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	04/14/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 27590 Based on observation, interview, and record review, the facility failed to provide adequate staff supervision for the bed mobility and reassess a resident's ability to assist after a room change and level of consciosness to prevent accidents for 1 of 3 sampled residents (Resident 2), reviewed for falls. Resident 2 experienced harm when they were rolled toward the edge of their bed by a staff member during a bed linen change, rolled off the bed headfirst onto the floor, required transfer to the hospital and sustained a subdural hematoma (a serious condition where blood collects between the skull and the surface of the brain, usually caused by a head injury). Findings included . Review of a facility assessment, dated 02/07/2025, showed Resident 2 had diagnoses to include heart failure, below the knee amputation, and obesity. Resident 2 was able to make their needs known. The Care Area Assessment summary (CAA), for functional ability, showed the resident had impaired functional mobility and was dependent on staff to transfer, toilet, and for bed mobility. During an observation and interview on 04/14/2025 at 12:50 PM, Resident 2 was lying in bed. The resident's bed was in an elevated position, the resident said they controlled their own bed. The resident had red areas around their left and right eye and yellow/black bruising on the left side of their forehead. Resident 2 was asked if they had pain and stated they had a headache which they have had since the fall. The resident stated they were rolled to be changed and fell off the bed. Resident 2 stated they went head first onto the floor. I woke up as I was falling to the floor. Resident 2's care plan, dated 08/23/2024, showed the resident required extensive assistance of one - two staff for bed mobility. On 04/02/2025 the resident's care plan was updated to have extensive assistance of two staff, one on each side of the bed. Review of the facility investigation, dated 04/01/2025, showed the nurse went to Resident 2's room around 4:30 AM after Staff D (nursing assistant certified - NAC) had called for assistance. The resident was lying on the floor, next to the bed, and the bed was in an elevated position. The resident stated they fell headfirst out of their bed. Emergency personnel were called and the resident was transferred to the hospital. The cause of the fall was determined to be related to the resident went to sleep during care, was rolled to their side towards the edge of the bed, and the size of the resident. The NAC needed assistance of another staff member to prevent a fall and injury. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a statement by Staff D, dated 04/01/2025, showed the Resident 2 was incontinent of bowel so needed changed. Staff D documented they asked the resident to stay awake during care but the resident went back to sleep. When Staff D rolled the resident towards them, they rolled off the bed. During an interview on 04/08/2025 at 10:30 AM, Staff C, NAC, was asked if a resident's bed mobility was an extensive assistance of one - two staff, how would they determine the number of staff needed. Staff C stated it would depend on if the resident could assist or not. If they could, they would do care with one, if not, they would have a second staff member assist. When asked about Resident 2, Staff C stated they always used two staff, even though the resident could grab onto the mattress, for safety. During an interview on 04/14/2025 at 10:22 AM, Staff E, NAC, stated if they needed to do care for a resident, they would determine how well the resident could assist them in order to determine if they needed a second staff member. When asked about Resident 2, Staff E stated prior to the resident's room move, the resident's bed was against the wall. The resident was able to grab the mattress to roll and then put their hand on the wall to brace themselves. On 04/14/2025 at 11:30 AM, Staff F, Resident Care Manager (RCM), stated when a resident was a one - two extensive assist with bed mobility, the staff would determine what the resident could do to help. Staff F stated Resident 2 was a one - two assist before the fall. Prior to the resident's room move, the resident's bed was against the wall and when rolled, the resident would put their hand on the wall. In their current room, the resident chose not to have the bed against the wall which could make it less safe to use one staff member. The resident's care plan was updated to have 2 staff, one on each side of the bed. On 04/14/2025 at 2:15 PM, Staff B, Director of Nursing (DNS), stated if a resident was a one - two extensive assist in bed, staff would determine the extent the resident could help. Resident 2 could usually help some when rolled in bed. Resident 2 was rolled toward Staff D during care and rolled out of the bed. Staff D was not able to hold the resident when they started to fall because of the resident's size. On 04/17/2025 at 9:45 AM, Staff D was interviewed and stated when they went to check on the resident, about 4:00 AM, the resident had been incontinent and needed changed. Staff D stated Resident 2 was able to help roll in bed but at times the resident would not comprehend what was going on and it was more difficult to keep the resident awake, like the night of the fall. Staff D stated they tried to keep the resident awake, rolled the resident toward them, and the resident rolled off the bed. Staff D was not able to stop the resident due to their size. Reference: WAC 388-97-1060(3)(g)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 27590 Based on interview and record review, the facility failed to administer the correct dose of pain medication for 1 of 3 sampled residents (Resident 1), reviewed for medication errors. Resident 1 experienced experienced harm when they had uncontrolled pain that required hospital transfer when Staff administered 50 mg of Tramadol (an opioid medication used for moderate to severe pain) instead of 100 mg, as ordered. Findings included . Review of a facility assessment, dated 03/17/2025, showed Resident 1 was admitted with diagnoses to include sciatica (a condition where a nerve root in the lower back was compressed or irritated which could cause pain and radiated down the leg along the affected nerve) and a progressive neurological disorder that affected movement. Resident 1 was able to make their needs known. Review of the Resident 1's care plan, dated 03/13/2025, identified the resident was on pain medication therapy. Saff were to administer the pain medications as ordered by the physician, monitor for side effects and effectiveness of the medication. Review of a facility investigation, dated 03/25/2025, showed the resident had only received one 50 milligram (mg) tablet of Tramadol instead of two 50 mg tablets (total of 100 mg) which was ordered. The resident had severe pain that was not fully alleviated with the 1 tablet. The resident was sent to the hospital later in the evening for uncontrolled pain. Review of Staff A, Licensed Practical Nurse (LPN) interview during the investigation showed the resident was medicated with Tramadol at 9:30 PM, the nurse followed up with the resident who continued to complain of severe pain. The resident was given Tylenol and continued to rate their pain as a 10 (scale 0 - 10; 0 no pain, 10 worst pain possible). The provider was called and the resident was sent to the hospital. Review of the resident's Medication Administration Record (MAR) for March 2025 showed the Resident 1 had an order for Tramadol 50 mg every six hours as needed and 100 mg scheduled at bedtime. The resident was also taking a muscle relaxant and a medication for nerve pain. Review of hospital records showed the resident arrived at the emergency room (ER) at 12:40 AM on 03/26/2025, complained of right leg pain, and rated it an 8 out of 10 (8 - intense pain, physical activity is severely limited). During an interview on 04/14/2025 at 1:30 PM, Staff B, Director of Nursing (DNS), stated Staff A no longer worked at the facility and confirmed Resident 1 had an order to give 100 mg of Tramadol in the evening and only received 50 mg. Staff B stated the facility reviewed ER transfers and that was how they discovered the medication error. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 04/15/2025 at 2:15 PM, Resident 1 was interviewed. The resident stated they asked the nurse to start with only 50 mg of Tramadol and if the pain continued, they would ask for the other 50 mg. When Resident 1 realized they needed the second tablet for pain, the nurse refused to give it to them, and told the resident they didn't not have an order for more. Resident 1 told Staff A they only had half the ordered amount and Staff A stated they were not getting more. The resident was then sent to the hospital with uncontrolled pain. Reference: WAC 388-97-1060(1)