STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505379	A. Building B. Wing	05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Park Health & Rehabilitation Center	7411 North Nevada Spokane, WA 99208

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 27590 Based on interview and record review, the facility failed to provide care in a manner that promoted resident dignity for 1 of 2 sample residents (Resident 1), reviewed for dignity. The facility failed to dress Resident 1 in appropriate attire before going to an appointment in the community. This failure placed Resident 1 and other residents at risk for embarrassment and diminished self-worth. Findings included . According to the 03/10/2024 facility assessment, Resident 1 had diagnoses which included blindness, a fracture and dementia. The resident was moderately impaired with decision making. Resident 1 required moderate assistance for dressing their upper body, and dependent on staff to dress their lower body. On 04/30/2024 at 09:45 AM, a State Agency representative stated they had received information Resident 1 was not dressed appropriately when they went out for an appointment. The person they spoke to was very upset and stated Resident 1 was in a night gown and had a saturated brief. On 04/30/2024 at 10:15 AM, a Collateral Contact (CC) was interviewed. The CC stated they went to meet Resident 1 at their appointment and found Resident 1 wandering, dressed in a large night gown (stating it didn't belong to the resident), no undergarments or socks on, and was wearing a sweater. The CC stated in addition, the resident was blind, did not have their hearing aides in and their hair had not been combed and was matted to their head. On 05/13/2024 at 2:28 PM, Staff C, Resident Care Manager (RCM), stated Resident 1 was very particular about their clothing and appearance, as well as the family. The day the resident went out to their appointment, Staff B, RCM, was working and saw the resident. Staff C stated the resident had refused to change clothing at times, but this was not their norm. Staff were expected to tell the nurse if a resident refused to be changed and re-approach. With Resident 1, Staff C stated they would have called the resident's family, who was very involved with the resident's care, to see if they could talk to the resident about changing clothes. On 05/13/2024 at 12:56 PM, Staff A, Social Services Director (SSD), stated they had gotten a call about how the resident went to their appointment. The resident's hair wasn't combed and they had another resident's gown on. Staff A stated they had received concerns prior to this when the resident would go out of the facility to visit or have dinner and they wouldn't be dressed appropriately. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/13/2024 at 2:44 PM, Staff D, Nursing Assistant (NAC), stated when a resident had an appointment, they were told by the nurse when the resident needed to be ready. If the resident had inappropriate clothing on for an appointment, Staff D would talk with the resident about being changed to go out of the facility. If the resident continued to refuse, the nurse would be notified. Staff D went on to say sometimes it took another staff member to approach a resident and they would be more receptive to them. If a resident continued to refuse to change, Staff D would let the nurse know. On 05/14/2024 1:35 PM, Staff B stated they worked the morning of Resident 1's appointment. Staff had brought Resident 1 out of their room with a gown on with a jacket over it and their hair was not combed. Staff B explained to the staff the resident could not go out to an appointment dressed they way they were and to take the back into the room to be dressed appropriately. Staff B did not hear anything after talking to staff and didn't see the resident until they came back to the facility from the appointment. The resident was dressed in the same way as they had seen prior to the appointment. Staff B stated they would expect staff to re-approach a resident if they refused to be changed and if they continued to refuse, talk to the RCM. REFERENCE: WAC 388-97-0180(1-4).

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 27590 Based on interview and record review, the facility failed to provide notification to the resident's representative of a change in condition for 1 of 3 sample residents (Resident 2), reviewed for notification of change. This failure prevented the resident's representative from being informed of Resident 2's worsening condition until the resident was being sent to the hospital. Findings included . The 03/04/2024 assessment showed Resident 2 had a spinal cord dysfunction and inability to move their lower extremities. Resident 2 was able to make their needs known. During an interview on 04/08/2024 at 1:50 PM, a Collateral Contact (CC) stated the resident's representative attended a care conference 03/19/2024 and was told Resident 2 was doing well. The CC stated the representative would get several phone calls a day from Resident 2 and those calls stopped, which was a concern. The CC went in to visit the resident and described the resident as listless (lack of energy). The CC stated no one had called and told them the change in the resident. The CC asked staff to have Staff F, facility physician, call them about the resident's condition. The CC did not receive a call until three days later when they were informed the resident was being transferred to the hospital. The CC stated, why didn't anyone call us to inform us [Resident 2] was sick prior to them going to the hospital? Progress notes were reviewed which showed a note on 04/04/2024 documenting the resident was nauseated and had not felt like eating the past few days. There was no documentation to show the resident's representative and/or family was notified of a change in condition until 04/08/2024, the day the resident was sent to the hospital. Review of Staff F's notes, dated 04/08/2024, showed the resident was seen for follow-up related to nausea. The resident had been having intermittent nausea and refused some meals. When the provider went in to see the resident, the resident was described as lethargic (fatigue and low energy) and was not able to respond well to Staff F's questions. The resident's family member was called and agreed for the resident to be sent to the hospital. During an interview on 05/13/2024 at 2:10 PM, Staff E, Director of Nursing, stated the facility didn't have a specific policy for a change in condition but used the standards of care. Staff would notify the provider and family at the time of the change, the resident would be placed on alert and monitored. Reference (WAC) 388-97-0320

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 27590 Based on interview and record review, the facility failed to consistently monitor and document a condition change for 1 of 3 residents (Resident 2), reviewed for change in condition. This failure placed residents at risk for worsening medical conditions and unmet care needs. Findings included . Review of a facility assessment, dated 03/04/2024, showed Resident 2 had a spinal cord dysfunction and was unable to move their lower legs. The resident was able to make their needs known and was dependent on staff for mobility in and out of bed. Review of nursing progress notes from 04/04/2024 through 04/08/2024 showed a note on 04/04/2024 related to the resident being nauseated and had not felt like eating the past few days. There was no further documentation of the resident's condition until 04/08/2024, when the resident was seen by Staff F, physician, and sent to the hospital. Review of a progress note by Staff F dated 04/08/2024, showed the resident was seen for follow-up related to nausea. When the provider went in to see the resident, the resident was lethargic (fatigue and low energy) and was not able to respond well to Staff F's questions. The resident's family member was called and agreed for Resident 2 to be sent to the hospital. On 05/13/2024 at 2:49 PM, Staff G, Licensed Nurse (LN), stated when a resident had a change in condition they would go and assess the resident. The provider would be called and any orders given would be followed. The family would be notified as well. The resident would then be put on alert charting and any changes would be placed in the nurse progress notes. During an interview on 05/13/2024 at 2:28 PM, Staff C, Resident Care Manager (RCM), stated if a resident had a change in condition the nurse would notify the provider, RCM, and Director of Nursing (DON). The resident would be on alert charting and documentation would be found in the nurses progress notes. The family would also be notified of any change in the resident. Staff C had been approached by nursing on 04/04/2024 and stated Resident 2 had been having nausea and not eating well. Staff C stated they were off a few days and when they returned on 04/08/2024, Resident 2 was sent to the hospital by Staff F. During an interview on 05/13/2024 at 2:10 PM, Staff E, DON, stated the facility didn't have a specific policy for a change in condition but used the standards of care. Staff would notify the provider and family at the time of the change, the resident would be placed on alert charting, monitored for any changes, and documentation would be in the progress notes. Additional information was requested related to the resident's change in condition and nothing further was provided. Reference: WAC 388-97-1060(1)