STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505346	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheney Care Center	2219 North 6th Street Cheney, WA 99004

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based upon observation, interview, and record review, the facility failed to ensure adequate disposition of personal belongings upon admission, throughout their stay at the facility, and at the time of discharge, for 6 of 6 sampled residents (Residents 1, 2, 3, 4, 5 and 6) reviewed for missing items. This failure placed the residents at risk for loss of personal belongings and a diminished quality of life. Findings included . Review of a 06/2024 facility policy titled Resident Personal Belongings showed, the facility assured the resident's belongings were rightfully returned to the resident or their representative in the event of a death or discharge from the facility. This policy instructed the staff to inventory all personal belongings at the time of admission and retain documentation in the medical record. Staff would add additional possessions brought in during the duration of the resident's stay to the existing Personal Belongings Inventory List. Following the discharge or death of a resident, all personal clothing and items were given to the designated resident representative (RR) after being reviewed and examined by the facility and the RR. At the time of discharge or death, recipients of such personal items signed off the inventory list with their signature, acknowledging receipt of all personal belongings presented. Review of a facility form titled Personal Belongings Inventory List showed it instructed the staff to complete the form upon a resident's admission. The form also instructed the staff to ensure the form was signed and dated by the persons completing the form and filed into the resident's chart. The form instructed the staff that valuables, HAVE TO BE photographed and placed in the resident's chart. <Resident 1> Review of the medical record showed Resident 1 admitted to the facility on [DATE]. Review of a 10/31/2024 progress note showed Resident 1 discharged from the facility to the community on 10/31/2024, with all paperwork, personal belongings and medications. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505346	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheney Care Center	2219 North 6th Street Cheney, WA 99004

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 11/15/2024 at 3:37 PM, Resident 1's RR stated that the facility packed up Resident 1's belongings and sent them with the resident to the community placement at the time of discharge. The RR stated that when they helped Resident 1 settle in their new living arrangement in the community, only one of the Nike pair of sneakers were sent. The RR stated that amidst the belongings, the facility also sent, a whole bunch of single shoes that weren't even [the resident's], and clothing items that did not belong to Resident 1. Review of the medical record showed a 02/23/2024 Personal Belongings Inventory List. The list showed no personal belongings, like clothing or shoes, were accounted for at the time of admission, throughout the resident's stay, and at the time of discharge. The inventory list only showed a brown lift chair. <Resident 2> In an interview and observation on 11/15/2024 at 8:50 AM, Resident 2 presented alert and oriented, sitting on the edge of the bed with personal clothing on. Resident 2 stated that, five or six night shirts, expensive and are satin, went missing. Review of the medical record showed Resident 2 admitted to the facility on [DATE]. Review of a 05/01/2024 Personal Belongings Inventory List showed various valuables, to include a gold necklace and gold watch, two rings, a purse and wallets. Miscellaneous items, multiple clothing items to include 9 blouses all different designs, and additional items were included. The form was signed by a staff and the resident with an incomplete date. Record review showed no photographs of the items listed in the Valuables section in the medical record. <Resident 3> An observation on 11/15/2024 at around 9:00 AM showed Resident 3 in their wheelchair completing oral hygiene. Resident 3 presented well dressed and groomed. Review of the medical record showed Resident 3 admitted to the facility on [DATE]. Review of the Personal Belongings Inventory List showed it was undated, unsigned, and no clothes added to the Clothing List section. Under Miscellaneous Items, subsection Luggage category, the words clothes? And white tennis shoes were handwritten next to it. Under the Valuables section, it showed a cell phone and eyeglasses. Record review showed no photographs of the items listed in the Valuables section in the medical record. <Resident 4> An observation on 11/15/2024 at 9:17 am showed Resident 4 sitting in their recliner. A blanket was over their lap. The resident lived in a private room which was personalized and decorated. Resident 4 was dressed in personal clothing. Review of the medical record showed Resident 4 admitted to the facility on [DATE]. The medical record showed no documentation the facility completed or maintained a Personal Belongings Inventory List to account for Resident 4's belongings over the past seven years they resided in the facility. <Resident 5> (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505346	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheney Care Center	2219 North 6th Street Cheney, WA 99004

