found no documentation the admission agreement and/or included paperwork had been reviewed or discussed with Resident 263 upon admission, as required. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/17/2025 at 10:37 AM, a list of admissions in the past 30 days and full admission packets that included the above information was requested from Staff A, Administrator. Review of the Admissions Report from 03/20/2025 through 04/17/2025 showed the facility had 36 admissions. Only two out of 36 admission packets were received. In an interview on 04/18/2025 at 2:53 PM, Resident 263 stated staff did not review items and services included in nursing services which the resident may and may not be charged for and costs of potential charges for services not covered under Medicare and/or Medicaid or by the facility's per diem rate with them, upon admission to the facility. In an interview on 04/21/2025 at 9:45 AM, Staff T, Social Service Assistant, stated they were unsure of the time frame the admission packets that contained information on basic charges, payments, nursing services which the resident may and may not be charged for and amount of potential costs for services not covered under Medicare and/or Medicaid or by the facility's per diem rate such as the facility $660 late discharge fee NOT payable by insurance for late discharges without prior arrangements made, and interest on late payments, were to be completed by. Staff T acknowledged residents and/or their representatives would not be fully informed of facility rules, rights, and responsibilities if admission paperwork was not reviewed with them timely. Staff T stated admission paperwork should be reviewed and filled out timely upon admission. In an interview on 04/21/2025 at 11:11 AM, Staff U, Director of Business Development, explained admission packets that contained information on basic charges, payments, nursing services which the resident may and may not be charged for and amount of potential costs for services not covered under Medicare and/or Medicaid or by the facility's per diem rate such as the facility $660 late discharge fee NOT payable by insurance for late discharges without prior arrangements made, and interest on late payments, were completed electronically. Staff U was informed the survey team requested admission packets for all admits in the past 30 days but only received two packets. Staff U acknowledged that was correct, they were only able to locate two admission packets for admits in the past 30 days. Staff U explained the facility had been struggling since January 2025 to complete admission packets timely because of the admissions director/coordinator position vacancy. Staff U acknowledged residents and/or their representatives would not be fully informed of potential charges, fees, interest and/or financial responsibility if admission paperwork was not reviewed with them timely. In an interview on 04/22/2025 at 10:22 AM, Staff A, Administrator, stated admission agreement packets that contained information on basic charges, payments, nursing services which the resident may and may not be charged for and amount of potential costs for services not covered under Medicare and/or Medicaid or by the facility's per diem rate such as the facility $660 late discharge fee NOT payable by insurance for late discharges without prior arrangements made, and interest on late payments were reviewed and completed with residents and/or their representatives by the admissions director/coordinator or Staff U. Staff A acknowledged the facility had identified admission packets were not being completed timely but were unable to implement corrective action due to staffing. Staff A stated they expected admission agreements to be reviewed and signed within 72 hours of an admission. MEDICARE COVERAGE NOTICES <Resident 19> (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Notice of Medicare Non-Coverage (NOMNC) form showed Resident 19's last day of Medicare Part A services ended on 01/30/2025. Record review found no documentation that showed the facility provided a SNF ABN to Resident 19 as required. Resident 19 currently resided at the facility. <Resident 85> Review of a NOMNC form showed Resident 85's last day of Medicare Part A services ended on 11/25/2024. Record review found no documentation that showed the facility provided a SNF ABN to Resident 85 as required. Resident 85 currently resided in the facility. On 04/23/2025 at 1:46 PM, the SNF Beneficiary Notification Review forms were reviewed with Staff A, Administrator. Staff A stated that the SNF ABN forms were not given to Residents 19 and 85 because, there was no BOM in the facility since the beginning of February [2025]. Staff A stated the BOM's duties were absorbed between them and Corporate oversight. Reference WAC 388-97-0300 (1)(e) (5), (6) Refer to F552, F578, F572, F579, F620, and F625 for additional information. 40297

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42802 Based on observation, interviews and record review, the facility failed to ensure a clean, comfortable and homelike environment for 3 of 7 residents (Resident 56, 64, and 69) reviewed for environment. Specifically, Resident 56's call light button was dirty, Resident 64's wheelchair was not maintained in a clean manner, and Resident 69's sheets were not changed regularly. These failures placed the residents at risk of a diminished quality of life. Findings included . <Resident 56> According to a comprehensive assessment dated [DATE], Resident 56 had diagnoses which included Chronic Obstructive Pulmonary Disease (COPD, a lung disease that causes chronic respiratory symptoms) and depression. Resident 56 made their needs known and was able to eat independently after their food was set up by staff. On 04/14/2025 at 2:47 PM, Resident 56 was observed in their bed with an unkempt appearance. Their fingers were tightly contracted with limited movement other than their thumbs. Their fingernails were long with brown matter beneath the nails. The resident stated they had refused any therapy or manipulation to their hands because it hurt too much. They further stated they would not allow staff to wash or soak their hands due to the pain and refused any pain medications. The residents call light button was in easy reach, hanging from the trapeze over their bed. The button and end of the cord was covered in an unknown brown, crusty matter. Similar observations of the call light button with brown, crusted matter were made on 04/17/2025 at 8:57 AM, 04/18/2025 at 9:36 AM and 04/22/2025 at 9:41 AM. During an interview on 04/23/2025 at 3:18 PM, Staff T, Nursing Assistant, stated they had tried to convince Resident 56 a warm washcloth might feel good on their hands, but the resident would not allow it. They further stated they would wipe down the call light button if they noticed it was dirty. During an interview on 04/24/2025 at 11:10 AM, Staff UU, Housekeeping, was mopping the floor in Resident 56's room. Staff UU stated that they wiped down the call lights when cleaning. On 04/24/2025 at 11:17 AM, this surveyor entered Resident 56's room with Staff F, Resident Care Manager. The call light was clean. Staff UU informed Staff F that they just cleaned Resident 56's call light because it was dirty with brown/reddish stuff. Staff F acknowledged that resident's rooms should be maintained and kept clean. During an interview on 04/24/2025 at 12:37 PM, Staff PP, Housekeeping Director, stated that high touch surfaces such as call lights, should be wiped down routinely, hopefully every day. <Resident 64> (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a comprehensive assessment dated [DATE], Resident 64 had diagnoses which included COPD and heart failure (where the heart cannot pump enough blood for the body's needs.) Resident 64 used a wheelchair for mobility. During a resident interview on 04/14/2025 at 11:09 AM, dried fluid was observed on the left side of the resident's wheelchair and seat cushion. Similar observations of the dried fluids on the left side of the wheelchair and seat cushion were made on 04/18/2025 at 9:46 AM, 04/21/2025 at 10:11 AM, 04/23/2025 at 2:37 PM and 04/24/2025 at 10:29 AM. A shower schedule posted in the North Nursing station showed the resident was scheduled for showers on Tuesday and Saturday's. A review of the Resident 64's record showed no schedule for routine cleaning of the wheelchair. During an interview on 04/21/2025 at 10:16 AM, Staff Y, Nursing Assistant (NA) stated that they would wipe down a wheelchair when they noticed it was needed. Staff Y was unsure if it was an assigned task. During an interview on 04/23/2025 at 3:18 PM, Staff T, NA stated that wheelchairs were supposed to be cleaned by the night shift NA's twice weekly, the same day as the shower was scheduled. Staff T did not think that the wheelchair cleaning was documented anywhere. During an interview on 04/24/2025 at 11:17 AM, Staff F, Resident Care Manager stated that wheelchairs were cleaned on night shift but was unsure of the exact schedule. After an observation of Resident 64's wheelchair with Staff F, Staff F acknowledged the wheelchair was dirty and should have been cleaned. 46115 <Resident 69> The 03/07/2025 significant change in condition assessment documented Resident 69 was cognitively intact, able to make their needs know, and had diagnoses which included high blood pressure, anxiety. In an interview on 04/16/2025 at 12:06 PM, Resident 69's family member stated staff were not changing the resident's sheets and the sheets that were currently on the bed had been on there for two weeks. Subsequent observations of Resident 69 having the same sheets on their bed were made on 04/18/2025 at 8:44 AM, 04/22/2025 at 1:55 AM, and 04/23/2025 at 10:51 AM. In an interview on 04/22/2025 at 8:47 AM, Staff W, NA, stated sheets were changed on the resident's showers days and whenever soiled. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/22/2025, Staff C, Assistant Director of Nursing, stated sheets were changed on showers days and when visibly soiled. Staff C stated it was important to change the resident's sheets for skin integrity, hygiene and infection control. Reference: WAC 388-97-0880

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	505322	A. Building B. Wing	04/24/2025

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

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review the facility failed to not request or require residents to waive potential facility liability for losses of personal property upon admission to the facility for 3 of 8 sampled residents (Resident 85, 463, and 41), reviewed for resident rights. This failure placed all residents at risk of inability to exercise their resident rights, unmet needs, and a diminished quality of life. Findings included . <Resident 41> According to the 02/10/2025 admission assessment, Resident 41 admitted to the facility on [DATE] with a diagnosis of spinal cord compression (pressure on the spinal cord). Resident 41 was cognitively intact and able to clearly verbalize their needs. Review of the 02/04/2025 facility admission agreement showed the facility will not be responsible for any of your valuables or personal effects stored in your room and/or kept on your person beyond the exercise of reasonable care. You may bring small items for your personal use, but you must label all items with your full name. The facility maintains a secure area available to use to secure small personal items, upon request. Residents and their legal representatives may request a bedside drawer or cabinet with a lock. The admission agreement was electronically signed by Resident 41. Review of the 02/11/2025 inventory list included the statement We urge you not to keep cash/valuables or irreplaceable items at the facility. We encourage you to take these items home or allow staff to lock them in the facility safe. The facility is not responsible for items of value that you elect to keep unlocked the form was signed by Resident 41. <Resident 463> According to the 03/15/2025 assessment, Resident 463 admitted to the facility on [DATE] with diagnoses which included weakness and need for assistance with personal care. Resident 463 was cognitively intact. Review of the 03/04/2025 facility admission agreement showed the facility will not be responsible for any of your valuables or personal effects stored in your room and/or kept on your person beyond the exercise of reasonable care. You may bring small items for your personal use, but you must label all items with your full name. The facility maintains a secure area available to use to secure small personal items, upon request. Residents and their legal representatives may request a bedside drawer or cabinet with a lock. The admission agreement was electronically signed by Resident 463. Review of the 03/04/2025 inventory list included the statement We urge you not to keep cash/valuables or irreplaceable items at the facility. We encourage you to take these items home or allow staff to lock them in the facility safe. The facility is not responsible for items of value that you elect to keep unlocked the form was signed and dated by Resident 463. (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	<Resident 85> According to the 03/30/2025 quarterly assessment, Resident 85 admitted to the facility on [DATE] with diagnoses which included weakness and need for assistance with personal care. The assessment further showed Resident 85 was cognitively intact and clearly able to verbalize their needs. Review of the 10/18/2024 facility admission agreement showed the facility will not be responsible for any of your valuables or personal effects stored in your room and/or kept on your person beyond the exercise of reasonable care. You may bring small items for your personal use, but you must label all items with your full name. The facility maintains a secure area available to use to secure small personal items, upon request. Residents and their legal representatives may request a bedside drawer or cabinet with a lock. The admission agreement was electronically signed by Resident 85. Review of Resident 85's undated and unsigned inventory of personal effects sheet showed they brought a cell phone into the facility. The bottom of the form included the statement I agree that the above is a correct listing of the personal belongings that I have chosen to keep in my possession while I am a resident/patient at this facility/community/center. I take full responsibility for these items and any other personal effects brought to me. Review of December 2024 through March 2025 nursing progress notes showed on 01/11/2025 around noon a nursing assistant (NA) entered Resident 85's room. Resident 85 asked them to complete a task, the nurse heard something fall, the NA stated Resident 85's phone had fallen, the phone was picked up and handed back to the resident. Resident 85 reported their phone had a cracked screen. No other documentation was found related to Resident 85's broken cell phone screen. Review of the facility January 2025 through February 2025 grievance log showed one entry for Resident 85, on 01/29/2025 related to a care issue concern. Review of Resident 85's 01/29/2025 grievance showed it was not related to their broken cell phone screen. In an interview on 04/14/2025 at 2:00 PM, Resident 85 stated staff broke their cell phone three months ago and they had spoken to Social Services about the issue, but the facility did not replace or reimburse them for the broken phone. In an interview on 04/22/2025 at 9:06 AM, Staff Y, NA, stated the facility completed a resident inventory sheet upon admission. Staff Y further stated they would notify Social Services, if a resident reported missing or broken personal items, so follow up could be completed. In an interview on 04/22/2025 at 9:14 AM, Staff X, Licensed Practical Nurse, stated the facility completed a resident inventory sheet upon admission. Staff X further stated a concern form was to be completed if a resident reported a missing or broken personal item. Staff X was unsure if the facility reimbursed residents for missing or broken personal items. (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	In an interview on 04/21/2025 at 11:11 AM, Staff U, Director of Business Development, reviewed the facility admission agreement. Staff U stated the admission agreement was to be reviewed and signed with every new admission 72 hours after their admission. Staff U read the verbiage on the admission agreement related to valuables and personal effects. Staff U acknowledged the verbiage sounded like it waived potential facility liability for losses of personal property. In an interview on 04/22/2025 at 9:40 AM, Staff F, Resident Care Manager, stated the facility completed a resident inventory sheet upon admission, the inventory sheet was recently revised. Staff F further stated a grievance form was to be filled out if/when a resident reported a missing or broken personal item and given to Social Services to track/resolve the issue. Staff F was unsure if residents were reimbursed for missing or broken items. A copy of the facility inventory sheet used was requested. In an interview and record review on 04/22/2025 at 9:49 AM, Staff C, Assistant Director of Nursing, provided a copy of the recently updated inventory sheet that was to be completed upon admission. Review of the inventory sheet provided included the statement We urge you not to keep cash/valuables or irreplaceable items at the facility. We encourage you to take these items home or allow staff to lock them in the facility safe. The facility is not responsible for items of value that you elect to keep unlocked. Staff C was asked if the inventory sheet statement waived potential facility liability for losses of personal property. Staff C referred the surveyor to Staff A, Administrator. In an interview and record review on 04/22/2025 at 10:05 AM, Staff V, Social Service Director, explained when a resident reported a missing or broken item, the inventory sheet would be checked, and a grievance filled out so the facility could follow up as needed. Staff V was shown the admission agreement and inventory sheet. Staff V acknowledged every resident should have that admission agreement and inventory sheet completed upon admission. Staff V reviewed verbiage on the inventory sheet and admission agreement related to valuables and personal effects. and acknowledged the verbiage sounded like it waived potential facility liability for losses of personal property. Staff V acknowledged there was no grievance for Resident 85's reported broken cell phone screen. In an interview and record review on 04/22/2025 at 10:22 AM, Staff A stated the facility would provide residents with the following options to secure their valuables, 1) take items home, 2) use of the facility safe, and 3) a lock box. The verbiage on the inventory sheet and admission agreement related to valuables and personal effects was reviewed with Staff A. Staff A stated verbiage referred to resident clothing. Staff A was asked if the verbiage waived potential facility liability for losses of personal property. Staff A stated the facility provided reasonable care for resident's property. Staff A was asked about Resident 85's broken cell phone screen. Staff A stated they thought there was a grievance about Resident 85's broken cell phone. A copy of the grievance was requested at that time, no documentation was provided. Reference WAC 388-97-0040 (2)(a)(b),-0180 (4)(i)(ii) Refer to F552, F578, F572, F579, F582, and F625 for additional information.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37544 Based on interview and record review, the facility failed to ensure 2 of 7 sampled residents (Resident 264, 79), reviewed for Pre-Admission Screening and Resident Review (PASARR, an assessment completed prior to admission into a skilled nursing facility to determine whether a resident with a diagnosis of a serious mental illness needed specialized mental health services) was completed prior to admission, accurately, and if indicated, a referral for a PASARR Level II (a more in-depth screening assessment) had been made. Specifically both residents admitted to the faciity with an exempted hospital stay and should have been referred for a Level II evaluation after they remained in the facility for more than 30 days. This failure placed the residents at risk for unidentified care needs related to their mental health. Findings included . <Resident 264> The 04/04/2025 quarterly assessment documented Resident 264 admitted to the facility on [DATE] from the hospital and had diagnoses which included traumatic brain injury, muscle weakness, and malnutrition. In addition, the assessment documented Resident 264 received anti-depressant medication. Review of the Order Summary Report from 01/10/2025 through 04/17/2025 documented Resident 264 had been prescribed anti-depressant medication, Lexapro and Mirtazapine, at the time of admission to the facility. Review of Resident 264's record showed a level I PASARR was completed on 01/03/2025 by the hospital prior to the resident's admission to the facility. The assessment documented Resident 264 had serious mental health indicators of a mood disorder and/or depressive disorder, and a level II PASARR was not needed, due to meeting the guidelines for an exempted hospital stay (meaning the resident was admitted to the facility directly from a hospital after receiving acute inpatient care, and the expected stay at the facility was 30 days or less). Additional record review which included progress notes from 01/10/2025 through 04/17/2025 found Resident 264 currently resided at the facility and had not been discharged within 30 days or less as expected. No documentation was found that showed the facility had sent the referral to have a level II PASARR completed as required, after the 30-day time period had elapsed. In an interview on 04/18/2025 at 2:29 PM, Staff V, Social Services Director, stated PASARR needed to be completed prior to a resident's admission to the facility, reviewed upon admission for accuracy, and if incorrect, a new assessment was completed. After discussion and review of Resident 264's record, Staff V confirmed a referral for a Level II PASARR should have been completed, as the resident had not discharged from the facility within the 30-day timeframe. 42802 <Resident 79> (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 02/27/2025 admission assessment, Resident 79 had diagnoses which included dementia (a long-term brain disorder that involved problems with memory, thinking, behavior and muscle control), anxiety (an excessive feeling of worry, fear or unease about the future) and depression (a serious mood disorder that causes persistent feelings of sadness and loss of interest in activities). The resident had severely impaired cognition. A review of Resident 79's PASARR level 1, completed and signed on 02/17/2025, documented the resident had depression and anxiety. The document further showed they met the criteria for an exempted hospital discharge, as it was anticipated they would be in the facility for less than 30 days. Further directions on the form showed a Level 2 must be completed if the scheduled discharge did not occur within 30 days. Per the medical record, Resident 79 was admitted to the facility on [DATE] and remained at the facility through 04/24/2025, (62 days). A review of Resident 79's medical record showed no referral for a level 2 evaluation was made, as required. During an interview on 04/23/2025 at 3:36 PM, Staff V, Social Services Director, stated for residents admitted under an exempted hospital discharge should be referred for a PASARR Level 2 if they had not discharged within 30 days. When asked about Resident 79, they looked in the record and confirmed there was no documentation a PASARR Level 2 was requested, and it should have been. Reference (WAC): 388-97-1915 (1)(2)(a-c)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37544 Based on interview and record review, the facility failed to ensure a baseline care plan was developed that contained resident-specific goals and interventions which included the minimum healthcare information necessary to properly care for each resident immediately upon their admission for 4 of 6 sampled residents (Resident 313, 312, 33, and 263) reviewed for baseline care plans. Failure to develop a baseline care plan for Resident 313 related to hospice and nutrition, failiure to develop a baseline care plan for Resident 263 for nutrition, and failure to develop baseline care plans for both Residents 312 and 33 related to Multiple Sclerosis (MS), a disease where the immune system attacks the nerves which resulted in various symptoms such as fatigue, difficult coordination, muscle weakness, and vision changes, placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . <Resident 313> The 03/31/2025 admission assessment documented Resident 313 admitted to the facility on [DATE] and had diagnoses which included malnutrition, adult failure to thrive, and dementia. In addition, the assessment documented Resident 313 received hospice services. Review of Resident 313's care plan showed interventions were developed to address the resident's care needs related to hospice on 03/28/2025, and nutrition on 03/30/2025, however, no documentation was found that showed a baseline care plan had been developed for hospice and nutrition within the 48 hours of admission as required. <Resident 312> The 12/18/2024 admission assessment documented Resident 312 admitted to the facility on [DATE], was cognitively intact to make decisions regarding their care and had diagnoses which included weakness and MS. Review of Resident 312's record found no documentation that showed a baseline care plan had been developed to instruct nursing staff of Resident 312's immediate care needs related to MS. <Resident 33> The 02/03/2025 significant change assessment documented Resident 33 admitted to the facility on [DATE], was cognitively intact to make decisions regarding their care, and had diagnoses which included weakness and MS. Review of Resident 33's record found no documentation that showed a baseline care plan had been developed to instruct nursing staff of Resident 33's immediate care needs related to MS. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/21/2025 at 6:48 AM, Staff C, Assistant Director of Nursing, stated baseline care plans were developed within the first 24 hours of the resident's admission to the facility. After discussion and review of Resident 313, 312, and 33's records, Staff C acknowledged the baseline care plans had not been completed. 42802 <Resident 263> According to an admission assessment dated [DATE], Resident 263 was admitted with diagnoses which included surgical aftercare following a hip fracture, Cirrhosis (a chronic condition which scar tissue replaced healthy liver tissue) and Ascites (an abnormal buildup of fluid in the abdomen, often caused by late-stage cirrhosis of the liver.) The resident was alert and able to make their needs known. A physician note, dated 04/02/2025, documented that the resident had required weekly paracentesis (a medical procedure in which a tube is inserted into the abdomen, to drain excess fluid) and was taking a diuretic (medication to decrease fluid retention) twice daily. The resident had admission orders for weekly weights for three weeks, then monthly for four weeks. The resident's weight dropped from 142.7 pounds on 03/31/2025 to 116.2 pounds on 04/15/2025, a loss of 26.5 pounds in 15 days. A review of the resident's care plan documented a focus of Nutrition/Hydration status: The resident was at risk for dehydration, weight loss or malnutrition related to chronic disease. The care plan goal was to have optimal nutrition and hydration status, and interventions included ice water at the bedside, record meal intake, dietician consult as needed, review dietary preferences and diet and weights as ordered. This care plan focus was initiated on 04/02/2025. Another care plan focus, dated 04/03/2025, documented the resident had a history of alcoholism with alcoholic cirrhosis with ascites. The care plan goal was for the resident to not have any adverse reaction related to alcoholism, and interventions included administer ordered medications, vital signs as needed and to observe for any signs of intoxication or alcohol withdrawal, and notify the physician as indicated. There was not any documentation in the resident's care plan that they required weekly paracentesis and daily diuretics, which would significantly impact their fluid retention and weight. A review of the medical record showed the resident was transferred to the hospital on 04/21/2025, three weeks after admitted . During an interview on 04/23/2025 at 3:47 PM, Staff HH, Registered Dietician (RD) stated that they were aware of her liver disease, ascites and paracentesis and expected weight fluctuation for that reason. They concurred that should be on the care plan, and the nutrition care plan was not resident specific. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 0424/2025 at 11:17 AM, Staff F, Residential Care Manager (RCM) stated that it was important for the care plan to show the resident got regular paracentesis, as it would impact their care, and they would add it to the care plan when the resident returned from the hospital. Reference: WAC 388-97-1020(3)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37544 Based on observation, interview and record review, the facility failed to repeatedly ensure care plans were developed that included resident specific goals and interventions related to their specific care needs for 3 of 60 sampled residents (Residents 264, 60, and 311), reviewed for care planning. Failure to develop care plans for Residents 264 for nail care, Resident 60 for shaving preferences, and for Resident 311 related to hospice placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . <Resident 264> The 04/04/2025 quarterly assessment documented Resident 264 was admitted to the facility on [DATE] and had diagnoses which included stroke, traumatic brain injury, muscle weakness, and was dependent on nursing staff to complete activities of daily living for personal hygiene such as nail care. On 04/14/2025 at 1:56 PM, Resident 264 was observed lying in bed wearing a hospital gown. Resident 264's fingernails were observed to have dark brown matter underneath them. Review of Resident 264's care plan found no interventions had been developed that instructed nursing staff what Resident 264's care needs were related to nail care. In an interview on 04/18/2025 from 10:21 AM to 10:27 AM, Staff P, Nursing Assistant (NA), stated the care plans informed them what the resident's type of assistance and specific care needs were. In an interview on 04/21/2025 at 6:55 AM, Staff C, Director of Nursing (ADON), stated care plans should be resident centered with interventions specific to the resident's care needs. After discussion and review of Resident 264's care plan, Staff C acknowledged the care plan did not include interventions or instructions related to nail care. 40297 <Resident 60> Review of a 03/16/2025 admission assessment showed Resident 60 admitted to the facility on [DATE] with medically complex conditions. The assessment showed the resident was cognitively intact and required supervision or touching assistance for personal hygiene (like combing hair, shaving, applying makeup, washing/drying face and hands). The assessment showed there was no rejection of care. Observations on 04/15/2025 at 10:40 AM, 04/16/2025 at 9:27 AM, and 04/18/2025 at 1:16 PM showed Resident 60 in bed under the linens. Resident 60 presented with a hospital gown and facial hair to the moustache area, the chin and below jaw area. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/16/2025 at 12:04 PM, Resident 60 said that they did not like the facial hair, preferred their spouse to shave them and the spouse decided when it was time for shaving. The resident stated the spouse shaved them in the facility and the staff did not offer to shave them. Review of the care plan or Kardex (a quick-reference guide that provides a concise overview of resident information) showed no instruction to the staff regarding the resident's preference to have their spouse shave them as needed or to offer them assistance with shaving when the spouse was unavailable. In an interview on 04/21/2025 at 7:10 AM, Staff Y, NA, stated they shaved residents, Only if requested. Sometimes we don't have time to do all that. If we see a lot of hair we will do it. We do offer. They will usually let us know or will have their own razors in the room. Staff Y said they would offer to shave a female resident because of, personal hygiene and I wouldn't want to have facial hair. Staff Y said Resident 60, refuses a lot of care. In an interview on 04/24/2025 at 10:20 AM, Staff V, Social Services Director, said there was no involvement of Resident' 60's spouse with their care at this time, and hasn't been in the facility since a month ago. In an interview on 04/18/2025 at 1:25 PM, Staff F, Unit Manager, said that preferences and inclusion of non-staff persons to provide cares was documented in the care plan, in the Tasks area of the electronic medical record, or under orders if clinically related, and flows into the Kardex. Staff F stated Resident 60's, spouse has taken a step back recently regarding coming in and if they were aware of the resident's preference to have their spouse shave them, they would, make that note in the care plan. Our staff should be offering to do it for [them] or assisting [the resident] if the spouse does not come in. Staff F acknowledged the resident's preference for shaving was not and should have been included in the care plan. 46115 <Resident 311> The 04/04/2025 admission assessment documented Resident 311 had diagnoses which included cancer. The resident had moderate cognitive impairments and was on hospice (a specialized type of care focused on comfort and quality of life for individuals with a serious illness and a life expectancy of six months or less). A review of the 04/05/2025 comprehensive care plan showed there were no interventions developed to delineate what care the nursing staff would provide versus what care hospice provided. The care plan had no contact information for the hospice facility. In an interview on 04/18/2025, Staff W, NA, stated they knew what care to provide the residents with by looking at their care plan. In an interview on 04/18/2025 at 2:10 PM, Staff AA, Licensed Practical Nurse, stated the care provided by the facility versus what care hospice provided needed to be included in the care plan. Staff AA stated this was important because if they had staff work that were unfamiliar with the residents they would need that information. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/18/2025 at 2:14 PM, Staff C stated hospice provided bathing and normally that was placed in the care plan. Staff C acknowledged the information was not a part of Resident 311's care plan and stated the care plan was basic and needed to be updated. Reference: WAC 388-97-1020(1), (2)(a)(b) Refer to F867 for additional information.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37544 Based on interview and record review, the facility failed to ensure care plan revisions were completed and failed to ensure care plan conferences were held for 3 of 60 sampled residents (Resident 33, 38, and 85) reviewed for care planning. Failure to ensure Residents 33 and 85's care plans were revised to include interventions after the resident;s care needs had changed, and failure to conduct care plan conferences as required for Resident 38, placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . <Resident 33> The 02/03/2025 significant change assessment documented Resident 33 admitted to the facility on [DATE], was cognitively intact to make decisions regarding their care, had diagnoses which included medically complex conditions, and needed substantial assistance from nursing staff to reposition while in bed. In addition, the assessment documented Resident 33 had pressure ulcers (wounds caused from prolonged pressure, friction, and/or shearing to the skin), had pressure relieving interventions implemented, and received pressure ulcer treatments. Review of the progress note from 12/13/2024 to 04/20/2025 found the following: - On 12/13/2024 at 2:19 AM, Resident 33 arrived at the facility. Large burn blisters to the top of the right foot, a small red blister to the top of the left foot, and redness to the coccyx were found during the admission skin assessment. - On 01/17/2025 at 9:09 PM, Resident 33 was sent to the hospital for evaluation after a change in condition. - On 01/28/2025 at 4:00 PM, Resident 33 returned to the hospital. Pre-existing skin issues that had been noted during the initial skin assessment on 12/13/2024 to the facility were noted, and a newly identified Stage II pressure ulcer (shallow wound with skin loss of the top two layers) was found on their coccyx during the readmission skin assessment. Review of Resident 33's skin care plan showed interventions were implemented on 12/13/2025 that included resident specific goals and interventions related to skin care and prevention of pressure ulcers, however, no additional interventions were found that included the specific care needs and/or treatment related to the coccyx pressure ulcer that was identified after the resident readmitted to the facility on [DATE]. In an interview on 04/23/2025 at 10:06 AM, Staff C, Assistant Director of Nursing (ADON), stated care plan revisions needed to be done when resident care needs changed. After discussion and review of Resident 33's skin care plan, Staff C acknowledged it had not been revised to include the interventions for the treatment of the coccyx pressure ulcer. (continued on next page)

