STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505411	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunshine Health & Rehab	10410 East Ninth Avenue Spokane, WA 99206

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46033 Based on observation, interview and record review, the facility failed to develop an individualized care plan for 1 of 3 residents (1) reviewed who had unique environmental fall risk concerns. Specifically, Resident 1 was at risk for tripping over their lengthy oxygen tubing, and this was not identified and included in their fall prevention care plan. This failure placed Resident 1 and other residents at risk for avoidable falls, injury and decreased quality of life. Findings included . The facility Resident Fall Prevention Protocol reviewed/revised 01/2024 documented the facility used a systems approach to preventing falls that included hazard identification and risk, analysis of hazards and risks, planning and implementation of individualized interventions to reduce fall risk, evaluation and monitoring for effectiveness, and updating the plan of care as necessary. An admission assessment dated [DATE] documented Resident 1 had diagnoses including right tibia fracture (shin bone) and chronic obstructive pulmonary disease (COPD, long term inflammation in the lungs that caused difficult breathing). Resident 1 was cognitively intact, was impaired on one side of their lower extremities, and required partial/moderate assistance for bed/chair transfers. The resident had a history of falls and wore oxygen. The 05/08/2024 care plan documented Resident 1 had a potential for injury related to their history of falls and deconditioning. Staff were instructed to keep the bed in the lowest position, complete frequent visual checks to determine the resident needs and whereabouts, orient the resident to the use of their call light, ensure the resident had shoes/nonskid slippers on when up during the day, and refer to physical therapy as needed. A review of nursing progress notes documented that on 05/19/2024 at 5:00 PM, Resident 1 had an unwitnessed fall in their room when they attempted to transfer from their wheelchair to their bed without assistance. Resident 1 experienced pain in their left hip and was transferred to the emergency room where they were diagnosed with a fractured left hip and elbow. The resident's hip fracture was surgically repaired, and they returned to the facility on [DATE]. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The fall investigation dated 05/19/2024 showed Resident 1 fell in their room and the fall was unwitnessed. It was documented that Resident 1 was alert and oriented but forgetful at times. The resident received supplemental oxygen, which added to their fall risk. Resident 1 was to have assistance of one staff for transfers so that their weight-bearing status was maintained and so they were able to maneuver safely with their oxygen tubing. Re-education regarding the use of their call light was completed with the resident and also with the resident's family. Resident 1 continued to self-transfer without calling for assistance and had poor safety awareness. Staff were to encourage the resident to be in the common area to increase their visibility, frequent visual checks were made, and the resident's needs were anticipated. Staff were to encourage use of the call light and ensure appropriate footwear and keep the bed in a low position. The investigation concluded that multiple interventions were implemented to ensure the resident's safety, and Resident 1 continued to self-transfer, and not use their call light. A 05/19/2024 Resident Occurrence Statement completed by Staff B, Nursing Assistant Certified (NAC), documented Resident 1 required oxygen tubing, and the resident self-transferred frequently. The Occurrence Statement form included the question, are there any other environmental factors that could have contributed to the occurrence? Staff B had written in response, Resident gets tangled in their O2 (oxygen tubing). The Occurrence Statement form was attached to the fall investigation documentation. A review of the 05/28/2024 Staff G, Physician Assistant (PA), progress note documented Resident 1 was readmitted for rehabilitation after hospitalization for left hip and left elbow fractures, had periods of confusion after their surgey and wore supplemental oxygen. The 05/29/2024 care plan showed Resident 1 had been reviewed in the falls/occurrence meeting due to a fall or injury related to deconditioning. The resident had an unwitnessed fall in their room when they attempted to self-transfer from the wheelchair to the bed and reportedly self-transferred frequently. If returned to the facility, the resident was to continue to be in a core room where they were best visualized by staff, they would encourage the resident to be in the common area to increase safety and would have a low bed and fall mat in place. The care plan documented Resident 1 had potential for injury related to deconditioning, pain, weakness, functional mobility decline, and history of falls. Staff were instructed to have a fall mat in place when the resident is in bed, make frequent visual checks on resident needs and whereabouts, bed in lowest position when in bed, orient to use of call light, shoes or non-skid slippers on when up during the day, and physical therapy screen as needed. The care plan was not updated to include interventions related to potential environmental tripping hazards identified by staff related to the Resident 1's oxygen tubing. On 06/05/2024 at 1:54 PM, Resident 1 was observed seated in their wheelchair in the common area of the nursing unit. They were visiting with family, were groomed, clean and were wearing oxygen via a nasal cannula. A portable oxygen concentrator was hanging on the back of the chair. When asked, Resident 1 stated staff knew they needed help because they called out and told them. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/07/2024 at 1:10 PM, Staff H, NAC, stated they often helped provide care for Resident 1, including around the time the resident fell . Staff H stated Resident 1 adamantly refused to use their call bell when they wanted to get up. Resident 1 wanted to do everything on their own as they were working hard to return home. Staff H stated they encouraged the resident to use their call bell for their safety and checked on Resident 1 often. Staff H stated the resident stayed in the common area often as well. Staff H stated Resident 1 wore oxygen all the time and remembered that on at least three occasions Staff H observed the resident attempting to move around in their room unassisted and had to enter their room and reposition the oxygen tubing out of the way. Staff H stated the oxygen concentrators were kept in the bathrooms to allow the residents to sleep because they were noisy, and because other items were plugged in the outlets in the main living area in the room. At this time, Resident 1's room and bathroom were observed with Staff H. The bathroom was on the right as the room was entered. The oxygen concentrator was against the wall just inside the bathroom door before the sink. There was a long length of oxygen tubing piled on top of the concentrator, not currently in use. The head of the resident's bed was positioned against the far wall of the resident's room on the same side of the room as the bathroom and oxygen concentrator. Staff H stated the resident wore the oxygen from the concentrator when they were in bed or in their room. On 06/07/2024 at 3:11 PM, a telephone interview was attempted with Staff B. A voicemail was left requesting a return call and none was received. During an interview on 06/07/2024 at 4:02 PM, Staff A, Director of Nursing, stated they had not been aware that Staff B had mentioned oxygen tubing as a potential contributor to Resident 1's fall. When asked, Staff A agreed that care plans were to be individualized according to each resident's needs and were to reflect those factors that were unique to each resident that might increase their risk for falls such as oxygen tubing. Reference: WAC 388-97-1020(1), (2)(a)(b)

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46033 Based on observation, interview and record review, the facility failed to ensure orders for oxygen were implemented during a transportation to the facility for admission for 1 of 3 residents (1) reviewed. Specifically, Resident 1 did not wear oxygen when transported from the hospital to the facility. Shortly after arrival, the resident had low blood pressure and developed chest pain and was returned to the emergency department for evaluation. This failure put the resident at risk for decompensation and unintended deterioration of their health. Findings included . The 05/08/2024 admission assessment documented Resident 1 had diagnoses including COPD (chronic obstructive pulmonary disease, long-standing inflammation of the lungs that can cause difficulty breathing) and atrial fibrillation (irregular heartbeat). Resident 1 was cognitively intact and wore oxygen. During an interview on 06/05/2024 at 2:55 PM, Resident 1's family representative stated Resident 1 had fallen at home and had broken their right knee and was sent to the local hospital. After the hospital stay, Resident 1 was to be admitted to the facility on [DATE]. The family member stated Resident 1 was brought to the facility in the facility's van but had not worn oxygen during the transfer and Resident 1 had worn oxygen for many years. They stated when the resident arrived at the facility their oxygen levels were extremely low, so Resident 1 was sent back to the emergency room by ambulance for further evaluation. A review of the 05/08/2024 hospital discharge instructions showed Resident 1 was to receive oxygen 2 liters (l) by a nasal cannula continuously all day. A 05/08/2024 at 11:50 AM facility nursing progress note documented Resident 1 was breathing fast, sweaty and complained of chest pain that radiated to their back. The provider was notified, and an order was given to send the resident to the hospital. A 05/08/2024 Staff C, Physician Assistant (PA) progress note documented that approximately 10 minutes after admission to the facility, Resident reported crushing chest pain that radiated to their back. The vital signs obtained at 11:42 AM were heart rate, 70 beats per minute (within normal limits), temperature, 98.6 Fahrenheit (within normal limits), respirations, 16 breaths per minute (within normal limits) and oxygen saturation, 91% on room air, and blood pressure 62/32, extremely low. A review of systems showed the resident's lungs were clear with a normal respiratory effort on room air. The resident appeared slightly sweaty and in pain. Resident 1 reported a long history of heart problems and the decision was made to send them to the emergency room for evaluation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 05/08/2024 at 12:56 PM emergency room (ER) provider progress note documented Resident 1 presented with low blood pressure. The resident had been discharged to the skilled nursing facility (SNF) and shortly after arrival developed chest pain. The resident reported they had not worn oxygen when transported to the SNF. The resident currently denied having chest pain. The physical exam revealed the resident was alert, in no acute distress, lungs with equal breath sounds, regular heart rate and rhythm. The vital signs on arrival were documented as pulse of 73, temperature of 98.6 Fahrenheit, respirations 17, oxygen saturation 100%, and blood pressure 117/43. An x-ray showed the lungs were clear, and the electrocardiogram (EKG, records electrical