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	06/16/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review the facility failed to ensure 1 of 5 sampled residents (Resident 5) were fully informed of their care in language they could understand. This failure placed the resident at risk of poor understanding in their health care decisions and a diminished quality of life. Findings included . Per the 04/20/2025 admission assessment, Resident 5's vision was severely impaired, and they did not use corrective lenses. Review of the 04/16/2025 care plan showed Resident 5 had a left eye prosthetic (medical device that replaces a missing body part) and was legally blind in their right eye. Review of the 05/06/2025 Notice of Medicare Non-Coverage (NOMNC; official document issued as a formal notice about termination or denial of coverage for specific healthcare services or items) showed it was signed by Resident 5. Per the form, if the resident wished to appeal the decision to end their skilled nursing facility services, they were required to do so by noon the following day, 05/07/2025, by calling a phone number listed on the form. In an interview on 06/11/2025 at 9:21 AM, Resident 5 stated facility staff did not adequately explain paperwork given to them to sign. Resident 5 stated they were blind, and staff did not allow them to ask questions about their paperwork. The resident further stated they had to have a family member talk to facility staff about their lack of comprehension regarding the NOMNC. In an interview on 06/16/2025 at 1:41 PM, Staff E, Social Services, stated they reviewed paperwork such as NOMNCs with visually impaired residents, and if the resident requested, they would reach out to their representative and would document who was included. Staff E stated Resident 5 was cognitively intact and initially did not want to review their NOMNC without their representative. Per Staff E they attempted to reach the resident's representative and were unsuccessful, after which the resident agreed to proceed with the paperwork without their representative. Review of the June 2025 progress notes for Resident 5 showed an entry on 05/06/2025 that the resident was served a NOMNC by social services staff that day. There were no entries documenting attempts to reach the resident's representative on or before the date the NOMNC was served. Reference: (WAC) 388-97-0300 (3)(a)

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and interview, the facility failed to ensure services provided met professional standards of practice related to nursing assessments for 1 of 5 residents (Resident 1), reviewed for quality of care. This failure placed the resident at risk for injury and adverse outcomes. Findings included . Per the Washington State Board of Nursing Frequently Asked Questions (https://nursing.wa.gov/practicing-nurses/frequently-asked-questions#NA-FAQ) assessments requiring the use of the nursing process must be completed by an individual with a nursing license (licensed practical nurse or registered nurse). Per the facility's policy titled, Resident Fall Prevention Protocol, revised August 2024, showed nursing staff were to complete fall risk assessments following a fall, and were to assess the level of injury present. Review of the March 2025 progress notes for Resident 1 showed on 03/29/2025 the resident had a fall in their bathroom and had been assisted up into their wheelchair before the nurse assessed them for injury. Per the note, the resident had pain and swelling to their ankle and required ice and further diagnostics to determine the extent of the injury. In an interview on 04/28/2025 at 4:41 PM Staff C, Registered Nurse, stated nursing assistants should let the nurse know prior to moving a resident who has fallen so the resident could be assessed for injuries to ensure it was safe to move them and prevent new/further injury. Staff C stated they were not notified of Resident 1's fall on 03/29/2025 until after the nursing assistant had already put the resident back into their wheelchair. In an interview on 05/23/2025 at 2:11 PM Staff F, Nursing Assistant, stated Resident 1 fell while their assigned nurse (Staff C) was on their lunch break. Staff F stated a nurse was available on another hallway, but they did not request their assistance in assessing the resident for injury prior to getting them up as Staff C was to return shortly. In an interview on 04/28/2025 at 4:18 PM Staff B, Director of Nursing, stated Staff F worked with the facility for four years and should know the facility policy to not get a resident up after a fall without waiting for the nurse to assess the resident. Reference: (WAC) 388-97- 1620(2)(b)(i)(ii),(6)(b)(i)

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to ensure that direct care staffing information was accurate upon submission to the Centers for Medicare and Medicaid Services (CMS) for Quarter 3 of 2024 (July 1, 2024 through September 30, 2024) reviewed for Payroll Based Journal (PBJ - mandatory reporting of staffing information based on payroll data) submission. This failure caused CMS to have inaccurate data related to facility staffing levels and had the potential to impact resident care and services. Findings included . Review of the Certification and Survey Provider Enhanced Reports (CASPER) PBJ Staffing Data Report showed the facility reported data for Quarter 3, 2024 at a level lower than required by mandated staffing levels. In an interview on 04/28/2025 at 3:43 PM Staff D, Payroll, verified the staff hours for Quarter 3, 2024. Staff D stated resident census data was pulled from the MDS (Minimum Data Set, a federally mandated process for clinical assessment of all resident in Medicaid- and Medicare-certified nursing homes) assessments, which were not current at the time the PBJ was initially submitted. Per Staff D the census data error was previously discovered and appeared to already be corrected when they logged in to view the PBJ. In an interview on 06/18/2025 at 11:22 AM Staff A, Administrator, stated the facility had corrected the census data related to Quarter 3, 2024 several months prior when they corrected census data for a previous quarter.