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	505322	A. Building B. Wing	04/24/2025

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47328 <Resident 85> According to the 03/30/2025 quarterly assessment, Resident 85 admitted to the facility on [DATE] with diagnoses which included weakness and need for assistance with personal care. The assessment further showed Resident 85 was occasionally incontinent of urine. Resident 85 was cognitively intact and clearly able to verbalize their needs. Review of the 10/31/2025 care plan showed Resident 85 required an indwelling urinary catheter (flexible tube inserted into the bladder to drain urine) related to urinary retention and instructed staff to change the catheter per provider orders, anchor the catheter tubing, provide catheter care every shift, and monitor for signs and/or symptoms of infection. Review of November 2024 nursing progress notes showed on 11/04/2025 Resident 85's indwelling urinary catheter was discontinued, their bladder was scanned to check for urinary retention, intermittent catheterization was to be done if they retained over a certain amount of urine, and long-term catheter inserted again as needed for continued urinary retention. Review of provider orders as of 04/14/2025 showed no active orders for Resident 85 to have an indwelling urinary catheter. In an interview on 04/17/2025 at 1:37 PM, Resident 85 stated they had a urinary catheter for approximately two weeks, but it was removed, and they have not had one for a while. In an interview on 04/22/2025 at 8:42 AM, Staff C, ADON, reviewed Resident 85's medical record. Staff C acknowledged Resident 85's urinary catheter was removed in November 2024, but the catheter was not removed from the care plan until 04/17/2025, four and a half months later. Staff C acknowledged it was important for the care plan to accurately reflect a resident's needs. In an interview on 04/22/2025 at 10:32 AM, Staff A, Administrator, stated they expected staff to ensure care plans accurately reflected a resident's needs. 46115 CARE CONFERENCE <Resident 38> The 02/01/2025 quarterly assessment documented Resident 38 was cognitively intact and able to make their needs known. In an interview on 04/14/2025 at 10:54 AM, Resident 38 stated they had never been invited to a care conference. A review of the progress notes from October 2024 through April 2025 documented there was a care conference held on 10/31/2024. There was no other documentation in the residents' record that indicated additional care conferences had been offered or completed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/22/2025 at 1:16 PM, Staff V, Social Service Director, stated care conferences were completed within 48 to 72 hours of admission, quarterly and as requested. Staff V stated it was important to have care conferences, so everyone knew the level of care needed for the residents and the plan going forward. In an interview on 04/24/2025 at 8:30 AM, Staff C stated care conferences were held within 48 hours of admission and anytime the family had concerns. Staff C stated it was important to have care conferences to ensure staff were meeting the goals of care for the residents and for the residents and family to voice concerns. Staff C added Resident 38 should have been invited to a quarterly care conference in February. Reference WAC 388-97-1020 (2)(c)(d) -1020 (5)(b) Refer to F655 and F656 for additional information.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on observation, interview, and record review the facility failed to ensure services provided consistently and routinely met professional standards of practice for 12 of 13 sampled residents (Resident 6, 262, 69, 16, 41, 83, 312, 63, 65, 311, 79, and 85), reviewed for skin conditions, constipation and accidents. Failure of staff to monitor wounds, follow and/or clarify physician orders when indicated, develop and implement an effective fall prevention policy and consistently monitor residents for injury after falls, placed residents at risk for a delay in treatment, injury, hospitalization , and a diminished quality of life. Findings included . The American Nurses Association (ANA) is a national professional organization that represents the interests of registered nurses in the United States and sets and promotes high standards of nursing practice to ensure quality and ethical care for patients. The ANA developed the document, Nursing: Scope and Standards of Practice, with its fourth edition released in 2021. The resource informs and guides nurses in providing safe, quality, and competent patient care. The resource outlined and described 18 standards of practice for nursing professionals to follow. Review of the Nursing: Scope and Standards of Practice resource showed the first six standards included: 1. Assessment: effectively collect data and resident information that is relative to their condition or situation. 2. Diagnosis: analyze the data gathered during the assessment phrase, to determine potential or actual diagnoses. 3. Outcomes Identification: effectively predict outcomes for the resident. 4. Planning: After identifying a diagnosis and outcomes, develop a plan or strategy to attain the best possible outcome for the resident in need. 5. Implementation: Implement the identified plan. This may be done by coordinating care for the residents, such as administering treatment, or implementing/following provider orders. 6. Evaluation: After implementation, a nurse must monitor and evaluate the patient's progress towards the expected outcome or health goals. FAILURE TO ASSESS AND IMPLEMENT TREATMENT FOR NON-PRESSURE SKIN CONDITIONS Review of an undated facility policy titled, Skin Tears, Abrasions, and Bruises Management showed, the nurses completed weekly skin observations and documented their findings in the medical record. The documentation included the location of the skin condition and its description, to include the size, along with treatment orders and interventions to promote healing. The policy instructed the nurses to evaluate the effectiveness of the treatment weekly. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 6> Review of a 02/23/2025 significant change in condition assessment showed Resident 6 admitted to the facility on [DATE] with medically complex conditions, to include Sjogren's syndrome (a chronic autoimmune disease that can cause dry skin). The assessment showed the resident had moderately impaired cognition and had no lesions, skin tears, or abrasions. An observation on 04/14/2025 at 11:28 AM showed Resident 6 sitting in a wheelchair in a resident lounge area. An undated dressing was observed towards the top of the resident's head, partially lifted on the right side and exposed an open area of an undetermined size. The exposed area was not actively draining and seemed to have a dry, red wound bed, like an abrasion. Resident 6 stated the staff, Change the dressing if I need it every day. Observations on 04/16/2025 at 09:25 AM and 04/17/2025 at 8:39 AM showed Resident 6 up in a wheelchair and out of their room, with no dressing present. Observed was a dry abrasion, approximately 1.5 centimeters (cm, a unit of measurement) by 2 cm. No active drainage or signs of infection were observed. Review of the April 2025 Treatment Administration Records (TAR) showed no instructions to monitor or care for the abrasion to Resident 6's head. A 03/06/2025 progress note documented Resident 6 had opened several scabbed wounds by scratching on [their] forehead and right leg resulting in bleeding. Antibiotic antibiotic ointment and skin prep was applied to the wounds and dressed with bordered dressings. Another 03/06/2025 progress note showed the staff identified abrasions to the right lower leg and to the right side of the scalp. Review of the March 2025 Treatment Administration Records (TAR) showed no orders for the application of the antibiotic ointment and bordered dressings to the wounds on the forehead or right leg. Review of a 03/13/2025 Wound Consultant note showed, the staff assessed Resident 6 had, bruises and abrasions from falls and scratching [themselves]. The consultant instructed the staff to apply one or more ounces of emollient [moisturizing] cream to all the skin at least two times a day. Subsequent notes by the Wound Consultant on 03/20/2025, 03/27/2025, 04/03/2025, and 04/10/2025 showed the same instructions. Review of the March and April 2025 TAR or care plan showed no documentation the nurses implemented the Wound Consultant's specific instruction. Review of the progress notes from 03/21/2025 to 04/12/2025 showed the staff identified various skin conditions as follows: - On 03/21/2025, an abrasion to the forehead - On 03/24/2025, skin tears and abrasions - On 03/26/2025, abrasions to knees - On 03/28/2025, skin abrasions - On 04/12/2025, a skin tear that is not covered; skin found to be open, size is about 8cm in length with moderate amount of blood; Per the documentation, the resident was sent to the hospital, returned to the facility at 8:15 PM, and had obtained 9 stitches and 5 steri-strips [adhesive strips]. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of provider notes showed they also identified the following various skin conditions: - On 02/19/2025 and 03/17/2025 - abrasions to both knees and scalp -On 03/06/2025, 03/11/2025, 03/14/2025, 3/27/2025, 03/28/2025, 4/17/2025 - Wound on scalp or Scabbed wound on scalp. Review of the medical record showed the nurses completed weekly Skin Observation assessments on 02/17/2025, 02/24/2025, 03/03/2025, 03/06/2025, 03/11/2025, 03/13/2025, 04/10/2025, and 04/17/2025. The medical record showed no documentation that showed the nurses assessed or evaluated the status or progress of the multiple identified non-pressure skin conditions, to include the substantial skin tear of unknown location, or developed and implemented measures to ensure adequate healing and/or prevent complications associated with the non-pressure skin conditions. Review of the physician orders showed no instructions to care for the substantial skin tear of unknown location that required the resident's transfer to the hospital for invasive treatment on 04/12/2025. The above findings were shared with Staff C, Assistant Director of Nursing (ADON), on 04/18/2025 at 11:21 AM. Staff C acknowledged the nurses should have, but did not procure or implement provider orders for the management of non-pressure skin conditions, assessed or evaluated the status or progress of non-pressure skin conditions, or developed and implemented measures to ensure adequate healing and prevent complications associated with the non-pressure skin conditions. <Resident 63> According to the 02/12/2025 quarterly assessment, Resident 63 was dependent on staff assistance to perform personal hygiene which included washing/drying their face. Resident 63 had moderate cognitive impairment and was able to clearly verbalize their needs. Review of the 02/04/2025 weekly skin assessment observation showed Resident 63 had dry skin. Review of the 02/11/2025 weekly skin assessment observation showed Resident 63 had extremely dry skin. Review of Resident 63's care plan showed no documentation or interventions to address Resident 63's extremely dry skin. During observation and interview on 04/14/2025 at 9:00 AM, Resident 63 had thick white dry skin flakes covering their entire forehead, down both sides of their face, inside both ear crevices, down both sides of their neck, and behind both ears. Resident 63 stated they had Psoriatic [skin condition that resulted in red patches covered with silvery scales] Arthritis [joint pain, stiffness, and swelling]. Resident 63 stated they were experiencing a bad flare up and explained their skin itched and was irritated. Resident 63 stated they had a cream to help but they had to request it and I never seem to get it. Resident 63 further stated it took their skin a while to calm back down after a flare up. Similar observations were made at 11:31 AM, 1:20 PM, on 04/15/2025 at 8:58 AM and 12:03 PM, on 04/16/2025 at 12:14 PM, and on 04/18/2025 at 8:43 AM. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/22/2025 at 1:18 PM, Staff C reviewed Resident 63's medical record. Staff C acknowledged Resident 63 had extremely dry skin and no treatment for psoriasis. Staff C stated they expected staff to follow up on skin issues as needed. <Resident 16> According to the 03/11/2025 assessment, Resident 16 was cognitively intact and able to clearly verbalize their needs. Review of the 04/07/2025 facility unwitnessed fall report showed Resident 16 attempted to self-transfer but their legs gave out and fell . Resident 16 sustained a skin tear to the back of their left hand that was closed with steri-strips (thin strips of tape used to close small cuts). Review of April 2025 nursing progress notes showed on 04/07/2025 Resident 16 fell and sustained a skin tear to the back of their left hand that was closed with steri-strips. On 04/08/2025 the left hand steri-strips were getting a little dirty and were covered with gauze. No documentation of skin tear monitoring or assessment for signs and/or symptoms of infection was found until 04/15/2025. On 04/15/2025 the left-hand dressing was dislodged, the wound was cleansed, assessed, and redressed. Resident 16 informed the staff the skin tear was an injury from their recent fall. Review of provider orders as of 04/14/2025, seven days after Resident 16 sustained a fall, showed no provider orders to monitor the left-hand skin tear for signs and/or symptoms of infection or to change the bandage. During observation and interview on 04/14/2025 at 11:18 AM, Resident 16 stated they sustained a skin tear to their left hand when they attempted to self-transfer recently and fell . Resident 16 pointed to a white undated bandage on the back of their left hand with a dark blood drainage stain spot observed through the bandage. Resident 16 stated the bandage had not been changed for a week and thought the skin tear was worsening because it was becoming painful, warm, and continued to bleed. Similar observation was made on 04/15/2025 at 8:52 AM. In an interview on 04/22/2025 at 12:02 PM, Staff H, Licensed Practical Nurse (LPN), explained if a resident fell and sustained a skin tear the provider would be notified and orders to monitor and/or skin treatment orders implemented. Staff H stated skin issues could worsen or get infected if they were not monitored. Staff H reviewed Resident 16's medical record. Staff H acknowledged Resident 16 experienced a fall on 04/07/2025, sustained a skin tear to the back of their left hand, and staff should have implemented orders to monitor the skin tear. In an interview on 04/22/2025 at 12:19 PM, Staff C, ADON, stated skin issues could worsen or get infected if they were not consistently monitored. Staff C reviewed Resident 16's medical record. Staff C acknowledged Resident 16 sustained a skin tear from a fall on 04/07/2025, but treatment orders were not implemented until 04/16/2025, nine days later. Staff C stated they expected staff to follow-up on skin issues. In an interview on 04/22/2025 at 2:01 PM, Staff A, Administrator, stated they expected staff to follow up on skin issues. FAILURE TO ASSESS AND IMPLEMENT ORDERS FOR CONSTIPATION (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of provider standing orders showed directions to address constipation before and after 48 hours of not experiencing a bowel movement (BM). The protocol was time-specific regarding administration of the different laxatives. The standing orders showed that after 48 hours of no BM, the nurses were instructed to administer Lactulose every two hours as needed and if the resident did not have a BM after six hours, then Milk of Magnesia (MOM). If the resident did not have a BM after six hours of receiving the MOM, the nurses were to administer a Bisacodyl suppository. If the suppository proved ineffective after six hours, the nurses were ordered to administer a Fleets enema once and to notify the provider if they wished to repeat it. The orders instructed the nurses to notify the provider if a resident did not have a BM greater than 3 days and to let them know of all medications that were already attempted. <Resident 262> Review of a 04/03/2025 admission assessment showed Resident 262 admitted to the facility on [DATE] with medically complex conditions, which included Parkinsonism (a neurological disorder) and chronic pain syndrome. The assessment showed the resident was cognitively intact and presented with a bowel pattern of constipation. An observation and interview on 04/18/2025 at 1:04 PM showed Resident 262 sitting up in a chair in their room. Resident 262 said they independently walked to the bathroom. The resident said they had a BM one every 4 or 5 days here [in the facility] which was a change from home where they had a BM, almost every day. The resident shared that at home they took a a big gulp of Milk of Magnesia about once a week and, Apparently [staff] don't know about Milk of Magnesia here. The resident referred to being offered a liquid twice a day that they thought was for the management of constipation but, I wonder about it because I'm still not pooping. Maybe I should mention it to [the staff]. That would make me go poop. I'd like that. When asked if the staff inquired if they had a bowel movement, Resident 262 stated, No, I don't think anybody has asked that. Review of the April 2025 Medication Administration Records (MAR) showed physician orders for routine or scheduled administration of medications that had the side effect of constipation, to include amiodarone (a cardiac agent), bupropion (an antianxiety agent), iron tablets, semaglitude (for diabetes), and carbidopa-levidopa (for Parkinsons). The MAR showed that both scheduled senna tablets and gavilax (both over the counter [OTC] medications used to treat constipation) were discontinued on 04/07/2025. The MAR showed no as needed orders for medications to treat episodes of constipation. Review of a 03/29/2025 care plan showed the staff assessed and determined the resident was at risk for constipation related to medications. The care plan showed, if the resident experiences constipation it will be resolved thru the review period. The interventions directed the nurses to administer medications as ordered, implement bowel protocol when indicated, observe for signs and symptoms of constipation or extended abdomen that may indicate constipation, and track and record bowel movements. Review of a Bowel Elimination Record from 03/28/2025 to 04/18/2025 showed Resident 262 did not have a BM recorded for three days from 03/28/2025 to 03/30/2025, for six days from 04/04/2025 to 04/09/2025, and for three days from 04/11/2025 to 04/13/2025 and from 04/15/2025 to 04/17/2025. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The above findings were shared with Staff C on 04/18/2025 at 1:30 PM. Staff C clarified that the bowel protocol the care plan referred to was the provider's standing orders and the nurses had to manually input those orders into the electronic medical record for their use. Staff C acknowledged the medical record showed no documentation the nurses assessed Resident 262 or implemented the standing orders for constipation, as per professional standards of practice, to include notifying the provider when Resident 262 did not have a BM greater than 3 days. 46115 <Resident 69> The 03/07/2025 significant change in condition assessment documented Resident 69 had diagnoses which included constipation and high blood pressure. The resident was cognitively intact and able to make their needs known. In an interview on 04/14/2025 at 10:04 AM, Resident 69 stated they had constipation and MOM helped. The 12/09/2025 care plan instructed nursing to monitor for signs and symptoms of constipation, implement bowel protocol when indicated, administer medications as ordered, and track and record bowel movements. The care plan documented if the resident experienced constipation it would be resolved through the review period. The bowel record from 03/01/2025 to 04/18/2025 documented Resident 69 did not have a BM on the following dates: 03/05/2025 to 03/12/2025, eight days 03/21/2025 to 03/24/2025, four days 04/14/2025 to 04/19/2025, six days Review of the March and April 2025 MARs showed Resident 69 had as needed Bisacodyl to treat episodes of constipation and none was administered. <Resident 38> The 02/01/2025 quarterly assessment documented Resident 38 had diagnoses which included diabetes and heart failure. The resident was cognitively intact and able to make their needs known. The 10/30/2024 care plan instructed nursing to monitor signs and/or symptoms of constipation, implement bowel protocol when indicated, administer medications as ordered, and track and record bowel movements. The care plan documented if the resident experienced constipation it would be resolved through review period. The bowel record from 03/01/2025 to 04/18/2025 documented Resident 38 did not have a BM on the following dates: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	03/18/2025 to 03/27/2025, ten days 04/01/2025 to 04/04/2025, four days 04/06/2025 to 04/12/2025, seven days Review of the March and April 2025 MARs showed Resident 38 had no as needed medications to treat episodes of constipation. In an interview on 04/22/2025 at 9:00 AM, Staff X, Licensed Practical Nurse, stated the bowel protocol was started on day three of no BM and they were to administer DOSS (a stool softener), Senna (a laxative) and Miralax (a stimulant). Staff X stated small bowel movements did not count. Staff X stated it was important to follow the protocol, so blockage and pain did not occur. In an interview on 04/22/2025 at 1:30 PM, Staff C stated they had standing orders for the bowel protocol from a group of their providers, and they had a provider that ordered MOM on day three of no BM, if no results a suppository was given, and if no results the next day an enema was given. Staff C stated the bowel protocol should have been followed for the above residents or a progress note made stating they spoke to the residents and inquired if they had a BM. Staff C stated it was important to follow the bowel protocol to prevent pain and blockage. <Resident 16> According to the 03/11/2025 assessment, Resident 16 was always incontinent of bowel and their bowel patterns showed constipation was present. Resident 16 was cognitively intact and able to clearly verbalize their needs. Review of the 02/21/2025 care plan showed Resident 16 was at risk for constipation and instructed staff to administer medications as ordered, track BMs, observe for signs of constipation, and implement the bowel protocol when indicated. Review of provider orders showed a 02/11/2025 order for Resident 16 to be administered MOM every 24 hours as needed for constipation, MiraLAX to be administered every 24 hours as needed for constipation, and a Bisacodyl suppository daily as needed for bowel care. Review of the bowel elimination record from 03/19/2025 to 04/17/2025 showed Resident 16 did not have a BM for three days from 03/27/2025 to 03/29/2025, for four days from 04/01/2025 to 04/03/2025, for four days from 04/05/2025 to 04/08/2025, and for four days from 04/11/2025 to 04/14/2025. Review of the March 2025 through April 2025 MAR showed Resident 16 was not administered any as needed bowel medication from 03/24/2025 through 04/16/2025. <Resident 41> According to the 02/13/2025 admission assessment, Resident 41 was continent of bowel, was cognitively intact and able to clearly verbalize their needs. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 02/05/2025 continence care plan showed Resident 41 was usually continent of bowel and instructed staff to record BMs, provide staff assistance with toileting, and provide toileting/incontinence supplies as needed. Review of provider orders showed a 02/04/2025 order for Resident 41 to be administered MiraLAX every 24 hours as needed for constipation. Review of the bowel elimination record from 03/20/2025 to 04/18/2025 showed Resident 41 did not have a BM for five days from 03/30/2025 to 04/03/2025 and for four days from 04/06/2025 to 04/09/2025. Review of the April 2025 MAR record showed Resident 41 was not administered MiraLAX for constipation as needed. <Resident 85> According to the 03/30/2025 quarterly assessment, Resident 85 was always incontinent of bowel and their bowel patterns showed constipation was present. Resident 85 was cognitively intact and able to clearly verbalize their needs. Review of the 01/14/2025 opioid (class of drugs used to reduce moderate to severe pain) use care plan showed Resident 85 was at risk for complications and instructed staff to administer medications as ordered, record/track bowel movements, and implement the bowel regimen protocol. Review of provider orders showed a 12/30/2024 order for Resident 85 to be administered a bisacodyl suppository every 24 hours as needed for constipation, and a 02/17/2025 order for Resident 85 to be administered MOM every 24 hours for constipation lasting more than 48 hours. Review of 12/18/2024, 12/30/2024, 02/06/2025, 03/01/2025, and 03/17/2025 provider progress notes showed Resident 85 struggled with recurrent constipation going up to several days before having a hard BM. Review of February 2025 nursing progress notes showed on 02/23/2025 Resident 85 had an incident of hard impacted stool. Several large hard stools were passed after Resident 85 was administered a Bisacodyl suppository. Resident 85 will require education on bowel maintenance when taking scheduled [opioid] medication. Review of the bowel elimination record from 03/18/2025 to 04/16/2025 showed Resident 85 did not have a BM for 10 days 03/20/2025 to 03/29/2025, for four days from 04/04/2025 to 04/07/2025, and for five days from 04/12/2025 to 04/16/2025. Review of the March 2025 through April 2025 MAR showed Resident 85 was not administered MiraLAX or a Bisacodyl suppository for constipation as needed. In an interview on 04/22/2025 at 9:23 AM, Resident 85 stated the facility did not monitor or track BMS and often went 9-10 days without a BM. Resident 85 further stated it was painful to have a BM after 10 days, staff did not offer bowel interventions and often had to request a suppository or enema. (continued on next page)