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 11/15/2024 at 9:34 AM showed Resident 5 in their room, alert and oriented, well groomed, and in a colorful dress that belonged to them. With the resident's permission, an observation of items inside their closet was completed. The observation showed 6 additional dresses, two jackets, a fleece gown, and a red bath robe. Review of the medical record showed Resident 5 admitted to the facility on [DATE]. Review of the 05/01/2023 Personal Belongings Inventory List showed it was signed by both the staff and Resident 5. The list showed the staff only accounted for one clothing item, one red bathrobe, and did not update the list to account for Resident 5's current clothing items. The Valuables section showed multiple items, to include 2 purses/wallets and a pair of eyeglasses. Record review showed no photographs of the items listed in the Valuables section in the medical record. <Resident 6> An observation on 11/15/2024 at 9:56 AM showed Resident 6 in a private room, well dressed and groomed. Record review showed Resident 6 admitted to the facility on [DATE]. Review of an undated and unsigned Personal Belongings Inventory List showed under Valuables, a pink purse and wallet but no indication of its contents, two pairs of glasses, a hearing aid, a cell phone, and next to subsection iPad/Tablet, the staff accounted for one tablet - blue case. Record review showed no photographs of the items listed in the Valuables section in the medical record. In an interview on 11/22/2024 at 9:23 AM, Staff B, Nursing Assistant, stated that when a resident admitted to the facility, there's a piece of paper we are given that keeps a record of the resident's belongings. Staff B stated that throughout a resident's stay in the facility, the staff accounted for clothing by writing the resident's name on the item with a Sharpie marker or have activities make a label then put it in the closet. Staff B stated that the clothing, ends up being added to the belongings list and did not know where the actual Personal Belongings Inventory Lists were located after admission. Staff B stated that if additional personal items were brought into the facility, they would label it and then inform laundry personnel or the nurse manager. Staff B stated that after admission of a resident, Somebody else updates the belonging list. Unsure who updates it. Staff B stated that at the time of discharge, they checked the resident's current belongings against the Personal Belongings Inventory List and if an item was missing, we look for it. The above information was shared with Staff A on 11/22/2024 at 11:23 AM. Staff A confirmed that an updated or current Personal Belongings Inventory List would be found in the electronic medical record. Upon review of the medical records of the sampled residents, Staff A acknowledged the incomplete, inaccurate, and missing Personal Belongings Inventory Lists. Staff A acknowledged the medical record did not show adequate disposition of the residents' personal belongings. Reference WAC 388-97- -0880(1), -0860(1-2), -0560(1)(a-c).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505346	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheney Care Center	2219 North 6th Street Cheney, WA 99004

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to implement their Abuse and Neglect Prohibition Policies and Procedures to include, not reporting or investigating an elopement and resident-to-resident altercation for 1 of 6 sampled residents (Resident 1) reviewed for accident hazards. This failure placed the resident and other residents at risk for repeated abuse and elopement and precluded the state agency (SA) from being aware of and investigating the circumstances surrounding the resident's elopement and resident-to-resident altercation. Findings included . Review of an undated facility policy titled Abuse, Neglect and Exploitation showed, the facility would immediately investigate when suspicion or reports of abuse, neglect or exploitation occurred. The policy directed the facility to identify and interview all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. The policy instructed the facility to report all alleged violations to the Administrator, SA, and all other required agencies immediately, but not later than two hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse nor resulted in serious bodily injury. Review of Appendix D in the October 2015 Nursing Home Guidelines The Purple Book showed, it instructed the facility to log elopements or missing resident events and resident-to-resident altercations in the SA Log within five days of event discovery. The facility would additionally report resident-to-resident altercations with psychological or physical harm and elopements/missing person events to the SA Hotline. Review of a 09/18/2024 annual assessment showed Resident 1 readmitted to the facility on [DATE]. This assessment showed the staff assessed Resident 1 had severe cognitive impairment and required partial to moderate assistance to mobilize in a wheelchair. <Resident to Resident Altercation> Review of a 07/17/2024 progress note showed the staff observed Resident 1 talking to another resident at the nurses' station. The staff witnessed the other resident said something to Resident 1, then Resident 1 yelled at the other resident and grabbed them by the arm. The staff removed the residents from the nurse's station. Review of the July 2024 SA log showed no documentation the facility reported the resident-to-resident altercation to the SA or completed a thorough investigation to prevent recurrence and rule out abuse or neglect. The above findings were shared with Staff A, Director of Nursing, on 11/22/2024 at 10:50 AM. Staff A confirmed the facility did not report the resident-to-resident altercation to the SA or complete a thorough investigation upon review of the SA log and medical record. Staff A stated, We probably didn't know about it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505346	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheney Care Center	2219 North 6th Street Cheney, WA 99004

