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	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Park Health and Rehabilitation	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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Based on interviews and record review the facility failed to ensure pharmacy services were provided to meet the needs of 1 of 3 sampled residents (Resident 1) reviewed for medication management. The failure placed residents at risk for adverse events related to missed medications.Findings included .<Resident 1>Review of Resident 1's care plan, dated 02/06/2025 showed they had a diagnosis of a shoulder fracture and chronic pain. The same care plan had interventions, dated 02/11/2025, that included: the resident's pain is alleviated/relieved by rest and medications and administer analgesia (pain medication) as per orders. Review of the resident's admit orders, dated 02/06/2025, showed the following narcotic pain medication:-Morphine 30 mg (milligram) immediate release (IR) (a short acting, strong narcotic pain medication): Take 1 tablet by mouth twice daily. Review of Resident 1's Medication Administration Record (MAR) for August 2025 showed an order dated 02/06/2025, for Morphine 30 mg to be given two times daily at 7:00 AM and 7:00 PM. On 08/07/2025 at 7:00 PM the MAR shows code OO (on order). On 08/08/2025 at 7:00 AM the MAR shows code 9 (other/see progress note). On 08/08/2025 at 7:00 PM the MAR shows code OO.Review of Resident 1's progress notes showed on 08/07/2025 at 9:20 PM, Staff D, Licensed Practical Nurse (LPN), wrote the residents Morphine 30 mg was on order from the pharmacy. On 08/08/2025 at 8:04 AM, Staff E, Registered Nurse (RN), wrote, med not available, pharmacy called and [stated] need new script provider called, waiting for script to be sent to pharmacy. Further review showed that on 08/08/2025 at 3:22 PM, Staff D, wrote, called pharmacy to check on status of Morphine order, was told that 60 tabs would arrive on the morning run. On 08/09/2025 at 2:41 PM Staff F, RN, wrote Pt endorsed withdrawal from morphine. Had missed 2 doses before MSER (morphine extended release) arrived from pharmacy on 8/9.Review of the medical provider communication book showed an untimed note dated 08/06/2025, that indicated Resident 1 needs MS (morphine) renewal order.Review of pharmacy records showed a prescription written by Staff C, Nurse Practitioner, on 08/06/2025 for Morphine 30 mg IR. A pharmacy communication was then returned to the facility at 1:52 PM which indicated Resident1's previous Morphine prescription had been for Morphine Extended Release (ER) and checking to see if the NP now wanted Morphine IR. A response was sent back to the pharmacy at 2:56 PM which stated the NP intention was to provide new rx (prescription) to continue same order. Void this rx for IR tab, [they] will send new surescript (electronic prescription) for ER formulation. The pharmacy responded on 08/06/2025 at 2:59 PM with dc' d (discontinued). The next pharmacy communication found was dated 08/08/2025, with a fax time at the top of the scanned page of 11:55 AM, marked urgent, for Resident 1's Morphine 30 mg ER, written by Staff C.Review of the Food and Drug Administration (FDA) package insert/prescribing information for Morphine ER showed under the heading Morphine ER dosage and Administration, provided direction Do not abruptly discontinue morphine sulfate extended-release tablets in physically dependent patient because rapid discontinuation of opioid analgesics has resulted in serious withdrawal symptoms, uncontrolled pain, and suicide.Review of the publication Pain Management in the Post-Acute and Long-Term Care Setting, Copyright 2021, indicates on page 63, that opioid dependence (i.e., the body's physical dependence on opioids to function normally) is common. A withdrawal syndrome can result from abrupt cessation, rapid dose reduction.During an interview with Resident 1 on 09/09/2025 at 11:50 PM, with their spouse also present in the room, Resident 1 stated that there was a day, last month, when I did not get my Morphine in the evening or the next day. They further stated that they had been on the same dose of Morphine for several years, related to chronic pain, and were dependent on the medication for pain relief. They stated that when they did not get the Morphine in the evening the nurse told them that the medication had not come from the pharmacy, and it would come the next day. On the next day it still did not come, and the nurse told them that they would get their as needed Hydrocodone (a narcotic mixed with Tylenol) until the Morphine arrived. They stated that they went through that day and experienced unrelieved pain and felt that they experienced withdrawal symptoms in the form of body aches and flu-like symptoms until the medication arrived from the pharmacy the next day. They further stated that they did not feel as if the nursing staff took the situation seriously and discounted their complaints of pain and withdrawal.In an interview on 09/09/2025 at 1:14 PM with Staff B, Resident Care Manager (RCM) and LPN, they stated that the facility policy for reordering medication was for the nurse to notify the pharmacy when there was a seven-day supply of the medication remaining. They further stated that if the floor nurse did not have an ordered medication for a resident, they should notify them so they could communicate with the medical provider. They further stated that they were the RCM responsible for oversight