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	505322	A. Building B. Wing	04/24/2025

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/22/2025 at 9:43 AM, Staff F, Resident Care Manager, stated residents were at risk for bowel blockages if the bowel protocol was not implemented when indicated and staff should document bowel interventions attempted and/or refused. Staff F reviewed Resident 85's medical record. Staff F acknowledged Resident 85 went 9-10 days without a BM and staff should have implemented the bowel protocol. In an interview on 04/22/2025 at 10:34 AM, Staff A, Administrator, stated they expected staff to implement the bowel protocol when indicated. 47328 FAILURE TO IMPLEMENT FALL PRECAUTIONS Review of the facility policy titled, Fall Safety- Everyone is at Risk of Falling dated October 2022, showed anyone could fall regardless of age, gender, or illness. The policy instructed staff to be alert to situations that could lead to falls and included some potential situations to avoid and interventions to implement. The Falling Leaves program consisted of a leaf sticker placed next to a high fall risk resident's door name tag. The sticker was to notify staff the identified resident required frequent rounding to help reduce falls. The policy did not instruct staff how to assess fall risk, what steps to take when a fall occurred, or how to monitor residents when falls were sustained. Review of an undated facility incident report form instructed staff to use the format as a guide on what steps were required after a resident sustained a fall. Staff were to place the resident on alert charting: every shift for 72 hours, or longer if not resolved. The form additionally instructed staff to complete a neurological evaluation (neuro and/or neuro checks, a series of tests that assess mental status, reflexes, movement, and pupil reaction to evaluate brain and nervous system function) if a resident hit their head or the fall was unwitnessed by staff. Review of the Neurological Evaluation Flow Sheet used by the facility to assess for any changes instructed staff to complete a neuro evaluation with vital signs every 30 minutes for two hours, then every hour for four hours, then every 8 hours for nine hours (72 hours), compare vital signs over time and pay close attention to respiratory patterns. The form included a graph to document the required information on. <Resident 65> According to the 02/11/2025 admission assessment, Resident 65 admitted to the facility on [DATE] with diagnoses including Dementia, syncope (to faint) and collapse. The assessment further showed Resident 65 sustained a fall in the month prior to admission and a non-injury fall since their admission. Resident 65 had severe cognitive impairment, disorganized thinking and inattention. Review of the 01/30/2025 hospital history and physical showed Resident 65 experienced a fall at home and was down for approximately an hour. The notes further showed Resident 65 had a history of falls, needed assistance with walking, had a soft-spoken voice, and spoke minimally per their baseline. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 02/05/2025 admission assessment showed Resident 65 arrived to the facility at 3:00 PM, had cognitive impairment, was confused, oriented to self only, and unable to make their needs known. The assessment further showed Resident 65 had post fall injuries including significant bruising, four lacerations, and an eyebrow abrasion. Review of the 02/06/2025 care plan showed Resident 65 was at risk for falls related to cognitive and functional impairments, weakness, recent hospitalization , unsteady gait, and incontinence. The care plan instructed staff to anticipate Resident 65's needs, have the bed against the wall in the lowest position, non-skid strips at bedside, educate resident on safe transfers, provide and use non-skid socks while out of bed. An intervention implemented on 02/13/2025 showed Resident 65 was added to the Falling Leaves program. Revisions on 03/03/2025 instructed staff that resident was to be in high visibility areas when up in the wheelchair (WC), and on 03/13/2025 a fall mat was to be placed to the left side of the bed. Review of the February 2025 through March 2025 facility incident reporting log showed fall entries related to Resident 65 were made on 02/05/2024, 02/13/2025, 02/28/2025, 03/12/2025, and 03/14/2025. Review of Resident 65's fall reports showed: - Unwitnessed fall on 02/05/2025 at 4:50 PM (1 hour and 50 minutes after their admission), staff entered Resident 65's room to answer their call light and found them lying on the floor. Resident 65 was restless, continued to attempt to self-transfer out of bed. Resident 65 had aphasia (disorder that made it hard to understand and speak) and could not explain the situation. Interventions implemented were to place the bed against the wall in the lowest position and provide the resident with non-skid socks. No documentation of neuro checks was found. - Unwitnessed fall on 02/13/2025, Resident 65 was found on the floor next to their roommate's bed. The mattress on the floor next to [Resident 65's] bed had been moved away from the bed about 4-5 inches and appeared the resident self-transferred. Intervention implemented was to add Resident 65 to the Falling Leaves program. The attached neurological evaluation flow sheet vital signs section showed only five of 12 sets of vital signs were documented. - Unwitnessed fall on 02/28/2025, Resident 65 slid out of their WC, was confused, unable to state what happened and neuro checks were started, however, no documentation of neuro checks were found. - Unwitnessed fall on 03/12/2025, Resident 65 was found sitting on the floor next to their bed with the fall mat again pushed away from the bed, neuro checks were initiated. The incident summary showed Resident 65's care plan remained appropriate. No documentation of intervention implemented, or neuro checks was found. - Unwitnessed fall on 03/14/2025, Resident 65 was found lying on the floor next to their WC near the nurses' station, and neuro checks were initiated. Intervention implemented was a therapy referral for WC evaluation. The attached neuro sheet showed omissions in documentation for four of 12 neuro assessments and eight of 12 sets of vital signs. Review of February 2025 through March 2025 nursing progress notes showed Resident 65 was inconsistently monitored for latent injuries after falls occurred. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/24/2025 at 10:34 AM, Staff H, Licensed Practical Nurse (LPN), stated residents were assessed for fall risk upon admission. Staff H explained when a fall occurred, an incident report was completed, the resident assessed for injuries, placed on alert to monitor for potential latent injuries, provider notified, and interventions implemented. Staff H further stated all unwitnessed falls and falls with head injury needed to have neuro checks completed and documented on the paper form. A fall intervention needed to be implemented when a fall occurred to prevent further falls and/or injury. Staff H acknowledged a resident's health and safety was in jeopardy if a resident was not consistently monitored after a fall occurred. In an interview on 04/24/2025 at 10:40 AM, Staff C, ADON, explained neuro checks were to be completed for unwitnessed falls or falls with head injury. Staff C stated staff were to document neuro checks on the paper neurological evaluation flow sheet when implemented. Staff C further stated residents were monitored for latent injuries via the neuro check flow sheet and nursing progress notes, if a resident was not monitored then staff would not know if or when a resident had a worsening injury, pain, or change of condition. Staff C reviewed Resident 65's fall reports and acknowledged there were omissions in Resident 65's neuro check monitoring, and staff should have monitored neuros consistently. <Resident 69> The 03/07/2025 significant change assessment documented Resident 69 had diagnoses including high blood pressure, anxiety and repeated falls. Resident 69 was cognitively intact and was able to make their needs known. The 12/10/2024 risk for falls care plan documented Resident 69 was at risk for falls related to weakness, poor vision, incontinence and functional impairments. The care plan had multiple fall interventions in place. Review of the September 2024 through March 2025 facility incident log showed Resident 69 sustained a fall on 09/19/2025. A 09/19/2024 progress note documented Resident 69 reported they fell in their room and had gotten themselves up off the floor. The resident stated they landed on their right side. The nurse stated they initiated neuros. The neuro monitoring sheet revealed 10 omissions and documented the resident was asleep. Review of Resident 69's record revealed there were no further progress notes regarding the fall. <Resident 311> The 04/04/2025 admission assessment documented Resident 311 had diagnoses including cancer, high blood pressure and diabetes. Resident 311 had moderate cognitive impairments and was able to make their needs known. The 12/10/2024 risk for falls care plan documented Resident 311 was at risk for falls related to deconditioning, pain and medications. The care plan had multiple fall interventions in place. <br[TRUNCATED]

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on observation, interview, and record review the facility failed to consistently and accurately assess residents smoking abilities and implement safety interventions to prevent smoking related injuries for 3 of 3 sampled residents (Resident 73, 86 and 461), reviewed for smoking. The failure to accurately assess residents' smoking abilities and implement safety interventions to prevent smoking related injuries represented an immediate jeopardy (IJ). On 04/15/2025 at 5:21 PM, the facility was notified of the identified IJ related to F689 CFR S483.25 Accidents and Supervision. Onsite verification by surveyors on 04/17/2025 showed, the facility removed the immediacy by placing Resident 73 on one-to-one surveillance, secured the resident's smoking paraphernalia, re-assessed the resident's ability to smoke, and revised the care plan to show the level of assistance and supervision the resident required to smoke safely. The facility closed access to unsupervised patio areas. The facility added a fire blanket and an outdoor ashtray to the designated smoking area. The facility interviewed other residents and staff to identify other residents who smoked and completed smoking safety evaluations of all the residents in the facility and for any residents identified as a smoker/tobacco user, to include development or revision of their care plans to show individualized interventions and supervision levels related to smoking preference. The facility completed a facility-wide sweep to remove unauthorized smoking materials. The facility notified the residents of the smoking policy. The facility educated the staff on the smoking policy, and identifying, managing, and reporting unsafe smoking behaviors. Immediacy was removed 04/16/2025. Findings included . Review of a facility admission agreement showed smoking or vaping was prohibited within and on the grounds of the facility. The agreement informed the residents that possessing smoking related items, like cigarettes and lighters, was strictly prohibited. Residents were informed that the facility would provide information and assistance with exploring smoking cessation interventions and products if they had a history of smoking or tobacco use prior to admission to the facility and if so desired. Violation of the Smoke-Free Facility policy endangered the health and safety of the residents in the facility and was ground for discharge. Review of the facility policy titled, Smoking Prohibited for Residents But Allowed For Staff dated October 2021, showed if staff found a resident with smoking materials, they were to be given to the nurse who secured them. The policy further showed staff would notify the provider for each incident of policy violation, document incident in the medical record, and investigated by the facility leadership team to evaluate the scope and potential endangerment to other residents and staff. The results of the investigation determined the course of action to protect other residents and staff from endangerment, to include re-education of the resident, removal of smoking materials, discussion about smoking cessation support, evaluation of the resident's ability to smoke safely without staff assistance or supervision in a location out of the facility and off the facility grounds, and/or discharge from the facility. During the entrance conference on 04/14/2025 at 8:42 AM, Staff A, Administrator, stated the facility was a non-smoking facility and there were no residents that smoked. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	<Resident 73> Review of a 01/24/2025 hospital document showed Resident 73 fell asleep easily during the interview but awakens easily again. The document showed the resident smoked cigarettes on some days. Review of a 02/03/2025 facility provider note showed Resident 73 was, Current smoker some days. Review of a 02/07/2025 facility admission assessment showed Resident 73 admitted to the facility from the hospital on 02/01/2025 with medically complex conditions, including Parkinson's disease (a neurological disorder) and diabetes. The assessment showed Resident 73's speech was unclear, was cognitively intact, experienced fluctuating altered levels of consciousness and required staff assistance during transfers and walking. The assessment showed Resident 73 did not use tobacco. Review of progress notes showed on 02/17/2025, the staff observed Resident 73, smoking outside in the parking lot. Social worker went out to speak to resident and remind [them] that we are a non-smoking facility. [The resident] was agreeable and put out [their] cigarette. Review of a 02/17/2025 Smoking - Resident Safety Evaluation, signed off as completed on 03/05/2025 (16 days later), showed the staff identified Resident 73 used tobacco products, allowed the resident to smoke, and used Cigarettes / Cigars. The staff assessed Resident 73 was unable to hold or extinguish a cigarette safely or use an ashtray to extinguish the cigarette. The staff concluded, Resident is not a safe smoker at this time. [They] agreed to Nicotine patches and to not smoke at this time. Family notified and nicotine patch order placed. Review of a 03/03/2025 progress note showed, the facility informed the resident, that this is a non-smoking facility as was noted to be smoking at one point. Smoking materials obtained until safety can be established. Review of a 03/04/2025 Tobacco Use care plan showed, Resident 73 preferred to smoke cigarettes. The goal was for the resident to follow non-smoking policy. The interventions included, Instruct the resident about smoking risks and hazards and about smoking cessation aids that are available, Notify social services or nurse manager if patient is found to be smoking, and smoking assessment as needed. The interventions were dated 03/04/2025 and 03/05/2025. The care plan showed no documentation the facility developed interventions to keep the resident safe from smoking related injuries or that compensated for their inability to manage smoking supplies. The care plan showed no documentation where smoking supplies were kept. Review of 03/03/2025, 03/06/2025 and 03/14/2025 facility provider notes showed once more Resident 73 was, Current smoker some days. Review of March and April 2025 Medications Administration Records (MAR) showed no documentation the provider prescribed nicotine patches for Resident 73 prior to 04/15/2025, as indicated in the 02/17/2025 resident smoking safety evaluation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An observation on 04/15/2025 at 2:23 PM, by the entire survey team, showed Resident 73 self-propelling in their wheelchair in the patio area with a lit cigarette in their hand. The resident attempted to enter the conference room where surveyors were with the lit cigarette, but was unable to open the door. Resident 73 then wheeled over to the barbecue area under the [NAME] and sat next to a propane tank with the lit cigarette. At 2:34 PM, a surveyor entered the patio area, and it smelled of cigarette smoke. No fire blanket or ashtrays were observed. Resident 73 stated that they liked to smoke three times a day, and when asked if there was an ashtray outside, they said, No. Observation of a white plastic fold-up table showed black streaks on its surface resembling the stubbing of a cigarette (to put out a cigarette by pressing the lit end against a surface, often done using a surface like an ashtray or the ground). Resident 73 again attempted to get into the conference room but was unable to do so. The resident then self-propelled across to the other side of the patio to enter another side of the building. A staff member was observed to escort Resident 73 back in the building. In an interview on 04/15/2025 at 3:23 PM, Staff Q, Registered Nurse (RN), stated that the facility was a non-smoking establishment, and smoking was allowed out on the street or off the premises. Staff Q became aware if a resident actively smoked and the assistance required by checking the resident's roster (a basic information sheet used by the staff). Staff Q stated that they did not have any resident smoking materials secured. Staff Q stated that they were unaware of any residents who smoked in the facility but that if they did see a resident smoke, they would stop the resident and notify the Unit Manager. In an interview on 04/15/2025 at 3:29 PM, Staff R, Nursing Assistant (NA), stated that they became aware of resident information by review of the Kardex (a summary of the care plan). Staff R stated, We are non-smoking so I am unsure if there are smokers [in the facility] but if they did smoke, they would have to go off property. Staff R stated that there was no designated place for a resident to smoke on facility premises. Staff R stated if they saw a resident violate the facility smoking policy they would, stop it from happening and let the nurse supervisor know and report it up above. Go through the chain [of command] not just the nurse. Staff R stated that smoking materials would be kept in a lock box with the Social Services department. In a confidential interview on 04/15/2025 at 3:36 PM, an Anonymous Staff stated, Not a lot of residents here smoke and As long as [the resident] is on the sidewalk, that's considered off property. The staff stated if they saw a resident violate the facility smoking policy they would, Ask them if they can go to the sidewalk and educate them on the policy. I'd let my Unit Managers know or the ADON [Assistant Director of Nursing]. The staff identified Resident 73 was the only resident they were aware of that currently smoked and stated the resident kept their smoking materials in their jacket and never has it out in the open. The Anonymous Staff was unaware how long Resident 73 smoked since admission to the facility. An observation and interview on 04/15/2025 between 3:36 PM and 4:00 PM showed, Resident 73 lying in bed. Resident 73 stated that they kept their cigarettes in their pocket along with the lighter and smoked more than twice a day and off the property. Additionally, Resident 73 stated that when the front doors to the facility were locked after 7:00 PM or 8:00 PM, I have to wait until someone sees me to let me in because the doors are locked. Resident 73 stated that their preferred smoking time began at noon or after lunch. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The above findings were shared with Staff A, Administrator, in an interview on 04/15/2025 at 5:21 PM. Staff A confirmed the patio was not a smoking area and that, North [Hall] staff said they were not aware of [any] smoker [in the facility]. Staff A stated that when staff escorted Resident 73 back to the facility, the resident had a faint smell of smoke. Staff A stated the resident was known to have paraphernalia on [them] which was relinquished to the facility and the resident, will not tell us how [they] got the smokes and lighter [afterwards and] we are assuming the family brought it in or visitors. Staff A stated that since Resident 73 refused to relinquish the cigarettes and lighter they were placed on a one-to-one surveillance after the 04/15/2025 observations in the patio. In an interview on 04/24/2025 at 9:45 AM, Staff C, ADON, described the process on how the facility identified residents who smoked and ensured their safety. Staff C stated that hospital paperwork was reviewed, and part of the facility's admission assessment completed by the nurse asked about smoking preferences. Once a resident was identified as currently smoking, We care plan if they are an active smoker and let them know we are a non-smoking facility and if they prefer to smoke, come up with a smoking plan and establish locations to smoke and smoking times. Staff C stated the facility identified concerns related to smoking, At initial assessment if admitting, observations of the resident, communication at Stand Up [a daily Inter-disciplinary meeting], and review of the 24-hour report [progress notes]. Staff C stated that when a resident was identified as unsafe to smoke or noncompliant with the smoking policy, the facility should ensure the resident, does not have smoking paraphernalia in their room, provide a smoking apron and supervision, and re-do their smoking assessment. On 04/28/2025 at 8:13 AM in a follow up telephone conversation, the facility provided additional information. Staff C stated the facility should have added instructions to the care plan to direct the staff on the level of supervision and amount of assistance Resident 73 required during smoking after completion of the 02/17/2025 Smoking Safety Evaluation, to include staying with the resident while they smoked. Staff C stated that the additional safety interventions did not show in the care plan because the evaluation concluded a smoking cessation program (nicotine patches) would be started. Staff C acknowledged upon review of the medical record that the nicotine patches never started as mentioned in the 02/17/2025 smoking evaluation. 47328 <Resident 461> According to the 01/03/2025 quarterly assessment, Resident 461 admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (COPD, progressive lung disease that makes it difficult to breathe). The assessment further showed Resident 461 was cognitively intact, did not exhibit behaviors and was able to clearly verbalize their needs. Review of the 07/04/2024 hospital history and physical provided to the facility during the admisson process showed Resident 461 smoked tobacco and had a tobacco abuse diagnosis. Review of the 07/11/2024 resident safety assessment showed Resident 461 used tobacco products including cigarettes/cigars and the facility did not allow smoking. A nicotine patch was listed as a smoking cessation intervention. Resident 461 was identified as safe to smoke with supervision. Review of provider orders showed a 07/12/2024 order for Resident 461 to use a nicotine patch daily for nicotine dependence. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the July 2024 through September 2024 MAR showed Resident 461 began to refuse the nicotine patch on 08/10/2024. The nicotine patch was discontinued on 09/11/2024. Review of the 08/21/2024 care plan showed Resident 461 smoked and was agreeable to smoke off premises. Interventions instructed staff to educate the resident about smoking risks and hazards, smoking cessation aids available, educate the resident about the facility smoking policy to include smoking off premises only, notify the charge nurse immediately if the resident was suspected of violating the facility smoking policy, and monitor clothing and skin for signs of cigarette burns. Review of the 08/22/2024 resident safety assessment showed Resident 461 used tobacco products including cigarettes/cigars and the facility allowed resident smoking. The assessment further showed Resident 461 was offered a nicotine patch but refused it and requested to smoke. Resident 461 was educated on not smoking in their room and to store cigarettes and lighter in a safe location. Resident 461 was identified as safe to smoke without supervision. Review of the 10/11/2024 resident safety assessment showed Resident 461 used tobacco products including cigarettes/cigars, resident declined smoking cessation interventions, and the facility allowed resident smoking. Resident 461 was identified as safe to smoke without supervision. No documentation was found that showed Resident 461's smoking materials were stored securely for safety after additional record review. Review of August 2024 through December 2024 nursing progress notes showed the following: - 08/21/2024, Resident 461 stated they had five packs of cigarettes, knew how to wean themselves off, and did not need a nicotine patch. - 08/22/2024 the facility non-smoking policy was reviewed with Resident 461, they were no longer wearing the nicotine patch and continued to smoke on the facility property, no additional smoking safety interventions were implemented at that time. - 12/27/2024 Resident 461 continued to demonstrate unsafe behavior of smoking on the facility property. When Resident 461 was reminded smoking was not permitted on the premises, Resident 461 stated they were not leaving the premises and would continue to smoke on the property. A 30-day notice was discussed with Resident 461 related to their health had improved sufficiently so they no longer needed services provided by the facility and their continued smoking on the property endangered other facility residents. No additional smoking safety interventions were implemented at that time. - 12/29/2024 the fire alarm was set off at approximately 2:30 AM, staff smelled smoke in Resident 461's bathroom, Resident 461 denied smoking indoors and refused to hand over their cigarettes or lighter, frequent checks for safety were implemented. At noon, Resident 461 was placed on 1:1 monitoring due to safety concerns. Resident 461 again refused to give staff their lighter and stated, I'm going to smoke no matter what. - 12/30/2024 Resident 461 was provided a discharge notice. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the 12/29/2024 fire alarm detailed activity report showed at 2:18 AM the fire alarm was activated, the fire department was dispatched, facility staff were contacted by the fire alarm monitoring company, the fire alarm was cleared and restored. Review of the 12/30/2024 nursing home transfer or discharge notice showed Resident 461's health improved sufficiently so that they no longer needed services provided by the facility and the safety of other individuals in the facility was endangered due to the status of the resident. A brief explanation showed Resident 461 was independent with all activities of daily living and left the facility daily in their car or motorcycle. Resident 461 continues to smoke on property and has been found smoking in [their] room. In an interview on 04/21/2025 at 9:29 AM, Staff G, Maintenance Director, acknowledged the fire alarm went off on 12/29/2024 because Resident 461 smoked in their bathroom. Staff G further stated Resident 461 was placed on 1:1 monitoring after that incident and did not smoke indoors after that. Staff G explained Resident 461 was a challenging resident and would ignore staff when asked to do things. In an interview on 04/21/2025 at 9:36 AM, Staff C, ADON, stated Resident 461 smoked, they were offered a nicotine patch but refused it and chose to smoke. Staff C explained on 12/29/2024, Resident 461 exercised their right to smoke in their bathroom and was placed on 1:1 monitoring after that incident. Staff C stated Resident 461 was not safe to smoke independently, they were self directed and did what they wanted to do. In an interview on 04/23/2025 at 2:44 PM, Staff A stated Resident 461 would smoke in the facility parking lot and refused to quit smoking. Staff A explained on 12/29/2024 the fire alarm went off, staff thought Resident 461 had smoked in their room, but Resident 461 denied it and refused to give staff their smoking paraphernalia. Staff A stated Resident 461 was placed on 1:1 monitoring after the 12/29/2024 fire alarm incident and was given a 30-day notice. <Resident 86> According to the 03/31/2025 quarterly assessment, Resident 86 admitted to the facility on [DATE] with diagnoses including weakness. Resident 86 had severe cognitive impairment and was able to verbalize their needs. Review of the 11/06/2024 hospital history and physical that was provided to the facility during the admission process showed Resident 86 smoked cigarettes every day. Review of the 11/12/2024 safety assessment showed Resident 86 did not use tobacco products and the facility did not allow resident smoking. Review of the 11/19/2024 tobacco use care plan showed Resident 86 preferred to smoke cigarettes daily. Interventions instructed staff to educate the resident about smoking risks and hazards, smoking cessation aids available, remind the resident the facility was non-smoking, there was no smoking on the facility property, and to complete a smoking assessment as needed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview on 04/16/2025 at 9:24 AM, Resident 86 stated they used to smoke but had not smoked in a while. Resident 86 further stated staff had not spoken to them about smoking and they were unaware the facility was a non-smoking building. In a follow-up interview on 04/24/2025 at 9:55 AM, Staff A stated they expected staff to accurately assess residents for tobacco use and safe smoking abilities when a resident chose to smoke. Staff A further stated they also expected staff to implement smoking safety interventions as needed for resident safety. Reference: WAC 388-97-1060 (3)(g) Refer to F572, F620, and F657 and F867 for additional information 42802 46115