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Elopement> Review of a 07/26/2024 progress note showed the staff identified Resident 1, Exited out the activities door on northside of facility via w/c [wheelchair]. The staff asked the resident where they were going and the resident told the staff, Just looking at the cars but I am ready to go back inside . The progress notes showed the incident occurred at 8:00 PM. In an interview on 11/22/2024 at 10:34 AM, Staff A defined elopement when a resident left the facility unattended and without prior arrangement, without supervision or assistance. Staff A stated that the staff incidentally found Resident 1 outside on the parking lot. When asked how long Resident 1 sat outside unsupervised, Staff A stated that the resident, was found like in less than a half an hour. Review of the SA log with Staff A showed the facility logged the elopement event but no findings or actions were identified to show the facility completed a thorough investigation of the event. Review of a 07/26/2024 investigation showed no conclusion of the event, no staff interviews, and no determination of how the resident went outside of the facility and unsupervised at 8:00 PM. In an interview on 11/22/2024 at 10:45 AM, Staff A acknowledged the facility did not complete a thorough investigation of the elopement event and stated, It [the investigation] doesn't look very good. Staff A acknowledged the facility should have but did not report the elopement to the SA Hotline as instructed in the October 2015 Nursing Home Guidelines The Purple Book. Staff A acknowledged the facility did not follow its abuse and neglect policies and procedures. No further information was provided. Reference WAC 388-97-0640(2).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505346	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheney Care Center	2219 North 6th Street Cheney, WA 99004

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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. 40297 Based on interview and record review, the facility failed to provide and document sufficient preparation or orientation for a safe discharge for 1 of 4 sampled residents (Resident 1) reviewed for discharge planning. This failure placed the resident at risk for unmet care needs and a diminished quality of life. Findings included . Review of a 01/2024 facility policy titled Transfer and Discharge showed, the nurse who cared for the resident would ensure a Discharge Summary was completed for anticipated or resident-initiated discharges. The summary would show a description of the resident's stay that included their diagnoses, the course of illness/treatment or therapy, any pertinent labs, radiology and consultation reports, and a final summary of the resident's status. In an interview of 11/15/2024 at 11:37 AM, Resident 1's Representative stated that when the resident was discharged to a community provider, the facility did not send with the resident their medical file and that the receiving provider had zero idea what was going on with [Resident 1]. Review of progress notes showed the staff identified Resident 1 experienced a change in condition on 10/19/2024. The staff transferred the resident to the hospital. On 10/20/2024, the staff followed-up with the hospital and were told Resident 1 experienced a stroke. Review of a 10/22/2024 progress note showed the community provider that accepted Resident 1 called the facility for an update. The nurses informed the owner of the [community] home that the hospital states resident is back at baseline and the facility would give owner a call back with an update. Review of the medical record showed the resident readmitted to the facility from the hospital also on 10/22/2024. A 10/24/2024 facility provider note showed they saw Resident 1 for follow-up after hospital readmission and blood in urine yesterday in the shower. The provider acknowledged the stroke diagnosis and that the resident was on antibiotics from the hospital secondary to a current urinary tract infection (UTI). The provider notes showed that therapy evaluated the resident and recommended a skilled nursing facility. The provider requested a repeat of the urine sample due to fever and possible UTI. Review of a 10/29/2024 progress note showed the urine sample resulted positive for UTI with yeast present. Culture results pending. The staff notified the provider that Resident 1 was expected to discharge to [the community] this week. The provider gave no new orders as the resident was on continued antibiotics and cleared [the resident] for discharge from a medical standpoint and will need to continue with follow up at [community setting]. Review of 10/31/2024 progress notes showed the nurses, assisted resident and medical records into the van for discharge and with all paperwork, personal belongings, and medications. Record review showed no results for the pending urine culture. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505346	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheney Care Center	2219 North 6th Street Cheney, WA 99004