activity in the heart) showed no signs of heart attack. Resident 1 was observed for 2.5 hours, their symptoms resolved, and they were declared stable for discharge. The final impression was determined to be atypical chest pain. On 06/05/2024, Resident 1 was observed seated in their wheelchair in the common area of the nursing unit at the facility. The resident was clean, groomed, and bright-eyed. The resident was receiving oxygen via a nasal cannula and was breathing easily. Resident 1 reported they were doing well but did not have good recall of the events of 05/08/2024, answering simple yes or no questions. On 06/07/2024 at 8:55 AM, a copy of a facility policy regarding resident transportation in the facility van was requested. At 10:25 AM, Staff A, Director of Nursing, stated the facility had no specific policy and provided a copy of the facility Admission Agreement, which documented the process for transportation to and from medical appointments such as physician office visits and dialysis, and facility outings. Trasnportation from the hospital was not part of the Admission Agreement. During an interview on 06/07/2024 at 11:40 AM, Staff D, Maintenance and Transportation staff, stated they were notified by the admission nurse if a resident needed oxygen when they picked them up at the hospital. Staff D stated it took approximately 15 minutes to get to the facility from the local hospital. They had not transported Resident 1 on 05/08/2024, but their process was when they arrived at the hospital for a pickup, they went to whatever room the resident was in, the hospital staff would attach the oxygen tubing if in use to the facility's oxygen tank hanging on the back of the wheelchair, and then Staff D loaded the residents in the van and drove them to the facility. Staff D stated they were not allowed in their role to put the oxygen on the residents. The facility wheelchair and transport van were observed with Staff D. There was a portable tank in the hanger on the back of the chair and two extra portable oxygen machines in the van. Staff D stated they checked the oxygen levels in the tank every day before they used the van. During an interview on 06/07/2024 at 2:09 PM, Staff E, Admission Registered Nurse, stated they were responsible for reviewing potential residents' records to determine if they were appropriate for admission to the facility, and if admitted they were responsible for coordinating transportation from the hospital to the facility. Staff E stated when they reviewed hospital records for potential admissions, it was often difficult to determine if a resident wore oxygen or did not. They stated several of the hospital providers also did not include orders for oxygen at discharge so it had been difficult to determine who needed oxygen during transport. Staff E stated they had instructed the van drivers to always have oxygen with them in the van so that if a resident required it, it was available. Staff E stated if the van driver arrived at the hospital and a resident was not wearing oxygen when they got there, they did not put oxygen on them. Staff E stated they were able to review hospital discharge orders before a resident left the hospital, and that was how they knew what equipment a resident required. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/07/2024 at 2:28 PM, Staff F, Maintenance and Transportation staff, stated they transported Resident 1 to the facility on [DATE]. They stated they did not place oxygen on residents. When they arrived at the hospital, if a resident wore oxygen, hospital staff unhooked the oxygen from the wall and attached it to the facility's oxygen tank.They stated when they got to the hospital, Resident 1 was not wearing any oxygen. Staff F transferred Resident 1 into the van and stated they had pleasant conversation with the resident during the trip to the facility. Staff F stated upon arrival to the facility, Resident 1 told them they felt a little anxious, and normally wore oxygen. Staff F stated they took Resident 1 to their room, then took the paperwork to the nurse and notified the nurse that Resident 1 reported feeling anxious and normally wore oxygen. During an interview on 06/07/2024 at 2:48 PM, Staff G, PA, stated they had assessed Resident 1 on 05/09/2024 and reviewed the documentation from the ER visit dated 05/08/2024. Staff G stated Resident 1's workup in the ER had been negative and no cause had been identified for the resident's chest pain. In a follow-up interview on 06/07/2024 at 3:15 PM, Staff E reviewed the hospital discharge instructions dated 05/08/2024 with the surveyor and noted there was an order for Resident 1 to wear 2 liters of oxygen continuously. Staff E stated if a resident had an order to be wearing oxygen, and they arrived at the hospital to pick them up and the resident was not wearing any, they assumed the resident was stable for transport on or off the oxygen. At 3:42 PM, Staff E reported after further review of the hospital documentation, they were able to see that Resident 1 wore oxygen at 2L at their baseline, and saw no documentation that the oxygen had been discontinued or weaned off. Staff E stated if a resident had an order for oxygen then they should have oxygen. They stated in the future, if there was uncertainty about a resident's oxygen use, they would be able to contact the case manager at the hospital, who would be able to physically lay eyes on a resident and confirm if oxygen was in use or not prior to being transported. During an interview on 06/07/2024 at 4:02 PM, Staff A, Director of Nursing, stated they would work with the hospital to ensure that discharge orders were complete and that if a resident wore oxygen there was an order for it, and if there was an order for a resident to wear oxygen they would ensure it was applied. Reference: WAC 388-97-1060(1)