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 42802 Based on observation, interview and record review, the facility failed to ensure a resident's CPAP machine (a machine connected to a mask, that kept airways open while sleeping) was functional and failed to accurately document its use for 1 of 1 sampled resident (Resident 17) investigated for respiratory care. This failure placed the resident at risk of worsening health complications. Findings included . According to the 03/26/2025 admission assessment, Resident 17 had diagnoses which included heart failure (where the heart cannot pump enough blood for the body's needs), Chronic Obstructive Pulmonary Disease (COPD, a lung disease that causes chronic respiratory symptoms and airflow limitations) and obstructive sleep apnea (OSA, a condition where the airway becomes blocked during sleep, causing pauses in breathing). The resident was alert and able to make their needs known. A review of the medical record showed the following provider orders for use of their CPAP machine: 1) CPAP home setting, to be worn at bedtime every evening and night shift, started on 03/20/2025. 2) CPAP on at bedtime, started on 03/20/205. 3) CPAP mask cleaning every morning on day shift, started on 03/21/2025. 4) Change CPAP tubing on night shift, every month on the 19th, started on 04/19/2025. Resident 17's Respiratory care plan, initiated on 04/02/2025, documented they were at risk for respiratory complications due to OSA. One of the interventions was to assist the resident as needed to administer/setup their CPAP machine. Review of the March 2025 Treatment Administration Record (TAR) documented the following: 1) CPAP home setting every evening and night, initialed by nurse as done on evening and night shift from 3/20/25 through 03/31/2025. 2) CPAP on at bedtime, initialed by the nurse as done on night shift from 3/20/25 through 03/31/2025. 3) CPAP mask cleaning every morning on day shift, initialed by the nurse as done on from 3/21/25 through 03/31/2025. Review of the April 2025 TAR documented the following: 1) CPAP home setting every evening and night, initialed by nurse as done on evening and night shift from 04/01/2025 through 04/14/2025. The only exception was the 04/09/2025 evening shift slot was blank. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) CPAP on at bedtime, initialed by the nurse as done from 04/01/2025 through 04/14/2025. The only exception was the 04/09/2025 slot was blank. 3) CPAP mask cleaning every morning on day shift, initialed by the nurse as done from 04/01/2025 through 04/15/2025. The only exceptions were the 04/09/2025 and 04/11/2025 slots were blank. A 03/22/2025 nursing progress note at 7:36 PM documented CPAP use noted. A 03/31/2025 nursing progress note at 1:20 PM documented CPAP use noted. Details as follows: set to home settings, tolerating well. Review of the nursing progress notes showed no mention of the CPAP not functioning, not in use or the resident stating that it was not working. Review of the provider notes on 03/21/2025, 03/24/2025, 03/26/2025 and 04/12/2025 documented the resident had not used their CPAP for over 6 months. During an interview on 04/15/2025 at 11:17 AM, Resident 17 stated they brought their CPAP from home, but it was not working. They were informed by the staff that they did not repair them and they had not helped them to replace the CPAP. Resident 17 further stated since they were unable to use it, they had difficulty falling sleep and woke up in the night and were unable to fall back asleep. During an interview on 04/23/2025 at 9:25 AM, Staff NN, Central Supply, stated if a resident needed a CPAP, it was easy to obtain. They would get a doctor's order with the settings and correct size mask and fax it over to the supply company to rent one and it usually arrived the same day. Staff NN further stated no one had asked about renting a CPAP for Resident 17. During an interview on 04/23/2025 at 9:55 AM, Staff BB, Licensed Practical Nurse (LPN) stated that they would ask Resident 17 if they needed help with their CPAP and many times they would say they could do it themselves at bedtime. Staff BB further stated they were not aware that Resident 17's CPAP was not working, or they would have told management. During an interview on 04/23/2025 at 10:55 AM, Staff C, Assistant Director of Nursing, stated they were not informed that Resident 17's CPAP was not working. Staff C stated that staff should have noted that the resident was not using the CPAP and followed up on it. During an interview on 04/23/2025 at 11:52 AM, Staff C and Staff E, Regional Director of Clinical Operations, acknowledged that staff were not following up on the use and function of the CPAP and the discrepancy of the documentation was failed practice. Reference: WAC 388-97-1060(3)(j)(vi)

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F 0696 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care/assistance for a resident with a prosthesis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on observation, interview, and record review, the facility failed to ensure 1 of 1 sampled resident (Resident 31) reviewed for prosthesis (an artificial limb designed to replace the function of an amputated or missing arm or leg) received the care and assistance required to be able to use the prosthesis. This failure placed the resident at risk for decreased mobility and balance, delayed discharge from the facility to the community, and a diminished quality of life. Findings included . An undated facility policy titled, Artificial Limb - Prosthesis showed, staff would assist the resident in caring for their prosthesis to encourage resident function and safety. The policy showed the use of the prosthesis would be addressed in the resident's plan of care. Care instructions included washing, rinsing, and drying the socket (the device that joins the residual limb [stump] to the prosthesis) every day, inspecting the prosthesis for loose or worn parts at least once each week, reporting the findings to the nurse, avoiding the use of any creams, ointments, or preparations that contained alcohol, and following the manufacturers guidelines for any special care of the prosthesis. The policy instructed the staff to ensure the limb sock (a sock worn over a residual limb to improve fit and comfort within a prosthesis) was free of wrinkles, fit well, cleaned daily with cool water and mild soap, and completely dry before reusing. The staff were not to pad the limb or prosthesis with towels or washcloths as any uneven distribution of pressure could cause pressure sores and infection to the residual limb. Review of a 02/22/2025 quarterly assessment showed Resident 31 admitted to the facility on [DATE] with the primary medical condition of an amputation (the surgical removal of all or part of a limb, typically an arm or leg). The assessment showed the resident was cognitively intact, no rejection of care, and was dependent on the staff or required assistance for Activities of Daily Living. The assessment showed no prosthesis in use during the assessment reference period. An observation and interview on 04/14/2025 at 1:40 PM showed Resident 31 sitting up in a wheelchair in their room. A leg prosthesis was lying on the windowsill. Observation of Resident 31's left leg showed a covered stump. Resident 31 said the prosthesis was not in use since they were not making progress with therapy and wanted to walk so they could discharge from the facility. The resident showed a business card of the clinic who built the leg prosthesis. An observation and interview on 04/21/2025 at 9:37 AM showed Resident 31 in bed, with the leg prosthesis standing upright on the windowsill. Resident 31 said the staff do not apply the leg prosthesis but applied a shrinker [a type of compression stocking that is worn to help shape and reduce swelling in the residual limb] in the morning and removed it at night. Review of a 09/06/2024 Quarterly Discharge Plan Review showed Resident 31, wants to remain in the facility until [the resident] receives [their] prosthetic leg and then wants to find an alternative placement. A subsequent review on 12/05/2024 showed the resident, wants to remain in the facility long term. (continued on next page)

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F 0696 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview 04/21/2025 at 7:36 AM, Staff V, Social Services Director, stated Resident 31 wanted to stay in the facility and was waiting to receive their prosthetic leg. When asked to elaborate what was meant by waiting to receive their prosthetic leg, Staff V stated, The appointments to get the prosthetic leg going and once they got the prosthetic leg maybe reconsider other alternative placements [for living]. Review of the 12/12/2024 progress note showed Resident 31 received their prosthesis and stood with therapy earlier this week. On 12/19/2024 it showed the resident continued to work with therapy with their prosthesis. A 12/23/2024 note showed, continues to make improvements with [their] prosthesis with therapy. On 01/28/2025, the notes showed the facility notified the resident of their last day with therapy services, and Resident 31 was upset as wanting to use [their] prosthetic leg more and the Resident agreed that [they] will get out of bed to increase [their] stamina and attempt to put [their] leg on. Review of progress notes showed no rejection of care from 12/12/2024 to 04/20/2025. Review of 12/06/2024 note from the prosthesis clinic showed Resident 31 received their prosthesis. The notes showed the clinic provided information on the function of the prosthesis, its care and cleaning, how and when to report problems related to the prosthesis or changes in physical condition, benefits and precautions to take, usage and break-in period, removing and applying the prosthesis, fitting issues, skin inspection, and other safety issues. Review of 12/27/2024 note from the prosthesis clinic showed the resident informed the clinic staff they were able to wear the prosthesis daily for short amounts of time, but mostly laying in bed with the prosthesis on, but has done some standing with a forearm walker. The resident complained of some discomfort when wearing the prosthesis when in bed or sitting, and the clinic staff discussed with the resident that wearing the prosthesis for a prolonged period of sitting or lying down changed the pressure in the socket and was the reason for the discomfort. The clinic educated the resident to ensure the full prosthesis was supported to decrease gravity pull. The notes showed the resident increased the limb sock thickness and currently wearing 5 ply [a thickness or layer] with good fit. In this visit, the clinic staff re-educated Resident 31 on applying the prosthesis and cleaning the liner, including written instructions. Review of 01/29/2025 note from the prosthesis clinic showed the clinic became aware all therapy was stopped as Resident 31 needed, to work on upper body strength from wheelchair and leg exercises from bed. The notes showed the resident wore the prosthesis for 30 minutes, three times a week while sitting, and a shrinker when not wearing the prosthesis. Review of the provider orders showed no directions on the care or management of the prosthesis, including application of the shrinker or limb sock. Review of the provider notes on 12/31/2024, 01/10/2025, 01/30/2025, 02/03/2025, 02/06/2025, 02/27/2025, 03/08/2025, 03/13/2025, 03/21/2025, 03/27/2025, and 04/09/2025 made no mention of a prosthesis in existence or use. Review of a 01/30/2025 Physical Therapy (PT) discharge summary showed Resident 31 was able to apply and remove the left leg prosthesis with minimum assistance. The summary showed the resident would not commit to being out of bed beyond trying to stand during their therapy session and would not wear the prosthesis limb except during the therapy treatment time. (continued on next page)

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F 0696 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/23/2025 at 8:39 AM, Staff FF, PT, stated Resident 31 would not wear the prosthesis except during therapy treatment time because, It's kind of a behavior thing. It was a lot of work to get out of bed. It was painful for [the resident], too, to a certain degree. Staff FF stated the resident was, not receptive to being out of bed for a longer period of time. Staff FF stated that prosthesis wear-time is gradual, starting at one to two hours a day, up to eight hours a day, and off at night. Staff FF said since discharge from therapy, I have not seen [the resident] with the prosthetic on. In an interview on 04/23/2025 at 8:30 AM, Staff M, Nursing Assistant, stated Resident 31 was transferred out of bed by use of a mechanical lift once a day and never saw the resident walk. Staff M stated they never put the prosthesis on Resident 31's stump and, I don't think [they] really use it during the day. Staff M stated they applied the shrinker in the morning and staff usually take it off at night. In an interview on 04/23/2025 at 8:34 AM, Staff X, Licensed Practical Nurse, stated, Never really seen [the resident] walk and occasionally [they] will ask for the prosthetic to be put on and the aides could do that. Staff X stated the aides also applied the shrinker. Review of a 06/11/2024 care plan showed, The resident has an amputation of left lower extremity and that The resident's wound will heal and progress without complications. The care plan showed no documentation that acknowledged the presence of the prosthesis, instructions on wear time, how to ensure proper fit to prevent skin breakdown, the care of the prosthesis, or the use of the shrinker and limb sock. On 04/21/2025 at 8:16 AM, a Collateral Contact (CC) from the clinic who built Resident 31's prosthesis was interviewed. The CC stated the prosthesis was issued on 12/06/2024. The CC stated the facility notify was supposed to notify the clinic when they identified issues with the fit of the prosthesis, pain, impaired skin integrity, or if any components were loose or feeling unstable when the resident wore the prosthesis. The CC stated the prosthesis should be worn daily by the resident, as long as no sores or not painful, and the shrinker also worn daily as it helps with swelling and phantom pain (when you feel pain in your missing body part after an amputation). The CC stated that the risk of the prosthesis not being worn daily was, not training your body to use it which can keep you wheelchair bound. The above findings were shared with Staff F, Unit Manager, on 04/21/2025 at 9:55 AM. Staff F stated they were not aware of any refusals with the prosthetic as Resident 31 was very eager to have it. Staff F stated, I believe [the resident] puts on the shrinker [themselves]. At first the nursing staff was helping [them]. Staff F acknowledged the care plan did not reflect the status of the stump and stated, I believe that area is healed. Staff F acknowledged the medical record showed no direction on the care of the prosthesis and associated components, including instructions from the prosthesis clinic, its care and cleaning, how and when to report problems related to the prosthesis, wear-time, skin inspection, and other safety issues. Reference WAC 388-97-1060 (3)(j)(ix).