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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a 10/29/2024 Transfer/Discharge Report showed Resident 1's basic demographics information, diet type, and contact information for provider and primary contacts. The report showed a list of diagnoses and medications with instructions for administration. Under Chief Complaint, the report showed, Family requested transfer to a lesser care setting. All items under Relevant Information were blank, to include behaviors, mobility status, bladder and bowel patterns, eating, and usual level of functioning. The report showed, Resident physician to be established upon admission. Review of the medical record showed no documentation the staff communicated to the receiving community provider Resident 1's needs, their clinical background, a final summary of the resident's status, and a post discharge plan of care to assist Resident 1 adjust to their new living environment and have their clinical needs met. In an interview on 11/21/2024 at 12:34 PM, a Collateral Contact (CC) from the community setting where Resident 1 was discharged to was asked what kind of communication or discharge paperwork they received from the facility. The CC stated, They give me the Transfer/Discharge Report. That's all they sent. The CC stated that the facility did not send a care plan, No, no. They didn't send me anything else. They didn't give me any more information than that. The CC stated that the last time they had a discussion with the facility about Resident 1's discharge was when the resident was still at the hospital and were informed that once the resident returned and stabilized, the community discharge would resume. The CC stated, No paperwork [was] received then or afterwards to update them on Resident 1's status. The CC stated that they communicated with a State Agency (SA) to coordinate Resident 1's admission to the community setting. In an interview on 11/21/2024 at 12:44 PM, the SA CC stated that they came to find out that the facility discharged Resident 1 to the community provider after the resident representative called me and the resident was back at the hospital from the [community setting] with a urinary tract infection and kidney stones. The SA CC stated, It did not sound like it was a good discharge plan, that it seemed rushed and did not ensure proper precautions to ensure safety. I don't think they included me in the discharge planning after I found placement [for the resident]. Review of an 11/03/2024 hospital record showed Resident 1 readmitted to the hospital from the community setting. The record showed the resident presented to the hospital with altered mental status and urinary complaints. Workup reveals sepsis [a life-threatening medical emergency that occurs when the body's immune system overreacts to an infection or injury] secondary to UTI, obstructing kidney stone, and possible pneumonia. The hospital started Resident 1 on intravenous (by vein) antibiotics. The above information was shared in a joint interview with Staff A, Director of Nursing, and Staff C, Resident Care Manager on 11/22/2024 at 11:10 AM. Staff A stated that at the time of a planned discharge to the community, they expected the nurse to send with a resident a face sheet, orders, progress notes, a care plan and probably like the last two or three history and physical [notes] and physician visits. Staff C stated that when Resident 1 discharged to the community provider, We sent the face sheet. Staff A and C were asked to describe what kind of follow-up Resident 1 required at the community setting. Staff A stated, I don't know and Staff C stated, I did not discuss that. I should've included that in my conversation [with the community provider]. Both Staff A and C acknowledged the facility did not adequately communicate or sufficiently provide relevant and vitally important information to the receiving community provider to ensure a safe and orderly discharge process for Resident 1. Reference WAC 388-97-0120 (3)(a).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505346	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheney Care Center	2219 North 6th Street Cheney, WA 99004