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on observation, interview and record review, the facility failed to ensure it obtained all treatment-related documentation from the dialysis center and the medical records showed the accurate dialysis access site and location of the dialysis center for 1 of 1 sampled resident (Resident 88) reviewed for dialysis (a procedure that removed waste products and excess fluid from the blood when the kidneys failed to do so). This failure placed the resident at risk for delayed treatment and post-dialysis complications. Findings included . Review of a 03/22/2025 admission assessment showed Resident 88 admitted to the facility on [DATE] with medically complex conditions. The assessment showed the resident was cognitively intact and received dialysis services. Review of 03/16/2025 hospital transfer orders showed a dialysis access site to the left subclavian (a large blood vessel located beneath the collarbone used for central line [a flexible tube inserted into a large vein near the heart placement used to deliver medications, fluids, nutrition, or blood products] placement). An observation and interview on 04/14/2025 at 10:12 AM showed Resident 88 sitting at the edge of the bed. The resident stated that they went to the dialysis center on Tuesdays, Thursdays and Saturdays from 2:00 PM to 7:30 PM. Observed to the resident's chest was a dressing that, according to Resident 88, covered a central line catheter. Resident 88 stated that the facility did not communicate with the dialysis center adding, I have to make sure I have all my records with me, so they [dialysis] know what's been happening. Review of Resident 88's medical record showed no presence of dialysis logs. Dialysis logs document key information about each dialysis treatment session. These sheets serve as a record of the resident's condition, the treatment settings, and any events or complications that occurred during the dialysis session. This information was crucial for monitoring the resident's progress, optimizing treatment, and ensuring resident safety. Review of the 03/16/2025 dialysis care plan showed the location of the dialysis center, treatment days, and access site corresponded to the observation of and interview with Resident 88 on 04/14/2025. Review of an April 2025 Order Summary showed a particular dialysis center with a pick-up time and scheduled dialysis days on Mondays, Wednesdays, and Fridays different to Resident 88's interview and care plan. Additionally, the orders directed the staff to, Check AV [arteriovenous, between an artery and a vein] Fistula [a surgically created connection usually in the arm] for bruit and thrill every shift, and if the fistula was bleeding, to apply pressure. A bruit was a sound heard with a stethoscope, while thrill was a vibration felt by hand, both caused by blood flow through the fistula. These assessments helped ensure the fistula was functioning properly and allowed for early intervention if issues arose. Central lines inserted into veins do not produce a bruit or thrill. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The above information was shared with Staff F, Resident Care Manager, on 04/21/2025 at 9:58 AM. Staff F confirmed Resident 88 had a central line and acknowledged the provider orders that showed an AV fistula and corresponding assessments, and the dialysis center location and days were inaccurate and, should be clarified and corrected. Staff F stated, I have yet to see [dialysis logs] come [to the facility]. No further information was provided. Reference WAC 388-97-1900 (1), (6)(a-c)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on observation, interview and record review, the facility failed to repeatedly ensure the facility had enough staff to provide care according to the facility acuity (the level of severity of residents' illnesses, physical, mental, and cognitive limitations, and conditions) and/or care plans for 9 of 17 sampled residents (Resident 16, 46, 61, 64, 65, 15, 22, 63 and 85), reviewed for sufficient staffing. This failure placed all residents at risk for potentially avoidable accidents, unmet care needs, and diminished quality of life. Findings included . Review of the facility assessment reviewed 09/01/2023 showed the assessment was conducted annually to determine and update the capacity to meet the needs of and competently care for the residents during day-to-day operations. The assessment further showed the facility was licensed for 125 beds, had an average daily census of 84 which included 55 long-term care residents and 29 short term skilled (received higher level of medical care and/or rehabilitation services) residents. The facility had between two to five admissions during the week and two to three admissions on weekends. The facility provided care to residents who required specialized care, had mobility impairments, required assistance completing activities of daily living (ADLS) such as toileting, and were incontinent (unintentional leakage of urine or stool). The assessment showed on average the facility cared for 78 residents with urinary incontinence, 44 residents with bowel incontinence, and 15 residents that required a toileting program. The assessment further showed the facility had adequate staffing, staffing was reviewed daily to ensure that adequate staff was available to meet the needs of facility residents, the facility employed a full-time staffing coordinator (during weekdays) and used contracted/agency staff when facility staff was unable to meet the needs of [facility] residents. <Resident 65> According to the 02/11/2025 significant change assessment, Resident 65 admitted to the facility on [DATE] with diagnoses including syncope (to faint) and collapse. The assessment further showed Resident 65 required substantial staff assistance for toileting hygiene, was frequently incontinent of urine and always incontinent of bowel. Resident 65 had severe cognitive impairment. Review of the 02/06/2025 rehabilitation care plan showed Resident 65 required maximum assistance from two staff for transfers and was dependent for toileting. The 02/06/2025 risk for falls care plan instructed staff to anticipate Resident 65's needs, ensure appropriate footwear, place common items within reach, keep the bed against the wall, and ensure Resident 65 was in areas of high visibility when up in their wheelchair. Review of the 02/15/2025 allegation of neglect incident investigation showed at 6:54 PM it was reported Resident 65 was not changed. Review of the February 2025 through March 2025 facility incident log showed Resident 65 sustained falls on 02/05/2025 (1 hours and 50 minutes after admission), 02/13/2025, 02/28/2025, 03/12/2025, and 03/14/2025. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	<Resident 46> According to the 03/29/2025 significant change assessment, Resident 46 required moderate staff assistance to complete most of their ADLS which included toileting hygiene. The assessment further showed Resident 46 had severe cognitive impairment and was frequently incontinent of bowel and bladder. Review of the 01/08/2025 continence care plan showed Resident 46 was frequently incontinent of bowel and bladder and instructed staff to assist with toileting, apply barrier cream, provide toileting hygiene, monitor for signs of a bladder infection, and check and change incontinence brief every two hours. The 01/08/2025 risk for fall care plan instructed staff to keep items within reach, do not leave in the bathroom unattended, ensure proper footwear, and encourage Resident 46 to stay in areas of high visibility when up in their chair. Review of the 03/25/2025 allegation of neglect incident investigation showed at 7:00 AM it was reported Resident 46 had not been checked and/or changed during the night shift. The investigation included a 03/25/2025 staff statement that showed Resident 46 had not been changed by night shift and was soiled through brief when checked on day shift. In an interview on 04/15/2025 at 9:31 AM, Resident 46's family member stated the facility needed more staff, Resident 46 did not get help needed, and had a few falls. Review of the November 2024 through March 2025 facility incident log showed Resident 46 sustained falls on 11/06/2024, 12/12/2024, 01/08/2025, 02/06/2025, 02/24/2025, 03/07/2025, 03/09/2025, and on 03/17/2025. <Resident 64> According to the 03/25/2025 annual assessment, Resident 64 was frequently incontinent of urine and was dependent on staff assistance for toileting. Resident 64 was cognitively intact. Review of the 01/07/2025 continence care plan showed Resident 64 was frequently incontinent of bowel and bladder and instructed staff to provide maximal assistance with toileting, apply barrier cream, and check and change their incontinence brief frequently as needed. Review of the 02/13/2025 Resident Council (group of facility residents that met normally to discuss care and/or concerns) Meeting Minutes showed the Council voiced concerns related to excessively long call light wait times. Review of the 03/26/2025 allegation of neglect incident investigation showed it was reported Resident 64 had not been changed. The investigation included a 03/26/2025 staff statement that showed Resident 64 was unhappy and yelling because staff had not checked or changed them. Resident 64 did not have their call light, their bed and brief was completely soaked with a wet brown ring of urine. In an interview on 04/14/2025 at 11:14 AM, Resident 64 stated there were excessively long call light wait times, sometimes up to an hour. <Resident 63> (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 02/12/2025 quarterly assessment, Resident 63 was always incontinent of bowel and bladder, and dependent on staff assistance for toileting hygiene and bed mobility. Resident 63 had moderate cognitive impairment and was able to clearly verbalize their needs. Review of the 01/03/2025 respiratory care plan showed Resident 63 utilized supplemental oxygen and instructed staff to administer oxygen as ordered, obtain vital signs as needed, and monitor for signs and/or symptoms of respiratory complications. The 02/11/2025 continence care plan showed Resident 63 was frequently incontinent of bowel and bladder and instructed staff to apply barrier cream, provide maximal assistance with toileting, provide the bed pan as requested, and check/change Resident 63's incontinence brief as needed. In an interview on 04/14/2025 at 1:22 PM, Resident 63 stated the facility did not have enough staff because they experienced excessively long call light wait times and seldom got changed on time. Resident 63 further stated they were unable to get up or walk, they wore oxygen but sometimes was unable to get to their call light or oxygen. <Resident 16> According to the 03/11/2025 significant change assessment, Resident 16 required substantial staff assistance for toileting hygiene and was always incontinent of bowel and bladder. The assessment further showed Resident 16 was cognitively intact and able to clearly verbalize their needs. Review of the 03/17/2025 rehabilitation care plan showed Resident 16 required substantial/maximal assistance with bed mobility and toileting. The 03/17/2025 continence care plan showed Resident 16 was usually continent of bladder and instructed staff to apply barrier creams and observe for signs and/or symptoms of a bladder infection. The 04/10/2025 interventions instructed staff to provide assistance with toileting, provide the bed pan upon request, provide toileting hygiene as needed, record bowel movements, and check and change the incontinence brief while in bed. Review of the 04/01/2025 allegation of neglect incident investigation showed at 2:15 PM Resident 16 reported they had not been changed since that morning and their bed was found to be wet with odor. The investigation included a 04/01/2025 2:18 PM staff statement that showed Resident 16's bed was found to be saturated when [Resident 16] got up. [Resident 16's] brief found to be completely soaked through and heavy. In an interview on 04/14/2025 at 11:08 AM, Resident 16 stated they were incontinent, did not know how much or when they urinated, and needed to be routinely checked and changed. Resident 16 stated the facility had been short staffed for a while. Resident 16 explained they could tell the facility was short staffed because they did not receive care when needed and have had to wait up to an hour for assistance, which occurred three weeks ago. Resident 16 further stated, I wish they could do something to level out this staffing issue, it is not the resident's fault they don't have enough staff, they got to be able to hire some more people. Review of the 04/07/2025 unwitnessed fall investigation showed Resident 16 attempted to self-transfer but their legs gave out and they sustained a fall with a left-hand skin tear. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	<Resident 85> According to the 03/30/2025 quarterly assessment, Resident 85 was dependent on staff assistance for toileting hygiene and bed mobility. The assessment further showed Resident 85 was always continent of bowel and occasionally incontinent of bladder. Resident 85 was cognitively intact and able to clearly verbalize their needs. Review of the 10/31/2024 care plan showed Resident 85 was administered diuretics (medication used to help rid the body of excess fluid). The 01/14/2025 rehabilitation care plan showed Resident 85 required extensive assistance for bed mobility and was dependent for transfers and toilet use. During observation on 04/14/2025 at 11:47 AM, Resident 85 was wheeled into their room by an unidentified female staff and then walked out of the room. With an upset and loud tone of voice, Resident 85 began to yell out, that girl took off! you need to find her! I need to go pee! At 11:48 AM Resident 85's roommate walked out into the hall in search of staff to assist Resident 85. At 11:50 AM, as an unidentified male staff walked past Resident 85's room, Resident 85 again yelled out, I am going to pee my pants! The lady that brought me in here disappeared! In an interview on 04/14/2025 at 1:44 PM, Resident 85 stated they had been out of the facility from 6:45 AM until 11:30 AM at a doctor appointment in Idaho and really needed to urinate. Resident 85 stated they did not like to be incontinent of urine. Resident 85 further stated the facility was short staffed and they were stuck in bed when there was not enough staff to get them up, because two staff were required to use the Hoyer, even though their record showed they needed to be up daily. Resident 85 preferred to be up in their wheelchair by 10 AM. Resident 85 stated they had excessively long call light wait times, waiting up to 50 minutes to be toileted. Review of provider orders showed an active 03/17/2024 order for Resident 85 to be out of bed and in their wheelchair twice daily for at least an hour. Review of the Medication Administration Record from 03/17/2025 through 03/31/2025 showed Resident 85 was not gotten out of bed and into their wheelchair 10 out of 29 times, only three refusals were documented. Review of 04/01/2025 through 04/15/2025 showed Resident 85 was not gotten out of bed and into their wheelchair 19 out 30 times, only three refusals were documented. During observation on 04/16/2025 at 11:54 AM 38 out of 60 residents on the North (100 hall, long-term care) were observed eating lunch in bed. Review of the 04/17/2025 allegation of neglect incident investigation showed Resident 85 was upset because they were not gotten out of bed. The investigation included a 04/17/2025 staff statement that showed Resident 85 reported they were very upset because they requested to get out of bed but was told most of the Hoyers were not working, only one Hoyer was in working order, but other residents needed to get up and Resident 85 was not gotten out of bed as requested. During observation and interview on 04/17/2025 at 1:37 PM, Resident 85 was observed lying in bed. Resident 85 stated staff did not get them out of bed today because staff told them there was only one functioning Hoyer lift and all staff were fighting to use it. Resident 85 stated I am stuck in bed for the day. I am not happy. I do not like to be in bed all day long. My preference is to be up in my chair for a while. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 04/17/2025 at 2:33 PM, the Resident Council stated the facility did not have enough staff, they experienced excessively long call light waiting times, up to an hour. The Resident Council explained sometimes staff were also unable to find a second staff to assist with cares, when cares required two staff. In a follow-up interview on 04/22/2025 at 9:34 AM, Resident 85 again stated they were stuck in bed all day yesterday because staff told them they were shorthanded, I was pissed. During a confidential interview on 04/18/2025 at 10:25 AM, Confidential Staff A, stated the facility did not have enough staff, the North (100 hall, long-term care) unit was heavy care, and normally staffed with only four nursing assistants but that was not enough staff, it was hard to get things done. Review of the 04/19/2025 facility census showed Residents 15, 16, 22, 46, 61, 63, 64, 65, and 85 all resided on the North 100 long-term care hall. In an interview on 04/22/2025 at 9:30 AM, Staff W, Nursing Assistant (NA), stated the facility was short staffed most of the time and they typically cared for about 15 residents. During observation on 04/22/2025 at 9:32 AM, Staff KK, NA, was observed asking several NAs for assistance to change the resident in room [ROOM NUMBER] but was unable to get help. Staff W told Staff KK to ask a manager for help because they needed to help a resident who asked for help. At 9:47 AM Staff KK was observed asking Staff LL, Registered Nurse, for help but Staff LL stated, I am sorry, I can't help you, I am running way behind and asked Staff KK to let them know when they changed the resident in room [ROOM NUMBER] because they needed to apply cream to them. Staff KK replied, that is what I have been trying to do, I have been trying to get help. At 9:49 AM Staff KK told the resident they would change them alone, since they were unable to find staff to help. In an interview on 04/23/2025 at 12:07 PM, Staff N, Staffing Coordinator, stated they used a HPD (hours per resident day, minimum staffing requirements) spreadsheet that was based on census, not based on acuity as a guide to see how many staff were needed. A copy of the spreadsheet was requested at that time. Staff N explained if the facility needed to provide 1:1 monitoring for a resident they would make an exception to the budget and cover the 1:1 needs. Staff N stated if the facility acuity increased they would have to pull staff from the other units and adjust section assignments to better staff the more acute unit. Staff N explained the North 100 hall was the easier unit, it was more consistent because the residents were long-term care and the South hall was the more acute unit because that was where residents admitted to and were typically more ill. Staff N was asked what would happen with staffing if the census increased. Staff N stated if the census increased they would have to schedule more agency staffing because the facility did not have enough facility staff. Staff N further stated the facility used agency staffing seven days a week, for both NAs and nurses. Staff N further stated the facility had a high staff turnover rate and needed more staff. Staff N acknowledged staff voiced staffing concerns related to the need for more staff, residents with excessively long call light wait times, and residents not changed timely. In an interview on 04/23/2025 at 12:43 PM, Staff A, Administrator, had a copy of the HPD spreadsheet used by Staff N as a guide for staffing. Staff A stated the form was just a quick and fast tool used to see if the facility had enough staff, based on census. Staff A did not provide a copy of the spreadsheet as requested. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In a follow-up interview on 04/24/2025 at 8:34 AM, Staff A, explained the facility reassessed staffing every shift and attempted to balance staffing, census, and acuity. Staff A stated they used agency staffing daily and staff would bring staffing concerns to them, if there were any. Staff A stated if/when residents reported excessively long call light wait times, it was reported as an allegation of neglect. Staff A acknowledged the facility had an increased number of allegations of abuse and/or neglect. Staff A stated, I am not short staffed. Reference WAC 388-97-1080 (1), 1090 (1) Refer to F658 and F919 for additional information.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47328 Based on interview and record review the facility failed to designate a Registered Nurse (RN) to serve as the Director of Nursing (DNS) on a full-time basis, as required. This failure placed all residents at risk of lack of RN oversight for care provided, unmet care needs, and a diminished quality of life. Findings included . In an interview on 04/14/2025 at 8:34 AM, Staff A, Administrator, identified Staff B as the interim Director of Nursing. Staff A stated the facility had no nurse staffing waivers in place. Review of the facility staff list provided on 04/15/2025 showed Staff B was the MDS (Minimum Data Set, standardized resident assessment tool) RN/DNS. Staff C was identified as Licensed Practical Nurse (LPN)/Assistant Director of Nursing (ADON). In an interview on 04/18/2025 at 11:29 AM, Staff C, explained they reviewed the facility incident reports after they were completed by floor staff, they tried to implement other interventions, but did not always have a chance to complete reviews. In an interview on 04/23/2025 at 11:16 AM, Staff B, Interim Director of Nursing, stated they were the MDS Coordinator. Staff B explained they became the interim DNS in February 2025 but Staff C, LPN/ADON, handled most of the DNS duties. Staff B further stated they worked a 40-hour work week and focused on MDS duties. Staff B stated they were not on-call after hours, staff contacted Staff C in case of emergencies and/or if there were allegations of abuse/neglect made but they were kept in the loop. In a follow-up interview on 04/23/2025 at 12:01 PM, Staff A, again stated Staff B was the interim DNS since 02/22/2025 and worked 40-ish hours a week. Staff A was asked if they expected Staff B to perform DNS duties 40 hours a week. Staff A stated Staff B was available to work 40 hours a week as a DNS if needed. Staff A further stated Staff B reviewed incident reports and was notified if/when allegations of abuse were made. Payroll data was requested at that time for Staff B from February 2025 until current. No documentation was provided. Reference WAC 388-97-1080 (2)(b) Refer to F552, F554, F622, F625, F655, F656, F657, F658, F689, F695, F698, F725, F730, F757, F761, F880, F881, F883, F887, WAC 1380 and 1480 for additional information.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 47328 Based on interview and record review the facility failed to complete annual staff performance reviews yearly as required and provide education based on the outcome of these reviews for 3 of 5 sampled staff (Staff K, L, and M), reviewed for performance reviews. This failure placed residents at risk of receiving care from inadequately trained and/or underqualified care staff, and a diminished quality of life. Findings included . <Staff K > Review of Staff K's, Nursing Assistant, personnel file showed they were hired on 04/01/2023. No documentation of a performance evaluation was found. <Staff L> Review of Staff L's, Nursing Assistant, personnel file showed they were hired on 11/29/2023. No documentation of a performance evaluation was found. <Staff M> Review of Staff M'S, Nursing Assistant, personnel file showed they were hired on 12/06/2023. No documentation of a performance evaluation was found. In an interview on 04/23/2025 at 3:18 PM, Staff A, Administrator, acknowledged Staff K, L, and M did not have performance evaluations on file. Staff A stated they expected staff to complete performance evaluations yearly, as required. Reference WAC 388-97-1680 (1), (2)(2-c)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 47328 Based on observation, interview, and record review the facility failed to consistently post nurse staffing information on a daily basis, as required for 4 of 4 months (January, February, March and April 2025), reviewed. This failure resulted in residents, families and visitors not being fully informed of the facility's current staffing levels and resident census information. Findings included . During an observation on 04/14/2025 at 10:19 AM, daily staffing information was not posted in a prominent place readily accessible to residents, families, and/or visitors. Similar observations were made at 1:15 PM, on 04/15/2025 at 8:28 AM, 9:50 AM, and 11:21 AM, on 04/16/2025 at 8:23 AM, 12:04 PM, 2:33 PM, on 04/17/2025 at 8:21 AM, on 04/18/2025 at 8:35 AM, 10:45 AM, and 3:17 PM, on 04/21/2025 at 4:17 AM and 7:45 AM. During observation and interview on 04/21/2025 at 8:21 AM, Staff N, Staffing Coordinator, stated nurse managers were to post the daily head count staffing information. Staff N walked the surveyor to Staff C, Assistant Director of Nursing's office. Staff N asked Staff C for the head count sheets. Staff C pulled out a blank daily staffing sheet and stated they thought Staff N had been posting the daily staffing information. Daily staffing sheets from January 2025 through 04/21/2025 were requested at that time. During an interview on 04/21/2025 at 8:36 AM, Staff N provided the daily staff posting sheets they had on file. Staff N acknowledged there were no daily staffing sheets after 03/14/2025. Review of the daily staffing sheets provided showed no daily staffing information for the following dates: - January: 01/03/2025, 01/07/2025-01/12/2025, 01/14/2025, 01/16/2025-01/19/2025, 01/21/2025, and 01/28/2025-01/29/2025 - February: 02/03/2025, 02/07/2025-02/10/2025, 02/11/2025, 02/14/2025-02/16/2025, 02/18/2025-02/20/2025, 02/24/2025-02/26/2025, and 02/28/2025 - March: 03/01/2025-03/09/2025, 03/11/2025-03/13/2025. No documentation was found after 03/14/2025. In an interview on 04/21/2025 at 8:43 AM, Staff A, Administrator, stated they expected staff to post the daily staffing, as required. No associated WAC

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 37544 Based on observation, interview, and record review, the facility failed to consistently ensure 2 of 3 sampled medication carts (Med Bridge unit carts 1 and 2) were free from expired medications, and medications were labeled and disposed of properly when unused. In addition, the facility failed to consistently ensure controlled medications (medications that have a high risk for abuse such as narcotics, anti-anxiety, hypnotic and hallucinogenic) were securely stored and monitored for loss or diversion as required for 1 of 2 sampled medication rooms (Med Bridge unit) reviewed for medication storage, and failed to ensure medications were stored securely for Resident 95 who was observed to have medicaiton in their room. Findings included . MEDICATION CARTS An observation of the Med Bridge Unit Cart 1 on 04/24/2025 at 9:09 AM showed opened insulins of Humalog Lispro dated 03/21/2025 and Novolin R dated 3/18/2025. Staff H, Licensed Practical Nurse (LPN), acknowledged the insulins were beyond the expiration date of 28 days and that they should have been discarded. An observation on 04/24/2025 at 11:27 AM of Med Bridge Unit Cart 2 with Staff C, Assistant Director of Nursing (ADON), showed the top left drawer had a medication cup with Resident 82's name hand written on it that contained six unknown medications, and the top center drawer of the cart contained an unlabeled/unopened bottle of nitroglycerin tablets, used for chest pain, and a plastic bag that contained an unopened EpiPen, an injectable medication used to treat life threatening allergic reactions. The plastic bag had Resident 46's name hand written on it, but aside from the bag, no other pharmacy label that included the resident's name, date, or other information was present on either the bottle of nitroglycerin or the EpiPen. Staff C stated medications needed to be labeled, and believed both medications had been pulled from the emergency cart, and should have been returned when it was determined they were not needed. 40297 SAFE STORAGE OF RESIDENT MEDICATION <Resident 95> An observation and interview on 04/14/2025 at 12:57 PM showed, 2 tablets of Imodium AD (anti-diarrhea) 2 mg (milligrams, a measurement) sat on Resident 95's bedside stand. The resident said, I have some. I haven't used them here. Last used them probably in late August. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview on 04/15/2025 at 11:30 AM showed, Resident 95 awake and in bed and the two Imodium AD tablets on the bedside stand. At this time, Staff X, Licensed Practical Nurse (LPN), confirmed the presence of the medication on the bedside stand and said that they should not be unsecured in the room. Resident 95 stated their family member brought them and that they had some more in their coin purse. Resident 95 then took out five more tablets, this time of generic Imodium (loperamide) 2mg. Staff F stated, The family should know not to bring in medications and if we find them, we take them or have family come pick them up. Staff X confirmed there were no physician orders for the use of Imodium or loperamide, or to keep medications at bedside. 46115 MEDICATION ROOM An observation on 04/24/2025 at 9:02 AM of the medication storage room on the Med Bridge unit with Staff C, showed two of the three emergency medication kits were not sealed and contained a controlled medication that was used to treat anxiety (Ativan). The first kit contained two vials of injectable Ativan and three bottles of oral liquid, and the second kit contained two vials of injectable Ativan and two bottles of oral liquid. When asked if the Ativan vials/bottles were counted by the nurses to ensure not being diverted, Staff C stated the kits should have seals and the Ativan was not counted. Additional observations of the medication room showed a locked medication safe was used to store medications that needed to be destroyed, including controlled medications. The safe was a drop box style with an opening that allowed the medications to be dropped into. Staff C stated medications were put in the safe until they could be destroyed and/or returned to pharmacy and there were only two keys to unlock the safe and they were kept by the nurse managers. On 04/24/2025 at 9:51 AM, when Staff C was asked if the controlled medications were counted to ensure diversion was not occurring during the waiting period to be destroyed, Staff C stated the count was not done once the medication had been placed in the safe. Reference (WAC): 388-97-1300 (2), 2340

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on observation, interview, and record review, the facility failed to ensure nutritional assessments were completed accurately and timely for 4 out of 5 sampled residents (Residents 60, 88, 313, and 263), accurate and timely weights were obtained after a significant weight loss occurred (Resident 60), and the required nutritional supplements were available and/or provided (Residents 88 and 313). These failures placed the residents at risk for weight loss, unmet nutritional needs, and a diminished quality of life. Findings included . Review of a 05/25/2023 facility policy titled, Weight Assessment and Intervention showed, the facility strived to prevent, monitor and intervene for undesirable weight loss for the residents. The policy defined a significant weight change as, 5% [percent] in one month, 7.5% in 3 months, and 10% in 6 months, and anything above these percentages considered a severe weight change. The policy instructed the staff to weigh residents upon admission and if no weight concerns were identified, then measured monthly. If an inaccurate weight was suspected or a 5% or more weight change identified, the facility reweighed the resident for confirmation. The facility notified the provider of significant weight changes once verified. The policy instructed the staff to investigate and analyze an unplanned significant weight change. <Resident 60> Review of a 03/16/2025 admission assessment showed Resident 60 admitted to the facility on [DATE] with medically complex conditions. The assessment showed Resident 60 weighed 162 pounds (lb) and experienced no weight loss. An observation and interview on 04/18/2025 at 1:11 PM showed Resident 60 in bed. Resident 60 said they did not know if they had lost weight or what their current weight was since their admission to the facility. When asked if the facility involved them in decisions about their diet, food preferences, and where to eat, the resident said, Not really. Resident 60 said they did not necessarily want to lose weight, that their weight prior to coming to the facility was 161 lb, and no staff reviewed their current weight with them. Review of 03/09/2025 hospital records showed Resident 60 weighed 162 lb. Another hospital record dated 03/10/2025 showed the resident weighed 168.6 lb. Review of a provider order showed the staff were ordered to weigh Resident 60 on the day of admission, then weekly for the next three weeks, then monthly. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the March 2025 Medication Administration Record (MAR) showed no documentation the staff obtained a weight on 03/10/2025 or 03/11/2025 as ordered by the provider. Additionally, the nurses documented Resident 60 refused to be weighed on 03/12/2025, NA [not applicable] for 03/24/2025, and refused again on 03/31/2025. The progress notes for March 2025 showed no documentation about why the resident refused to be weighed and what the staff did to address the reason for the refusals and obtain a weight. Review of the Weight Summary section in the electronic medical record (EMR) showed the staff obtained Resident 60's first weight on 03/17/2025, seven days after admission. The weight obtained was 149.4 lb, a severe weight loss of almost 8% in one week and under 30 days compared to the hospital weights. Record review showed no documentation the staff re-weighed Resident 60 to confirm the severe weight loss, or completed weekly weights as ordered on or around 03/24/2025 and 03/31/2025. Review of a 03/17/2025 Nutritional at Risk Assessment completed by Staff HH, Registered Dietitian (RD), showed it was an initial assessment and acknowledged the 03/17/2025 weight of 149.4 lb. as the most recent weight. The assessment showed Staff HH assessed Resident 60 with a moderate decrease in food intake over the past three months due to loss of appetite, digestive problems, chewing or swallowing difficulties. The assessment asked if there was weight loss during the last three months, to which Staff HH answered, does not know. The assessment concluded that Resident 60 was at risk of malnutrition due to two or more medical conditions and established a goal to maintain weight. Approaches to achieve weight maintenance included monitoring significant weight loss. Staff HH documented they, Need updated weight. The assessment showed no documentation Staff HH reconciled the hospital or resident's reported weight of 161 lb against the facility's weight of 149.4 lb and ruled out severe or significant weight loss. Review of provider notes showed on 03/12/2025, Patient's current weight not recorded. Hospital weight 168 lb. The 03/17/2025 and 03/26/2025 notes showed the provider acknowledged the 03/17/2025 weight of 149. 4 lb. Record review showed no documentation the provider identified or reconciled severe or significant weight loss or was notified of it by the facility. Review of March 2025 Nutrition and Hydration meeting notes scanned into the EMR showed: - 03/20/2025, Staff HH reviewed Resident 60 because they were a new admit and acknowledged the 03/17/2025 weight of 149.4 lb and no weekly weight was available. Staff HH concluded there was no weight trigger or meal refusals. The summary showed that the staff would obtain the second weekly weight in a few days. This document was signed by Staff HH and Staff C, Assistant Director of Nursing (ADON). The notes showed no documentation Staff HH reconciled the resident's reported weight of 161 lb or the hospital weights supporting the resident's weight range in the 160 lb. - 03/27/2025, Staff HH reviewed Resident 60 because they were a new admit, weight of 149.4 # [lb] 3/17/25 and, No change this week as an updated weight is needed. The summary showed, will review next week, no new interventions and provider aware. The notes showed no documentation Staff HH reconciled the resident's reported weight of 161 lb or the hospital weights supporting the resident's weight range in the 160 lb. Review of the April 2025 MAR showed the staff weighed Resident 60 on 04/07/2025 at 149.4 lb, a sustained severe and significant weight loss of about 8% in under 30 days. Record review showed no documentation the staff re-weighed the resident to confirm or reconcile the weight loss. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of April 2025 Nutrition and Hydration meeting notes scanned into the EMR showed: - 04/03/2025, Staff HH reviewed Resident 60 and documented the resident was, refusing weights, reattempts made to obtain a weight, intake variable but adequate, no supplements, no new interventions, provider aware, and no meal refusals. The review showed no documentation to demonstrate why Resident 60 refused to be weighed and how the facility addressed those refusals. Staff HH requested a weight from the staff. - 04/10/2025, Staff HH reviewed Resident 60 and noted, no new weights as resident is known to refuse weights, meds [medications] and cares. Intake remains variable, however, [the resident] is likely meeting [their] needs. The review showed no documentation Staff HH investigated and analyzed why the resident refused to be weighed and how the facility addressed those refusals. The notes showed no documentation Staff HH acknowledged or reconciled the sustained severe and significant weight loss of 149.4 lb. A 04/07/2025 and 04/17/2025 provider notes showed, Patient's current weight 149 lb. The notes showed no documentation a reconciliation or confirmation of Resident 60's Hospital weight [of] 168 lb, mentioned in the 03/12/2025 provider notes, occurred. In an interview on 04/18/2025 at 1:54 PM, Staff QQ, Nursing Assistant (NA) said they managed resident refusals by reapproaching the resident and letting the nurse know. Staff QQ said Resident 60 refused meals because the resident, is just not hungry. The meal doesn't look good to her. Staff QQ said the floor NA weighed residents and Resident 60 did not like to get out of bed because, I think [they are] depressed. Staff QQ said they notified the nurse when Resident 60 refused to be weighed. In an interview on 04/18/2025 at 2:30 PM, Staff C described how the facility identified weight concerns for a newly admitted resident. Staff C said they and Staff HH attended a Nutrition and Hydration meeting every Thursday. Staff C said staff obtained weights on admission, then weekly after that, and go on to monthly weights if stable. Staff C said the facility determined a change in weight from the time of admission occurred, by reviewing hospital records of weights, interviewing the resident, and Staff HH went to meet the resident. Staff C said, If [the resident is] of sound cognition they will usually give you a baseline of what [their weight] is. Staff C said they expected the provider and resident representative to be notified of a significant weight change. Staff C said they did not know why Resident 60 refused to be weighed. Staff C acknowledged Resident 60's weights from the hospital upon record review and that a significant weight change should have been identified in the 03/20/2025 nutrition meeting with Staff HH. In an interview on 04/18/2025 at 02:01 PM, Staff HH stated they provided services at the facility Monday through Friday. Staff HH said they identified weight concerns for a newly admitted resident by completing an overview of their admit paperwork upon admission and participate in their initial care conference. Staff HH said they evaluated new residents weekly and determined weight changes from the time of admission by reviewing weight measurements obtained by the staff. Staff HH said, Sometimes I don't consider a hospital weight to be reliable and not having a current weight, makes it harder to gather a baseline for new admit. I can't always come up with a proper intervention if there needs to be one. Staff HH stated that when they identified a significant weight loss, We evaluate the reason for that weight loss and Yes, I notify family and providers. Staff HH said it was unknown to them why Resident 60 refused to be weighed by the staff. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/18/2025 at 2:21 PM, Staff HH calculated Resident 60 experienced a significant weight loss of 8%, from the 03/09/2025 hospital weight of 162 lb to the facility weight of 149.4 lb on 03/17/2025 and 04/07/2025. Staff HH said, Because we did not have the hospital weights in the [weight summary section of the EMR, the resident] did not trigger for the significant weight loss. When asked if they reviewed Resident 60's hospital records on their first assessment of the resident's nutritional status, Staff HH stated, Yes, I did a comparison. I noted in my assessment that I needed weights. <Resident 88> Review of a 03/22/2025 admission assessment showed Resident 88 admitted to the facility on [DATE] with medically complex conditions. The assessment showed the resident was cognitively intact and received dialysis (a procedure that removed waste products and excess fluid from the blood when the kidneys failed to do so) services. Review of March 2025 Medication Administration Record (MAR) showed an order that instructed the nurses to provide Resident 88 Nepro (a therapeutic liquid nutrition specifically designed for dialysis patients to help meet their unique nutritional needs, offering higher protein content and lower levels of potassium and phosphorus) prior to dialysis on Mondays, Wednesdays and Fridays. The order showed kitchen staff would stock the North Nutrition Room refrigerator with the supplement. The Nepro was scheduled for administration at 5:00 AM. The order asked the nurses to document the amount consumed in mL [milliliter, a measurement], if possible, and to document refusals of the supplement. Review of administration documentation showed a 9 [Other/See progress notes] on 03/10/2025, 03/21/2025 and 03/24/2025, a 3 [absent from facility/hospitalized] on 03/12/2025, a 2 [refused] on 03/19/2025, and left blank on 03/14/2025. Further review of the MAR showed the days of the Nepro administration changed to Tuesdays, Thursdays, and Saturdays, with a 9 documented on 03/27/2025 and 237 mL on 03/29/2025. Review of progress notes associated with the March 2025 MAR Nepro order showed the nurses documented on 03/10/2025, Resident 88 experienced a transfer to the hospital, on 03/21/2025 is going Saturday to dialysis, on 3/24/2025 change in dialysis day and time, and on 03/27/2025, dialysis is later in the day. There was no documentation that showed why Resident 88 refused Nepro on 03/19/2025. Review of the April 2025 MAR showed an order that instructed the nurses to provide Resident 88 Nepro prior to dialysis on Tuesdays, Thursdays, and Saturdays at 5:00 AM. The order showed kitchen staff would stock the North Nutrition Room refrigerator with the supplement. Every administration from 04/01/2025 to 04/17/2025 was signed by a nurse and 9 [Other/See progress notes]. Review of progress notes associated with the April 2025 MAR Nepro order showed on 04/01/2025 no documentation of the amount of Nepro Resident 88 consumed. On 04/03/2025 and 04/05/2025, the nurses documented no intake due to, takes own later in the day. On 04/08/2025 the nurse documented, dialysis is later in the day. On 04/10/2025, the nurse documented, takes later. On 04/15/2025 the nurse documented, Takes [their] own later in the day due to dialysis scheduled later. On 04/17/2025 the nurse documented, drinks own later in the day. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview on 04/21/2025 at 5:02 AM showed Resident 88 sitting on the edge of the bed. When asked about their knowledge of the Nepro supplement, the resident stated, Oh it was just horrible. It tasted horrible. I didn't like it at all. I wouldn't wish it on my worst enemy. It was really watered down. It made me sick to my stomach. Resident 88 said they bought their own supplement locally, their significant other brought it to the facility, and the resident would then take it to dialysis with them. Resident 88 identified the supplement they took with them on dialysis days as Ensure Plus (a general-purpose nutritional supplement for those with increased nutritional needs). Resident 88 said Staff HH saw them physically, Just once, a month ago, about 35 days ago. Review of March 2025 Nutrition and Hydration notes showed Staff HH acknowledged the staff sent the Nepro with Resident 88 to the dialysis center on Mondays, Wednesdays, and Fridays (03/20/2025 and 04/03/2025), 100% of the Nepro was given to the resident on dialysis days (03/27/2025), and the resident accepted the Nepro three times a week 100% of the time. There was no documentation that showed Staff HH ascertained how much of the Nepro Resident 88 consumed when the nurses documented 9 or the extent of Resident 88's refusal of the supplement. An observation of the North Nutrition refrigerator and interview with Staff TT, Licensed Practical Nurse on 04/21/2025 at 4:14 AM, showed no presence of Nepro. Staff TT stated Resident 88 chose to buy their own supplement, and staff stored the supplement then gave it to the resident whenever they asked for it. Staff TT stated the supplement Resident 88 purchased was, I think it's an Ensure Plus. Staff TT stated the Nepro, That was the one [they] didn't like. That's why I chart [the resident] refuses. Staff TT said Resident 88 did not like the taste of Nepro and that's why they chose to buy another supplement. When asked about night nurses documenting in the MAR that they gave Resident 88 their supplement at 5:00 AM, Staff TT stated, I'm not here to say if [they] drank it. Staff TT said the resident told staff they did not like the taste of Nepro. In an interview and observation of the facility dry food storage area on 04/21/2025 at 5:14 AM, Staff GG, Dietary Manager, showed the availability of Nepro. Staff GG stated one resident in the facility was on Nepro. Staff GG said they knew which supplements to provide the residents with when the nurses ordered them or by instructions in the meal ticket. Staff GG stated a doctor's order of the supplement required of the nurse to, come to the kitchen to get them. Staff GG showed a Dialysis Sack Lunch schedule with the name of two residents, of which Resident 88 was one of them. The schedule showed their dialysis days, when to be ready for dialysis transport pick-up, the type of diet, and what to provide with their sack lunches. The schedule showed it was created by Staff HH. There was no documentation in the schedule that showed Resident 88 required Nepro prior to dialysis. In an interview on 04/21/2025 at 6:57 AM, Staff RR, Registered Nurse (RN), stated they were unsure what Resident 88's dialysis sack lunch included. Staff RR stated Resident 88's significant other, was bringing [the resident] the Boost [a general nutritional drink] and stopped supplying the Boost and was doing the Ensure. Ensure is not very good for dialysis patients so they switched [Resident 88] to the Nepro. Staff RR stated the resident was, now on the Nepro and that just started this week. Staff RR stated that they saw Resident 88 take the Boost to dialysis. In an interview on 04/21/2025 at 7:12 AM, Staff SS, NA, stated they were unsure if Resident 88 took a bottle of supplement with them to the dialysis center because, [the resident] packs a bag [themselves] of stuff [they] take. But I do know for sure [the resident has] bought some Glucerna [a liquid supplement specifically designed for individuals with diabetes or prediabetes to help manage blood sugar levels] and takes with [them] to dialysis. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The above findings were shared with Staff F, Resident Care Manager, on 04/21/2025 at 10:18 AM. Staff F stated if a resident refused a supplement, they expected documentation in the medical record of the refusal and provider notification and identify if there is a trend and, see what's driving the refusals. Staff F stated that Nepro was, a supplement for dialysis patients and had no knowledge Resident 88 did not like to drink the Nepro. Staff F was asked how the facility determined consumption of the Nepro when the night shift nurses documented the resident consumed it later in the day or drinks their own and stated, by [Staff HH] looking [in the medical record]. Staff F acknowledged the medical record showed no documentation the facility identified and addressed Resident 88's refusal of the Nepro. The above findings were shared with Staff HH on 04/21/2025 at 10:25 AM. Staff HH stated that when a resident had orders for a supplement, they checked the MAR to verify and make sure the nurses documented the amount of supplement consumed. Staff HH stated they, lean on what's documented in the MAR to estimate percentage consumed. Staff HH stated they were unaware Resident 88 did not like and was not consuming Nepro. 42802 <Resident 263> According to an admission assessment dated [DATE], Resident 263 was admitted with diagnoses which included surgical aftercare following a hip fracture, cirrhosis (a chronic condition which scar tissue replaced healthy liver tissue) and ascites (an abnormal buildup of fluid in the abdomen, often caused by late-stage cirrhosis of the liver.) The resident was alert and able to make their needs known. A physician note, dated 04/02/2025, documented that the resident had required weekly paracentesis (a medical procedure in which a tube was inserted into the abdomen, to drain excess fluid). Review of the medical record showed the resident had admission orders for weekly weights for three weeks, then monthly for four weeks. The resident's weight dropped from 142.7 lb. on 03/31/2025 to 116.2 lb. on 04/15/2025, a loss of 26.5 lb. in 15 days, which indicated a significant and severe weight loss. A Nutrition and Hydration meeting note dated 04/10/2025, documented the significant weight change and that their food/fluid intake had been adequate. Per the note, Staff HH attended. A further review of the medical record showed no comprehensive nutritional assessment was completed by Staff HH as required. During an interview on 04/23/2025 at 3:47 PM, Staff HH stated they completed the comprehensive assessment within one week of admission, or sooner if their admission paperwork showed a concern. Staff HH acknowledged they had done Resident 263's full assessment as they were behind on them. 37544 <Resident 313> (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 03/31/2025 admission assessment documented Resident 313 had severe cognitive impairment and diagnoses which included dementia, malnutrition, and adult failure to thrive. In addition, the assessment documented the Resident 313 received hospice services. On 04/15/2025 at 9:51 AM, Resident 313 was observed in their room lying in bed watching television. The resident was very thin in appearance and a glass of untouched vanilla protein drink was sitting on the bedside tray table. When asked about their care, Resident 313 stated they had been at the facility for a long time, but was unable to give details or the date. In an interview on 04/15/2025 at 10:29 AM, Resident 313's representative stated the resident's appetite was very poor and that was to be expected, but they would drink Ensure, a brand that makes nutritional drinks. When asked if Ensure was provided, the representative stated they had been told the facility used a different kind of nutritional drink, and it was their understanding Ensure was not available, so they purchased and brought it in for Resident 313. Review of Resident 313's record found the following information: - The meal monitor records from 03/25/2025 through 04/16/2025 documented Resident 313 refused meals on 12 out of the 25 days they resided at the facility. - The care plan had nutritional interventions implemented on 03/30/2025, but did not include resident specific goals or interventions related to the resident's diagnoses of malnutrition or adult failure to thrive. The interventions were generic and not resident centered, nor did they provide instruction and/or information to the nursing staff to inform them of Resident 313's dietary likes/dislikes or preferences. - The admission nutrition assessment was completed on 04/16/2025, 22 days after the resident was admitted to the facility. The assessment showed Resident 313 was offered and refused the facility's house nutritional drink, but aside from monitoring food intake at meals and encouraging food and fluid intake, no other nutritional interventions or considerations were offered or implemented. The assessment documented Resident 313's dietary preferences and dislikes were included on the dietary profile and referred nursing staff to the profile for details, however, no dietary profile was found in Resident 313's record. - Review of the progress notes from 03/25/2025 through 04/15/2025 found no documentation related to the nutritional or dietary needs for Resident 313. In an interview on 04/18/2025 at 10:29 AM, Staff P, NA, stated they encouraged Resident 313 to eat, they often refused meals, but liked chocolate, water and juice, so they tried to make sure it was provided. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/22/2025 at 11:33 AM, Staff HH stated they attempted to complete nutritional assessments within a week of a resident's admission to the facility, but was behind on getting them completed. When asked what nutritional interventions were offered for Resident 313, Staff HH stated the house supplement was offered, but was refused. When asked if there were other nutritional interventions such as offering ice cream or NEM (nutritionally enhanced meals which contain more nutrients than a normal meal), Staff HH stated yes, once they spoke to Resident 313's representative, they would have a better idea of what to offer. When asked if they had spoken to Resident 313's representative, Staff HH stated no, but now that they were aware they would. Reference: WAC 388-97-1160(1) Refer to F804 and F806 for additional information.

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	505322	A. Building B. Wing	04/24/2025