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to ensure the staff implemented recommendations to help prevent kidney stones for 1 of 6 sampled residents (Resident 1) reviewed for urinary tract infections (UTI). This failure placed the resident at risk for repeated kidney stone development and associated discomfort. Review of the medical record showed Resident 1 readmitted to the facility on [DATE]. Review of the diagnoses list showed but was not limited to, dementia, a history of UTI, kidney stones, and chronic kidney disease. Review of a 04/10/2024 Urology (branch of medicine that focuses on surgical and medical diseases of the urinary system and the reproductive organs) Visit Summary showed Resident 1 was seen for kidney stones. In this visit, the provider removed a stent (tube that allows urine to flow from the kidneys into the bladder) and gave the following recommendations to help prevent kidney stones, Drink 8 - 10 cups (64 - 80 ounces) of water daily to maintain proper hydration, which dilutes urine and reduces kidney stone risk. Limit sodium intake to less than 2,300 mg [milligrams, a unit of measurement]/ [per] day and consume an appropriate amount of dietary calcium. Reduce high-oxalate sodium- rich foods such as dark [NAME] or energy drinks. Include citrus fruits in your diet for their citrate content, which helps prevent stone formation. [NAME] light is a lemonade drink powder that is high in citrate and orange juice is a healthier alternative. Review of Resident 1's 04/19/2024 nutrition care plan showed no instruction to the staff to limit high oxalate and sodium rich foods, the amount sodium intake was limited to, or include citrus fruits in their diet. A bladder incontinence CP showed, Encourage fluids during the day to promote prompted voiding (10/15/2021) but no specific interventions to prevent kidney stones as recommended by the urology clinic, like drinking eight to 10 cups of water daily. Review of a 05/30/2024 and 09/20/2024 Nutrition Assessment showed Resident 1, has been having recurrent UTIs. Those and a 10/29/2024 Nutrition Assessment, showed no documentation the facility acknowledged the urology clinic recommendations to help prevent kidney stones and incorporate it in the resident's nutrition plan of care. Review of a physician order summary showed, a No Added Salt diet started on 10/22/2024, six months after the initial recommendation for sodium intake limit was made by the urology clinic. The above findings were shared with Staff A, Director of Nursing, on 11/26/2024 at 11:01 AM. Staff A described that when the staff received recommendations from community providers, the nurses reviewed the visit summary, then forwarded them to the facility provider for final review and approval. Staff A acknowledged the staff did not implement recommendations from the urology clinic to help prevent kidney stones and stated, Doesn't look like it happened. Reference WAC 388-97-1060 (3)(c).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505346	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheney Care Center	2219 North 6th Street Cheney, WA 99004

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to ensure the staff provided and monitored the required amount of fluids to ensure adequate hydration for 1 of 6 sampled residents (Resident 1) reviewed for hydration. This failure placed the resident at risk for outcomes associated with insufficient fluid intake, like dehydration and urinary tract infections (UTI). Findings included . Review of a 09/18/2024 annual comprehensive assessment showed Resident 1 admitted to the facility on [DATE] with medically complex conditions. The assessment showed the staff assessed Resident 1 to have severe cognitive impairment and was independent with eating. In an interview on 11/14/2024 at 3:45 PM, a Collateral Contact stated that the staff, didn't hydrate [Resident 1] enough and that's why [the resident] ended up in the hospital with a urinary tract infection (UTI). Review of a 01/2024 facility Hydration policy showed, sufficient fluid was the amount needed to prevent dehydration and maintain health. The amount of fluid needed was specific for each resident and changed as the resident condition fluctuated. Review of a 04/10/2024 Urology (branch of medicine that focuses on surgical and medical diseases of the urinary system and the reproductive organs) Visit Summary showed the provider recommended to Resident 1 to, Drink 8 - 10 cups (64 - 80 ounces) of water daily to maintain proper hydration, which dilutes urine and reduces kidney stone risk. Eight to 10 cups of water were the equivalent of 1,920 to 2,400 cc (cubic centimeter, a unit of measurement). Review of a 04/19/2024 Nutrition Assessment showed the Registered Dietitian (RD) assessed Resident 1 secondary to a change in condition unrelated to nutritional needs. The RD assessed Resident 1 required 1800 cc of fluids daily. Review of Resident 1's September and October 2024 Medication Administration Record (MAR) showed an order that instructed the staff to, Encourage fluids since 04/19/2024. The MARs showed no documentation the staff provided fluids to Resident 1. Review of fluid intake flowsheets showed it instructed the staff to document the Amount of Fluids taken in CC's. For September 2024, the documented amount of fluids the staff provided to Resident 1 was below 1, 000 cc for 26 of the 30 days reviewed. For October 2024, the documented amount of fluids the staff provided to Resident 1 was below 1,000 cc for 22 of the 31 days reviewed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505346	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheney Care Center	2219 North 6th Street Cheney, WA 99004

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The above findings were shared with Staff A, Director of Nursing, on 11/22/2024 at 10:00 AM. Staff A stated that the staff documented the fluid intake of residents to help determine if the resident is having difficulty hydrating and to have a better idea if they are meeting hydration goals. Staff A was asked who monitored fluid intake and they stated that the Resident Care Manager, the providers, and the RD looked at it when residents had symptoms of fluid overload, repeat UTI, or low blood sodium levels. Staff A stated that Resident 1 had an order for staff to encourage fluids, probably because of [their] history of UTI. Staff A stated that when a resident did not meet fluid goals, they expected the staff to find out why the resident was not drinking the recommended amount of fluids. No further information was provided. Reference WAC 388-97-1060 (3)(i).