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

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on observation, interview, and record review, the facility failed to provide appetizing and palatable food for 8 of 9 sampled residents (Residents 262, 63, 89, 56, 3, 15, 47, and 16) reviewed for food. This failure placed the residents at risk for decreased nutritional intake, potential weight loss, and a diminished quality of life. Findings included . <Resident 262> Review of a 04/03/2025 admission assessment showed Resident 262 admitted to the facility on [DATE] with medically complex conditions. The assessment showed the resident was cognitively intact. In an interview on 04/14/2025 at 10:28 AM, Resident 262 stated, The food is not good. The cold food is lukewarm, and the hot food is cold. There is no variety, and the portion sizes are small. An observation and interview on 04/17/2025 at 11:38 AM showed, the staff delivered a lunch tray to Resident 262's room. Resident 262 stated of the meal, It's actually hot. First time I've had [the meal hot] in a week. You need to come more often. An observation and interview on 04/21/2025 at 7:52 AM showed the staff delivered a breakfast tray to Resident 262's room. The resident stated of the breakfast, That's an improvement, it's usually cold. 42802 <Resident 56> According to the quarterly assessment dated [DATE], Resident 56 had diagnoses which included depression and malnutrition. Resident 56 made their needs known and was able to eat independently after their food was set up by staff. During an interview on 04/15/2025 at 9:33 AM, Resident 56 stated that they only had about three hot meals for a while. They further described the food as horrible, and without much variety. During a follow-up interview on 04/22/2025 at 9:41 AM, Resident 56 stated that breakfast was scanty and lunches and dinners were usually chicken and occasionally hamburger. They repeated that the meals were cold, not tasty and they didn't eat much of them. 46115 <Resident 3> The 03/08/2025 annual assessment documented Resident 3 was cognitively intact and was able to make their needs known. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/14/2025 at 11:19 AM, Resident 3 stated the food was not that good. In an interview on 04/16/2025 at 2:45 PM, Resident 3 stated they ordered a sandwich that day because they did not like the food that was served. <Resident 15> The 01/01/2025 quarterly assessment documented Resident 15 was cognitively intact and was able to make their needs known. In an interview on 04/14/2025 at 1:59 PM, Resident 15 stated they had peanut butter and jelly sandwiches because the food was horrible and served cold at times. In an interview on 04/16/2025 at 12:05 PM, Resident 15 stated the mashed potatoes served for lunch had no flavor. In an interview on 04/18/2025 at 8:47 AM, Resident 15 stated their hashbrowns were served cold that morning. <Resident 47> The 03/05/2025 quarterly assessment documented Resident 47 was cognitively intact and was able to make their needs known. In an interview on 04/14/2025 at 2:50 PM, Resident 47 stated some days the food was good, and some days was unrecognizable and if it looked bad, they did not want to eat it. In an interview on 04/17/2025 at 12:27 PM, Resident 47 stated they got some type of meat that resembled a bird patty. Resident 47 stated they guessed what kind of food they were eating because some days it was unidentifiable. <Resident 89> The 01/23/2025 significant change assessment documented Resident 89 was cognitively intact and was able to make their needs known. In an interview on 04/14/2025 at 1:50 PM, Resident 89 stated the food was not good and was not always served hot. In an interview on 04/16/2025 at 12:29 PM, Resident 89 stated they ordered a sandwich at lunch because they did not like the food that was served. In an interview on 04/17/2025 at 8:50 AM, Resident 89 stated the food was excellent, it was like someone flipped a coin. In an interview on 04/18/2025 at 8:49 AM, Resident 89 stated the hashbrowns were served cold and the sausage was gross. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	47328 <Resident 16> According to the 03/11/2025 significant change assessment, Resident 16 was cognitively intact and able to clearly verbalize their needs. In an interview on 04/14/2025 at 11:14 AM, Resident 16 stated the food was bland, and not always hot or cold. Resident 16 explained if the food was delivered on time it was warmer and colder when it was delivered later. <Resident 85> According to the 03/30/2025 quarterly assessment, Resident 85 had diagnoses which included diabetes. The assessment further showed Resident 85 required a mechanically altered therapeutic diet, was cognitively intact and able to clearly verbalize their needs. In an interview on 04/14/2025 at 1:49 PM, Resident 85 stated the food was terrible. Resident 85 explained the hot food was lukewarm and the cold food was often hot. In a follow-up interview on 04/17/2025 at 1:37 PM, Resident 85 stated the menu lacked variety, and they ordered out for lunch that day. <Test Tray> Review of the menu for the 04/22/2025 lunch meal showed the meal consisted of roasted chicken, mashed potatoes, buttered corn and peach cobbler or ravioli and tossed salad. On 04/22/2025 at 12:31 PM, a test tray of the lunch meal was sampled by the survey team. The entree meal consisted of roasted chicken that appeared colorless and dry, without sauce or toppings, mashed potatoes without butter or gravy, corn, ravioli with marinara sauce, and peach cobbler. The roasted chicken was bland, dry, and tasted like plain boiled chicken breast, not roasted chicken. The mashed potatoes tasted bland, similar to plain unseasoned instant boxed mashed potatoes. The ravioli had dried edges which made it difficult to cut, the marinara had good flavor. The peach cobbler appeared watery and soupy but had good peach cobbler flavor. During an interview on 04/22/2025 at 2:12 PM, Staff GG, Dietary Manager, was informed of the survey team's evaluation of the test tray (unflavorful, chicken was dry and food not hot). Staff GG stated that they changed food suppliers when the facility had a change of ownership, and just started the new spring/summer menu from that new company three days ago. They usually prepared the food exactly as directed the first time, then would make adjustments with the dietician after that. Staff GG acknowledged that today's lunch was bland, looked colorless and not very appetizing. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a follow-up interview on 04/24/2025 at 8:34 AM, Staff GG, stated they tasted the food, after they made it. Staff GG acknowledged they received complaints of the food being bland. Staff GG further stated they tried to alter the recipes to their abilities to make them more palatable but could not add too much salt because of the resident's dietary restrictions. Staff GG stated the food was cooked to the proper temperatures then placed onto hot plates, but it was up to nursing to get the meal trays passed. Staff GG stated they had occasional complaints of the food not being hot and they replaced the meals. Reference WAC 388-97-1100 (1),(2) Refer to F806 for additional information.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 46115 Based on observation, interview and record review, the facility failed to ensure resident food preferences were honored for 3 of 13 sampled residents (Residents 15, 63 and 89) reviewed for food preferences. This failure placed the residents at risk of unintended weight loss, less pleasure in dining and diminished quality of life. Findings included . <Resident 15> The 01/01/2025 quarterly assessment documented Resident 15 was cognitively intact and was able to make their needs known. On 04/16/2025 at 12:05 AM, Resident 15's meal was observed. They were served barbequed ribs and mashed potatoes. Resident 15 stated they were upset. They had ordered the shrimp scampi and filled out their menu twice. Resident 15 attempted to eat the ribs and stated they were going return their meal. On 04/17/2025 at 12:13 AM, Resident 15's meal included a chicken patty, green beans and mashed potatoes. Resident 15 stated they had ordered the alternate menu choice but their menu must have been lost. They stated they had filled out their menu twice and had given it to an aide. They were going to request a sandwich. On 04/18/2025 at 8:47 AM, Resident 15 stated they were frustrated because they were supposed to get boiled eggs but was served scrambled eggs. On 04/18/2025 at 12:34 PM, Resident 15 had pudding and fluids on their meal tray. They stated they had been given fish and that was not what they ordered. Resident 15's visitor stated Resident 15 did not eat rice, but it was served to them. Resident 15 stated they were tired of getting sent the wrong things despite filling out the menus. <Resident 89> The 01/23/2025 significant change in condition assessment documented Resident 89 was cognitively intact and was able to make their needs known. On 04/18/2025 at 8:49 AM, Resident 89 stated they did not get their yogurt and milk and got orange juice instead of apple juice. On 04/18/2025 at 12:32 PM, Resident 89 stated they were upset because they did not get yogurt again. Resident 89's tray card instructed staff to send yogurt on the meal trays. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/21/2025 at 8:39 AM, Resident 89 stated they did not get any apple juice and were given oatmeal. Resident 89's tray card instructed staff to send cold cereal, apple juice, toast and milk for breakfast. During an interview on 04/23/2025 at 1:13 PM, Staff JJ, Regional Food Service Manager, stated residents sent their menus to the kitchen then staff wrote the menu requests on meal tickets. Staff JJ stated it was important to provide the residents their requests because this was their home, and staff were there to serve the residents. During an interview on 04/23/2025 at 1:26 PM, Staff II, Nursing Assistant, stated they had to take meals back to the kitchen because residents were served the wrong things. <Resident 63> The 02/12/2025 quarterly assessment documented Resident 63 had diagnoses that included failure to thrive. Resident 63 had moderate cognitive impairment and was able to clearly verbalize their needs and received a therapeutic diet. The 03/14/2025 dietary profile documented Resident 63's food dislikes including sweet potatoes, potatoes, and scrambled eggs. On 04/18/2025 at 8:43 AM, Resident 63 was observed lying in bed with their breakfast tray in front of them. The plate contained an uneaten scoop of scrambled eggs and hashbrowns. Resident 63 stated they did not like scrambled eggs or potatoes and only ate a piece of sausage and their oatmeal. Resident 63 stated they were not offered alternative options. Review of the breakfast tray card documented Resident 63 disliked scrambled eggs and potatoes. During an interview on 04/22/2025 at 1:22 PM, Staff C, Assistant Director of Nursing, stated resident food preferences were obtained by completing a dietary profile assessment and the preferences were printed on the tray cards. Residents were also able to circle meal options on provided menus. Staff C stated they expected staff to honor a resident's food preferences. During an interview on 04/24/2025 at 8:34 AM, Staff GG, Dietary Manager, acknowledged staff returned meals to the kitchen because it was not what residents ordered. Staff GG stated at times residents were not provided menus, or the menus were not returned to the kitchen timely. At other times, menu selections contradicted information on the tray cards. Staff GG stated they were unsure why the named residents received foods they did not want or disliked. It was possible kitchen staff hurried, did not look at the menu items closely, or were new employees. Reference: WAC 388-97-1120 (2)(a), -1100 (1), -1140 (6) 47328

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42802 Based on observation, interview, and record review, the facility failed to store and prepare food in accordance with professional standards for food safety. Specifically, some foods were not labeled with the date opened or type of food item, labeled with a resident name (in the nourishment refrigerators) or discarded when expired. Additionally, the facility failed to maintain a clean kitchen environment, ensure dietary personnel wore appropriate hair coverings that fully covered their hair and performed hand hygiene when indicated. These failures placed residents at risk for food borne illness and diminished quality of life. Findings included . Review of the facility policy titled Food Brought by Family/Visitors dated February 2019 documented, perishable foods must be stored in the refrigerator. The policy instructed staff to label containers with the resident's name, and a use by date as appropriate. During the initial kitchen tour on [DATE] at 9:02 AM with Staff GG, Kitchen Manager, the following was observed: Food crumbs and debris were noted in the following areas: 1) Shelves of a rolling cart near hot service area with jelly and butter packages 2) Shelves of a rolling cart with cold cereal packages 3) Top shelf of the cart with the toaster 4) Shelf under the coffee station that contained bins with peanut butter and honey 5) Flat surfaces around one of two stoves with drips of an unknown, dried substance down the right side of the a stove. 6) The floor under the stove and 2 ovens had food debris and crumbs. 7) The floor of the walk-in freezer had crumbs covering the rubber mats, two vanilla ice cream cups and a clear plastic wrapper on the back left corner of the floor, under the shelving unit. <Hair Coverings> Staff VV, [NAME] was wearing a hairnet and beard covering. Staff VV had a full beard about 2 inches long. The beard net only covered their chin which left the hair of their upper lip, cheeks and neck uncovered. <Food Storage/Cleanliness> (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1) Three opened, large bags of shredded cheese, about half full on a shelf in the refrigerator. There was no date that showed when the bags were opened. 2) A full pitcher of white liquid with a date of ,d+[DATE]. There was no label that showed what the white liquid was. Per Staff GG, it was a health shake. 3) Opened, partially used spice containers on a shelf over the food prep area had seasoning salt, garlic powder, garlic salt, dill, lemon pepper, steak seasoning, thyme, parsley, paprika, poultry seasoning and pepper. The poultry seasoning was dated ,d+[DATE] in black marker, and the pepper was dated ,d+[DATE]. It was not clear if that meant day/month or month/year. None of the other nine spice containers were clearly marked with the date opened. The seasoning salt container had an unknown dried substance dripped on the cover. 4) On the same spice shelf, there was an opened bag of rock hard brown sugar with plastic wrap over an opened corner of the bag. There was no date that showed when it was opened. 5) On a rolling shelf next to refrigerators, a large opened container of caramel sauce and white chocolate sauce was observed, both undated with an open date. The caramel sauce container did not have a cap, had dried caramel drips down the sides of the whole container, and it was past the manufacturer expiration date of [DATE]. The container of white chocolate sauce was also past the manufacturer expiration date of [DATE]. There were three shaker containers (approximately one cup each) that contained colored powder granules; two had shakers were covered and one was uncovered. These containers were not labeled with a date or contents. The shelf had spills of a sticky, dried red substance, that some of the containers were stuck to. During a concurrent interview on [DATE] at 9:02 AM, Staff GG acknowledged that the sauces should be discarded since they were expired. Staff GG further stated all foods should be dated when opened, so that they would know when to throw them out but was unsure how long spices were ok to use for once opened. Staff GG explained the powder in the shaker containers was jello powder used to sprinkle over desserts using a [NAME]. Staff GG acknowledged items should be properly labeled with the contents and an open or discard date. On [DATE] from 10:52 AM to 12:14 PM, during the lunch meal preparation in the kitchen the following was observed: <Hair Coverings> Staff VV's beard was about half covered, as described on the initial visit to the kitchen on [DATE]. During the meal observation, Staff VV checked food temperatures, served all of the food onto plates and placed the plates on a shelf for Staff WW, Dietary Aide, to put onto trays. Staff WW had a short neat beard that you could not see skin though and did not wear a beard covering. Staff WW was on the other side of the steam table, put the insulated bases and plate covers on the food filled plate, placed them on the trays and into the rolling meal carts. Staff JJ, Regional Food Service Director, had a beard that was about half an inch long and did not wear a beard covering. Staff JJ was on the far side of the kitchen, past the red line on the floor near the entrance that indicated hair coverings were required past that point. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Hand Hygiene> Staff WW did not wear gloves while in the kitchen. During the meal preparation, they opened cart doors, moved carts, filled cups with coffee or hot water for tea. At 11:49 AM, Staff WW scratch their face and adjust their headphones and did not perform hand hygiene before returning to place the food filled plates on the insulated bases, covering them and placing them on the tray. During an interview on [DATE] at 2:12 PM, Staff GG, Kitchen Manager, explained the red line near the kitchen entrance was a visual reminder for staff that they could not go past the red line without a hairnet or cap. Staff GG stated they had not received clear guidance on beard coverings but acknowledged beard coverings/nets should also be worn past that red line. Staff GG acknowledged Staff WW should have washed their hands after touching their face and headphones and before returning to their tasks. Staff GG was informed of the unclean areas of kitchen observed earlier. Staff GG acknowledged surfaces should be cleaned and acknowledged there was no cleaning schedule/log sheet for those tasks at this time. NOURISHMENT REFRIGERATORS <North Hall> During an inspection of the North hall nourishment refrigerator on [DATE] at 5:15 AM, the following was observed: 1) Three strawberry Ensure and 4 Premier Protein Shakes labeled with room numbers but no resident name. 2) One container from Olive Garden labeled with a last name and room number, but no date. 3) A partially used container of roasted red pepper hummus, without a resident name, room number or date. <South Hall> During an inspection of the South hall nourishment refrigerator on [DATE] at 7:40 AM, the following was observed: 1) Two opened containers of Simply Orange juice with a room number, but no resident name or open date. 2) A pitcher of clear yellow liquid, about a quarter full, without a date or label identifying the liquid contents. During an interview on [DATE] at 3:47 PM, Staff HH, Registered Dietician, stated any staff that past the red line in the kitchen should have appropriate hair and beard coverings on. Staff HH was informed of the surveyor's observations including staff in kitchen without full coverage of beards, incidents of missing hand hygiene, incomplete labeling/dating of foods, and crumbs/spills on surfaces in the kitchen. Staff HH acknowledged the findings did not meet their expectations for food service safety. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference WAC [DATE](3) and WAC [DATE]

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. 40297 Based on interview and record review, the facility failed to establish and maintain a written transfer agreement with at least one area hospital approved for participation with Medicare/Medicaid programs. This failure placed all residents at risk for delayed hospital transfers, lack of access to hospital level of care and diminished quality of life. Findings included . On 04/23/2025 at 11:17 AM, Staff A, Administrator, and Staff E, Regional Director of Clinical Operations, were asked to provide the facility-hospital transfer agreements. In an interview on 04/23/2025 at 1:11 PM, Staff E acknowledged the facility did not have a transfer agreement with any local hospital. Reference: WAC 388-97-1620(6)(a) Refer to F622, F623, and F625 for additional information.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 46115 Based on interview and record review, the facility failed to implement an effective Quality Assessment and Assurance (QA&A) program that ensured corrective actions for identified problem areas [activities of daily living, falls/monitoring, care planning conferences and admission procedures] were monitored and sustained. This failure precluded facility staff the opportunity to analyze potential and actual system deficiencies and modify corrective actions for deficiencies placing all residents at risk for a diminished quality of life and care. Findings included . The undated facility Quality Assessment Performance Improvement (QAPI) Plan documented the QAPI Committee was to analyze data gathered through a variety of sources, including recertification surveys, to look for trends and negative outcomes. The committee would then establish benchmarks or targets to achieve through the implementation of performance improvement plans (PIPs). The plans were to be monitored for effectiveness. During the unannounced Recertification Survey conducted from 04/14/2025 to 04/24/2025, the following areas of repeated deficiency were identified by the survey team: -Activities of Daily Living Similar deficiencies were cited during a complaint survey dated 01/23/2025. <Resident 3> The 03/08/2025 annual assessment documented Resident 3 had diagnoses including chronic obstructive pulmonary disease (COPD, a lung disease that makes it difficult to breathe), seizures and chronic pain. Resident 3 was cognitively intact and able to make their needs known. In an interview on 04/14/2025 at 11:20 AM, Resident 3 stated they were supposed to get two showers per week and a lot of times they only received one. The 03/10/2025 care plan stated Resident 3 needed assistance with activities of daily living (ADLs) related to chronic health conditions and weakness. The care plan instructed nursing staff to assist the resident with showers. A shower binder documented Resident 3's showers were to be given on Tuesdays and Fridays. A review of Resident 3's record revealed they did not receive two showers per week on 03/09/2025, 03/16/2025, 03/23/2025 and 04/06/2025. <Resident 15> (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The 01/01/2025 quarterly assessment documented Resident 15 had diagnoses including COPD, high blood pressure and depression. Resident 15 was cognitively intact and able to make their needs known. In an interview on 04/14/2025 at 1:59 PM, Resident 15 stated they had not consistently received two showers per week. The 03/24/2023 care plan stated Resident 15 needed assistance with activities of daily living (ADLs) related to their disease processes and physical limitations. The care plan instructed nursing staff to assist the resident with bathing on Tuesday and Friday evenings. A review of Resident 15's record revealed they did not receive two showers per week on 03/09/2025, 03/16/2025 and 04/06/2025. In an interview on 04/22/2025 at 9:30 AM, Staff W, Nursing Assistant, stated showers were given every three to four days and documented in the plan of care or the shower binder. In an interview on 04/23/2025 at 11:05 AM, Staff C, Assistant Director of Nursing (ADON), stated showers were supposed to be given twice a week. Staff C stated it was important for the residents to have their showers for overall health and skin integrity. <Resident 264> The 04/04/2025 quarterly assessment documented Resident 264 had diagnoses which included stroke and muscle weakness. In addition, the assessment documented Resident 264 was dependent on nursing staff to complete activities of daily living for oral care and personal hygiene such as nail care. On 04/14/2025 at 1:56 PM, Resident 264 was observed lying in bed wearing a hospital gown. When the resident opened their mouth to respond after being greeted, their breath smelled very foul and their teeth were observed to be broken and unclean. Resident 264's fingernails were observed to have dark brown matter underneath them. Similar observations of Resident 264 with foul-smelling breath and dark matter under the fingernails were made on 04/15/2025 at 9:10 AM and 04/16/2025 at 12:11 PM. On 04/17/2025 at 11:15 AM, Resident 264 was observed lying in bed watching television. When asked if the staff assisted them with brushing their teeth or cleaning/trimming their nails, Resident 264 shook their head side to side, indicating no, then verbally stated No. Resident 264's breath was still foul-smelling, and the dark brown matter was observed to still be present under the fingernails. In an interview on 04/18/2025 from 10:21 AM to 10:27 AM, Staff P, Nursing Assistant (NA), stated the care plans informed them what the resident's type of assistance and specific care needs were. When asked when oral and nail care were done, Staff P stated oral care was part of morning care that was supposed to be provided daily, and nail care was done on shower days and when needed. In an interview on 04/21/2025 at 6:55 AM, Staff C was informed of the multiple observations of Resident 264 with foul smelling breath and dirty fingernails Staff C stated nail care was to be done when the resident was bathed, and as needed, and oral care was to be done daily during morning cares. (continued on next page)

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	505322	A. Building B. Wing	04/24/2025

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 04/24/2025 at 1:17 PM, Staff A, Administrator, stated they had concerns with showers and were not sure if they were back in substantial compliance. The facility alleged a back in compliance date of 02/21/2025. Staff A stated they did a plan of correction and audits were completed and they still had some holes. -Falls/Monitoring See F658 for additional information. Similar deficiencies were cited during the annual recertification survey dated 01/19/2024 and during a complaint investigation on 05/29/2024. In an interview on 04/24/2025 at 1:17 PM, Staff A stated they were not aware there were concerns with monitoring after falls occurred. Staff A stated the previous Director of Nursing (DNS) completed a PIP in December 2024 in which they performed audits and educated the staff. Staff A stated the DNS felt the PIP was successful as they reduced their number of falls from 28 to 23 and they no longer needed to do a full QAPI on falls. -Care Conferences See F657 for additional information. In an interview on 04/24/2025 at 1:17 PM, Staff A stated they were unaware there were issues with care conferences not being offered or held. Staff A asked how they were out of compliance, and it was explained that 12 residents were reviewed and only one resident had a care conference for those that were scheduled in February 2025. Staff A stated the PIP included looking at the scheduled care conferences daily and asking if they had been completed and the staff said they were. Staff A did not check to see that the care conferences had been completed. -Admission Processes See F552, F572, F579, F582, and F625 for additional information. In an interview on 04/24/2025 at 1:17 PM, Staff A stated they were aware they were out of compliance with completing admission documents with the residents. Staff A stated they monitored the progress of the PIP through a report from the admissions staff on who was still outstanding. Staff A stated the PIP was not sustained. Reference: WAC 388-97-1760 (1)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on observation, interview, and record review, the facility failed to ensure hand hygiene was followed during medication administration and wound care for Resident 89 and during the observation of the lunch meal service, failed to serve food in a sanitary manner for an unidentified resident, failed to ensure signage was placed to inform the staff of residents (Resident 6, 88, 89, 462 and 82) who required Enhanced Barrier Precautions (EBP, infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO, germs that are resistant to many antibiotics]), failed to sanitize equipment between resident use, and failed to timely change and maintain infection control practices for a central line (a thin, flexible tube inserted into a large vein until the tip rested in a major vein near the heart) for Resident 89. These failures placed the residents at risk for the spread of infections, illnesses and unintended health consequences. Findings included . ENHANCED BARRIER PRECAUTIONS According to a 06/28/2024 Centers for Disease Control article, EBP involved gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO, as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). EBP expanded the use of gown and gloves beyond anticipated blood and body fluid exposures. EBP directed staff to don (put on) gowns and gloves when dressing, bathing/showering, transferring, changing linens, providing hygiene, wound care and assisting with toileting. <Resident 6> Review of the 02/23/2025 significant change assessment showed Resident 6 admitted to the facility on [DATE] with medically complex conditions. The assessment showed Resident 6 had moderately impaired cognition and an indwelling urinary catheter. Review of the medical record showed the staff treated Resident 6 for wounds to the right foot. An observation on 04/14/2025 at 11:31 AM showed Resident 6 in their wheelchair, and the urinary catheter bag was covered. No EBP signage was observed near Resident 6's room to show the staff needed to don PPE prior to entering the room when providing high contact activities. <Resident 88> Review of a 03/22/2025 admission assessment showed Resident 88 admitted to the facility on [DATE] with medically complex conditions, including an MDRO. The assessment showed the resident was cognitively intact and received dialysis (a procedure that removed waste products and excess fluid from the blood when the kidneys failed to do so). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview on 04/14/2025 at 10:12 AM showed Resident 88 sitting at the edge of the bed. The resident stated they went to the dialysis center and received dialysis through a central line. Resident 88 showed a dressing that covered the central line to the left side of their chest. No EBP signage was observed near Resident 88's room to show the staff needed to don PPE prior to entering the room when providing high contact activities. <Resident 82> According to the 03/03/2025 quarterly assessment, Resident 82 had an indwelling urinary catheter (flexible tube inserted into the bladder to drain urine). Review of the 11/27/2024 care plan showed Resident 82 had a urinary catheter related to urinary retention and instructed staff to maintain the tubing anchored, provide catheter care every shift, observe for signs of a bladder infection, and to keep the catheter in place until seen by a urologist (doctor that specialized in the urinary system). Review of 02/06/2025 urologist progress notes showed Resident 82's urinary catheter was to remain in place to prevent recurrent urinary retention. During an observation on 04/14/2025 at 9:19 AM, no EBP signage was observed to be posted outside Resident 82's room. Similar observations were made that same day at 11:53 AM and 12:36 PM. <Resident 462> According to the 04/03/2025 admission assessment, Resident 462 received liquid nutrition via a feeding tube (flexible tube inserted into the digestive system to deliver nutrition when unable to eat). Review of the 03/28/2025 care plan showed Resident 462 received nutrition via tube feeding and instructed staff to administer flushes and feedings as ordered, provide oral care daily, and check the tube insertion site. During observation on 04/21/2025 at 4:45 AM, Staff Q, Registered Nurse (RN), put on a pair of gloves without performing hand hygiene, pulled items out of their pocket including a cell phone to check the time prior to labeling a bottle of tube feed formula, adjusted the bedside table, touched Resident 462's left shoulder to get their attention, and raised the head of the bed up. Without changing gloves, performing hand hygiene, or putting a gown on, Staff Q flushed Resident 462's feeding tube, connected the tubing to the resident and began running their formula. The above findings were shared with Staff D, Infection Preventionist, on 04/21/2025 at 9:14 AM. Staff D stated they identified residents who required EBP to be implemented during cares by reviewing the admission orders. Staff D stated residents required EBP during cares if they presented with an indwelling medical device or uncontainable wound and the requirement was communicated to the staff through signage. Staff B acknowledged EBP signage was not posted during the 04/14/2025 observations and that it should be put up upon admission [to the facility]. 46115 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 89> The 01/23/2025 significant change assessment documented Resident 89 had diagnoses which included a left leg fracture and depression. The assessment further showed Resident 89 was on isolation or quarantine for an active infectious disease process, was cognitively intact and able to make their needs known. A review of provider orders documented a 04/11/2025 order for Resident 89 to be administered cefazolin (antibiotic) intravenously (IV) every eight hours to treat an infection associated with an internal fixation (implants such as plates, screws or rods used to stabilize fractured bones) device in Resident 89's left leg. A 04/11/2025 order showed Resident 89 was to be on EBP related to a peripherally inserted central catheter (PICC, a long thin tube inserted into a vein in the arm and threaded up to a larger vein near the heart used for administration of medications). The 04/13/2025 care plan documented Resident 89 had a PICC and required EBP. During observation on 04/14/2025 at 9:31 AM, no EBP signage was observed to be posted outside of Resident 89's room and there was no plastic tote containing personal protective equipment such as gowns near the room entrance. Similar observation was made at 12:36 PM. In an observation on 04/14/2025 at 2:26 PM, Staff LL, Registered Nurse (RN), put on gloves, wiped Resident 89's PICC with an alcohol swab, flushed the line, wiped off the IV tubing and connected it to the PICC line and had not worn a gown. In an interview on 04/17/2025 at 8:50 AM, Resident 89 stated the staff had not always worn a gown when administering their antibiotics. In an interview on 04/23/2025 at 1:29 PM, Staff D stated a gown needed to be worn when administering medication through a PICC line and it was important to prevent the spread of microorganisms. HAND HYGIENE <Resident 89> The 01/23/2025 significant change in condition assessment documented Resident 89 had diagnoses including a left leg fracture and depression. The assessment further showed Resident 89 was on isolation or quarantine for an active infectious disease process, was cognitively intact and able to make their needs known. A review of provider orders documented a 04/11/2025 order for Resident 89 to be administered cefazolin (antibiotic) intravenously (IV) every eight hours to treat an infection associated with an internal fixation (implants such as plates, screws or rods used to stabilize fractured bones) device in Resident 89's left leg. A 04/11/2025 order showed Resident 89 was to be on EBP related to a peripherally inserted central catheter (PICC, a type of central line). The 04/13/2025 care plan documented Resident 89 had a PICC and required EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 04/14/2025 at 2:26 PM, Staff LL, Registered Nurse (RN) put on a pair of gloves, wiped the PICC with alcohol, flushed the PICC line, wiped end of IV tubing and connected it to the PICC line, programmed the IV machine, and whiile wearing the same gloves placed a medicated patch on Resident 89's back. In an observation on 04/17/2025 at 1:57 PM, Staff LL put on a gown and pair of gloves, picked up the IV machine cord, plugged it in, and then programmed the IV machine. Without changing gloves or performing hand hygiene, Staff LL then swabbed the PICC and IV tubing with alcohol, flushed the PICC line and reprogrammed the IV machine. Staff LL then removed their gloves and without performing hand hygiene, put on a new pair of gloves. In an interview on 04/17/2025 at 2:18 PM, Staff LL stated they should have removed their gloves and performed hand hygiene after plugging the IV machine in and programming it to prevent the spread of germs. During an observation on 04/21/2025 at 4:58 AM, Staff Q, RN, did not perform hand hygiene, and put a pair of gloves, gown, and surgical mask on. With their gloved hands, Staff Q took items out of their pocket, opened the IV tubing, draped the tubing around the back of their neck, grabbed the trashcan with their right hand to move closer to the bedside, and used it to drip IV solution into when priming the tubing. Without removing gloves or performing hand hygiene, Staff Q then inserted the tubing into the IV pump, cleansed Resident 89's IV access line with alcohol, connected the tubing, and began to administer the IV medication. In an interview on 04/23/2025 at 1:29 PM, Staff D, Infection Preventionist, stated hand hygiene needed to be performed, and gloves changed after touching things and prior to administering medications. Staff D stated hand hygiene needed to be performed prior to putting on a new pair of gloves. WOUND CARE <Resident 89> The 01/23/2025 significant change assessment documented Resident 89 had diagnoses which included a left leg fracture and depression. The assessment further showed Resident 89 was on isolation or quarantine for an active infectious disease process, was cognitively intact and able to make their needs known. A review of provider orders documented a 04/11/2025 order for Resident 89 to be administered cefazolin (antibiotic) IV every eight hours to treat an infection associated with an internal fixation device in Resident 89's left leg. A 04/11/2025 order showed Resident 89 was to be on EBP related to a PICC. The 12/06/2024 skin impairment care plan documented Resident 89 had a surgical incision to their left knee and instructed nursing to keep the skin as clean and dry as possible and to apply treatment per the treatment administration record (TAR). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 04/17/2025 at 1:57 PM, Staff LL had not performed hand hygiene and put on a pair of gloves. Staff LL set up their treatment supplies on a plastic blue sheet, opened the clean dressings, removed the dressings from Resident 89's left leg, cleansed the wounds, and without removing the gloves and performing hand hygiene, applied the new dressings and touched the part of the dressing with their fingers that covered Resident 89's wound. Staff LL then discarded the old dressings and supplies into the garbage, and wearing the same gloves grabbed a marker out of their pocket and dated the dressings on the resident's left leg. In an interview on 04/17/2025 at 2:18 PM, Staff LL stated they should have removed their gloves and performed hand hygiene prior to the dressing change, and after removing the soiled dressings and cleaning the wounds prior to putting the new dressings on to prevent the spread of germs. In an interview on 04/23/2025 at 1:29 PM, Staff D stated gloves needed to be changed after the old dressings were removed and hands sanitized. Staff D stated a new pair of gloves were worn to put on the new dressing and this was important to prevent the spread of infection. SANITIZATION In an observation on 04/22/2025 at 10:32 AM, Staff W, Nursing Assistant (NA), and an unidentified nursing assistant used the mechanical lift in room [ROOM NUMBER]. The nursing assistant pushed the mechanical lift to the tub room and closed the door without cleaning it. In an interview on 04/22/2025 at 3:16 PM, Staff C, Assistant Director of Nursing (ADON), stated staff needed to wipe the lifts between residents to prevent the spread of germs. In an interview on 04/22/2025 at 3:25 PM, Staff D stated staff needed to wipe the lifts between residents to prevent the spread of microorganisms. PICC LINE DRESSING CHANGE <Resident 89> The 01/23/2025 significant change assessment documented Resident 89 had diagnoses which included a left leg fracture, depression, was cognitively intact and able to make their needs known. In an observation on 04/14/2025 at 1:50 PM, Resident 89 was sitting on their bed. Resident 89 had a PICC line dressing on their right arm that was dated 04/06/2025. A review of the provider's orders documented on 04/11/2025 PICC line dressings changes needed to be changed every Tuesday. The 04/13/2025 care plan documented Resident 89 had a PICC and the dressing was to be changed per the order. In an observation and interview on 04/16/2025 at 9:02 AM, Resident 89 was sitting on their bed. The resident's PICC line dressing was dated 04/16/2025. Resident 89 stated the dressing was changed yesterday but was not placed correctly so it had to be re-done. The resident went nine days between dressing changes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/22/2025 at 12:07 PM, Staff C stated PICC line dressing changes needed to be completed every seven days and this was important for infection control. In an interview on 04/24/2025 at 12:47 PM, Staff D stated Resident 89's PICC line dressing should have been changed within seven days from the last dressing change and this was important to prevent infections. 47328 DINING OBSERVATION During observation on 04/14/2025 at 12:26 PM, Staff MM, NA, did not perform hand hygiene and delivered a tray to a resident in the small assisted dining room. Staff MM adjusted the resident's wheelchair (WC) closer to the table, placed a new clothing protector on the resident, did not perform hand hygiene, then sat down to start assisting the resident with their meal. Staff MM pulled the resident up in their WC by grabbing the back of their pants, did not perform hand hygiene, and sat down to continue assisting the resident with their meal. Staff MM pulled down the surgical mask they were wearing, blew on the resident's food to cool it down, and asked the resident is that better? as they placed the food into the resident's mouth. In an interview on 04/22/2025 at 2:54 PM, Staff Y, NA, stated hand hygiene was using alcohol-based (ABHR) hand rub when entering/exiting resident rooms or touching anything soiled. Staff Y stated staff should perform hand hygiene when indicated to prevent the spread of germs. Staff Y further stated staff should not blow on a resident's food to cool it down because it could spread germs. In an interview on 04/22/2025 at 2:57 PM, Staff H, Licensed Practical Nurse (LPN), explained hand hygiene was washing hands with soap and water for 20 seconds or using ABHR and should be performed before/after resident cares and before/after dispensing/administering medications. Staff H stated staff should perform hand hygiene when indicated to prevent the spread of infection from person to person. Staff H acknowledged staff should not blow on a resident's food to cool it down as that could spread germs. In an interview on 04/22/2025 at 3:16 PM, Staff C explained hand hygiene was washing hands with soap and water or using ABHR before/after resident cares, before applying gloves, and after glove removal. Staff C stated staff should perform hand hygiene when indicated to prevent the spread of germs and infections. Staff C acknowledged staff should not blow on a resident's food because staff could pass germs onto a resident's food. In an interview on 04/22/2025 at 3:25 PM, Staff D stated hand hygiene was washing hands with soap and water or using ABHR before entering a resident's room, after exiting a resident's room, between providing care to different residents, between delivering different resident meal trays, and after adjusting residents in their WCs. Staff D stated staff should perform hand hygiene when indicated to prevent the spread of microorganisms. Staff D acknowledged staff should not blow on a resident's food to cool it down because it was an infection control issue. In an interview on 04/22/2025 at 3:31 PM, Staff A, Administrator, stated they expected staff to change gloves and perform hand hygiene when indicated. Staff A acknowledged staff should not blow on residents' food to cool it down because that was a potential infection control issue. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference WAC 388-97-1320 (1)(a), -1320 (2)(b), -1320 (1)(c).

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 40297 Based on interview and record review, the facility failed to follow an established Antibiotic Stewardship Program (ASP) to promote the appropriate use of antibiotics (ABT) for newly admitted residents or those prescribed an ABT by community providers for 3 of 3 months (January, February, and March 2025) reviewed for infection control practices. This failure increased resident risk for multi-drug-resistant organisms (MDRO, germs that are resistant to many antibiotics) and had the potential for adverse outcomes with inappropriate and/or unnecessary use of ABT. Findings included . The 08/2023 facility policy titled Administrative Infection Control Processes documented the elements of the Infection Prevention and Control program included antibiotic stewardship. The staff used surveillance data to determine whether ABT usage patterns required change. The policy documented the facility used McGeer Criteria, a set of standardized definitions that helped identify potential infections and guided appropriate ABT use. A review of Monthly Infection Surveillance Logs for January, February, and March 2025 with Staff D, Infection Preventionist, occurred on 04/21/2025 at 8:44 AM. Staff D clarified that residents identified with CA [community acquired] infections, admitted from the hospital with an ABT or were prescribed the ABT by a community provider. Review of the January 2025 Monthly Infection Surveillance Log with Staff D showed 28 residents identified with CA infections received an ABT. The log showed no answer to the question, If ABT used, McGeer's minimum criteria met?, for eight of the 28 residents. Review of the February 2025 Monthly Infection Surveillance Log with Staff D showed 24 residents identified with CA infections received an ABT. The log showed no answer to the question, If ABT used, McGeer's minimum criteria met?, for nine of the 24 residents, N/A [not applicable] for four other residents, and No for one resident. Review of the March 2025 Monthly Infection Surveillance Log with Staff D showed 35 residents identified with CA infections received ABT. The log showed no answer to the question, If ABT used, McGeer's minimum criteria met?, for 31 of the 35 residents, No for one resident, and N/A for two other residents. On 04/21/2025 at 8:44 AM, Staff D acknowledged the ASP was not implemented for new admissions to the facility or residents prescribed an ABT by community providers. Staff D stated they did not apply the ASP process because, I am under the impression the hospital ensures McGeer is being followed on their end. No further information was provided. No Associated WAC

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to ensure 2 of 5 sampled residents (Residents 88 and 6) reviewed for infection control practices, received vaccinations for influenza and pneumonia as consented to. This failure placed the residents at risk of contracting pneumonia and influenza and potential complications associated with those illnesses. Findings included . Review of the 08/10/2023 facility policy titled Influenza Vaccine documented the facility offered residents an influenza vaccine within 5 working days of their admission to the facility between October 31st and March 31st (generally accepted as influenza season) each year. Review of the undated facility policy titled Pneumococcal Vaccine documented that before or upon admission, the staff assessed residents for eligibility to receive the pneumococcal vaccine series and, if indicated, offered the vaccine within 30 days of admission to the facility, unless previously received or medically contraindicated. <Resident 88> The 03/22/2025 admission assessment documented Resident 88 admitted to the facility on [DATE] with medically complex conditions. The assessment documented the resident had not received the influenza vaccine, the pneumococcal vaccine was not up to date, and neither vaccine was offered by the facility. Review of the medical record showed no documentation the facility screened Resident 88 for influenza and pneumococcal vaccination eligibility or offered them. The above findings were shared with Staff D, Infection Preventionist, on 04/22/2025 at 10:55 AM. Staff D stated they would grab consent. On 04/22/2025 at 1:10 PM, Staff D provided an undated but signed Vaccine Consent Form which showed Resident 88 requested both the influenza and pneumococcal vaccines. Staff D stated the consent was completed on 03/16/2025 and the pneumococcal vaccine was ordered just today. Staff D acknowledged it was past the 30 days for staff to offer Resident 88 the pneumococcal vaccine. No further information was provided to show what efforts the facility made to show they provided Resident 88 the influenza vaccine during the remaining influenza season. <Resident 6> The significant change assessment dated [DATE] documented Resident 6 admitted to the facility on [DATE] with medically complex conditions. The assessment documented the resident did not receive the influenza vaccine during the influenza vaccination season because it was not offered. An undated but signed Vaccine Consent form documented Resident 6 requested vaccination for influenza. The Vaccine Consent Form was scanned into the electronic medical record on 02/03/2025. Review of the February, March and April 2025 Medication Administration Records had no documentation Resident 6 received the influenza vaccination during the remaining influenza season as requested. (continued on next page)

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	505322	A. Building B. Wing	04/24/2025

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

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The above findings were shared with Staff D on 04/22/2025 at 1:10 PM. Staff D acknowledged Resident 6 should have but did not receive the influenza vaccine as consented to. Reference: WAC 388-97-1340 (1) (2) (3)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 42802 Based on observation, interview and record review, the facility failed to ensure equipment was maintained in a safe operational condition for 1 of 4 sampled residents (Resident 17) reviewed for environment. This failure placed the resident at risk of possible injury. Findings included . According to the 03/26/2025 admission assessment, Resident 17 was cognitively intact to make decisions regarding their care and able to make their needs known. On 04/15/2025 at 11:11 AM, Resident 17's call light/television (TV) cord was observed with various colored wire cords exposed near the control. The resident stated they told staff and asked if it could be replaced, but nothing had been done about it. Similar observations of the call light/TV cord with exposed wires were made on 04/17/2025 at 11:30 AM, 04/18/2025 at 1:45 PM, 04/21/2025 at 7:35 AM, and on 04/22/2025 at 9:22 AM. During an interview on 04/23/2025 at 9:26 AM, Staff G, Maintenance Director, stated if a call light was not working, there was usually a spare one in a drawer in the nurses station. For any non-urgent maintenance issues, staff filled out a work order on the computer. Staff G was informed of the observations of Resident 17's call light/TV cord with exposed wires. During a follow-up interview on 04/23/2025 at 10:36 AM, Staff G stated they replaced the call light in Resident 17's room. They verified that it was the first work order they received about the call light. Staff G stated that even though the break in the plastic did not go though the individual coating of the wires, it was still a safety issue and should have been replaced when first noticed. During an interview on 04/23/2025 at 10:55 AM, Staff C, Assistant Director of Nursing, stated they expected staff to let maintenance know when they noted any issues, and if it was urgent, they should inform management to contact Staff G. Staff C further clarified that Resident 17's call light should have been replaced as soon as staff noticed or were informed of it. Reference: WAC 388-97-2100

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 47328 Based on observation, interview and record review, the facility failed to repeatedly ensure residents' call lights were readily accessible for 2 of 4 sampled residents (Resident 21 and 65), reviewed for resident call systems. This failure placed residents at risk of potentially avoidable accidents, unmet care needs, and a diminished quality of life. Findings included . <Resident 21> The 03/29/2025 quarterly assessment documented Resident 21 had diagnoses that included muscle weakness and left below the knee amputation. Resident 21 was dependent on staff assistance to perform most activities of daily living (ADLs). Resident 21 had moderate cognitive impairment and was able to clearly verbalize their needs. The 01/09/2025 care plan documented Resident 21 was at risk for falls related to lower extremity weakness, impaired physical mobility, and a history of falls. Staff were instructed to anticipate Resident 21's needs, provide education and remind the resident to use their call light to request assistance with ADLs. On 04/14/2025 at 9:09 AM, Resident 21's room was observed. The right side of the bed was placed against the wall in a high position. The call light cord ran across the top of the over bed light fixture, the soft touch call light pad dangled down the wall, unreachable from the left side of the bed if sitting in a wheelchair. Similar observations were made at 10:09 AM, on 04/15/2025 at 8:45 AM, 10:37 AM, 12:06 PM, and 3:23 PM, on 04/16/2025 at 8:46 AM, 12:06 PM, and 2:38 PM, and on 04/21/2025 at 7:49 AM. On 04/21/2025 at 10:24 AM, Resident 21 was observed seated in their wheelchair on the left side of their bed watching television. The call light cord ran across the top of the overbed light fixture as previously observed. Resident 21 stated they were unable to reach the call light. They stated they would have to wait for staff to walk past their room and yell out for help if they needed assistance. During an interview on 04/21/2025 at 10:42 AM, Staff O, Registered Nurse, observed Resident 21's call light cord running across the top of the over bed light fixture and dangling down the wall. Staff O acknowledged Resident 21's call light should be within their reach so they could call for help when needed. <Resident 65> The 02/11/2025 admission assessment documented Resident 65 had diagnoses that included syncope (to faint) and collapse. Resident 65 sustained a fall in the month prior to admission and had a non-injury fall once admitted . (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 01/30/2025 hospital history and physical documented Resident 65 experienced a fall at home and was down for approximately an hour. Resident 65 had a history of falls, needed assistance with walking, had a soft-spoken voice, and spoke minimally, which was their baseline level of functioning. The 02/06/2025 care plan documented Resident 65 was at risk for falls related to cognitive and functional impairments, weakness, recent hospitalization , unsteady gait, and incontinence. Staff were instructed to anticipate Resident 65's needs, have the bed against the wall in the lowest position, place common items within reach, and educate the resident on safe transfers. The facility Incident Log documented Resident 65 sustained falls on 02/05/2024 at 4:50 PM (1 hour and 50 minutes after their admission), 02/13/2025, 02/28/2025, 03/12/2025, and 3/14/2025. On 04/14/2025 at 9:08 AM, Resident 65's room was observed. The right side of their bed was against the wall. The call light was pinned to the cord that came out of the wall, unreachable from the left side of the bed if sitting in a wheelchair. Similar observations were made at 10:09 AM, and on 04/15/2025 at 8:47 AM, and 10:37 AM. On 04/16/2025 at 8:47 AM, Resident 65's bed was observed in a high position. The call light was on the floor behind the bed. Similar observations were made at 12:06 PM, and 2:38 PM, on 04/17/2025 at 8:37 AM, and on 04/21/2025 at 7:48 AM and 10:25 AM. On 04/21/2025 at 10:37 AM, Staff P, Nursing Assistant, observed the call light on the floor with the surveyor and stated the call light needed to be left where the resident could call for assistance when they needed to. During an interview on 04/21/2025 at 10:54 AM, Staff A, Administrator, stated they expected their staff to leave resident call lights where residents could use them to call for assistance. Reference WAC 388-97-2280 (1)(a)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46115 Based on observation and interview, the facility failed to ensure a sanitary, comfortable and homelike environment for 1 of 7 sampled residents (Resident 87) reviewed for environment. This failure placed the resident at risk of an unpleasant, uncomfortable living environment and a decreased quality of life. Findings included . The 03/24/2025 quarterly assessment documented Resident 87 had diagnoses including heart failure, high blood pressure and depression. Resident 87 was cognitively intact and able to make their needs known. In an observation on 04/14/2025 at 1:33 PM, upon entrance to shared room [ROOM NUMBER], there was a very strong foul odor that resembled sweat and urine. The odor became stronger as you passed Resident 87's side of the room. Resident 87 shared a room with Resident 22. The 04/01/2025 significant change in condition assessment documented Resident 22 had diagnoses including diabetes, high blood pressure and depression. Resident 22 had moderately cognitive impairments and was able to make their needs known. In an observation and interview on 04/14/2025 at 1:33 PM, Resident 22 was lying in bed and their hair appeared greasy. Resident 22 stated they received a shower once a week when they allowed it. Resident 22's tray table was unclean with multiple napkins, a washcloth, container of ice cream that looked like it had been there for quite some time, the floor had food and fluid on it that had spilled. Subsequent observations of the foul odor in room [ROOM NUMBER] were made on 04/15/2025 at 12:12 PM, 04/16/2025 at 9:11 AM, 12:03 PM, and 2:52 PM, 04/17/2025 at 8:56 AM and 12:35 PM, and 04/18/2025 at 9:00 AM. In an interview on 04/17/2025 at 8:59 AM, Resident 87 was asked if the foul odor in the room bothered them, and they stated yes and they had mentioned it numerous times to the staff, but nothing was done. In an interview on 04/23/2025 at 12:15 PM, Staff OO, Licensed Practical Nurse, stated Resident 22 did not take showers very often and there was a foul odor in the room at times. Staff OO stated they smelled the odor when they entered the room to provide medications. In an interview on 04/23/2025 at 12:20 PM, Staff PP, Environmental Service Director, stated room [ROOM NUMBER] had a foul odor and they had replaced Resident 22's mattress a few times. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/23/2025 at 12:23 PM, Staff V, Social Service Director, stated room [ROOM NUMBER] had a foul odor as Resident 22 refused their showers. Staff V stated they had not spoken to Resident 87 regarding the foul odor in the room to determine if the condition of the room or the foul odor was bothersome to them. In an interview on 04/23/2025 at 1:47 PM, Staff C, Assistant Director of Nursing, stated Resident 22 refused cares and had a foul odor in their room off and on. Staff C stated they did not have a conversation with Resident 87 regarding the foul odor in the room. In an observation on 04/23/2025 at 1:54 PM, when Staff V informed Resident 87 they were being moved to a new room, Resident 87 stated that was great and thanked Staff V. Reference WAC 388-97-3220 (1)