STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505411	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024

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 0554

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Allow residents to self-administer drugs if determined clinically appropriate.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47328

Based on observation, interview, and record review the facility failed to ensure the resident was evaluated and assessed by the interdisciplinary team (IDT), a physician order was obtained, and care planned for safe self-administration of medications, as required for 1 of 4 sampled residents, (Resident 23), reviewed for resident rights. This failure placed residents at risk of medication errors, adverse side effects, and diminished quality of life.

Findings included .

Review of the facility policy titled, Preparation and General Guidelines for Self-Administration of Medications effective January 2020, showed residents who desired to self-administer medications were permitted to do so after the IDT determined it was safe for the resident and other residents of the facility and there was a provider's order to self-administer. An assessment would be completed of the resident's cognitive, physical and visual ability. The IDT would verify the resident's ability to self-administer medication by conducting a skills assessment that included the ability to read the medication labels, ability to remove medications from the package or container, and administration techniques for the different dosage forms. The skills assessment would be completed on a quarterly basis and/or when there was a significant change of condition. Bedside medication storage would be assessed for safety, medications authorized for self-administration or to be left at bedside would be documented on the provider orders.

According to the admission assessment, dated 07/13/2024, Resident 23 admitted to the facility on [DATE] with diagnoses including cancer. The assessment further showed Resident 23 had adequate vision with corrective lenses and had no range of motion impairment to their upper extremities. Resident 23 was cognitively intact and able to clearly verbalize their needs.

Review of the 07/10/2024 care plan showed Resident 23's discharge plan was to return home and instructed staff to educate and facilitate training to resident and/or family as needed. No documentation Resident 23 was evaluated and/or assessed by the IDT, was safe to self-administer medications or store/keep medications at bedside was found.

Review of provider orders as of 10/22/2024 showed no documentation Resident 23 was safe to self-administer medications or store/keep medications at bedside.

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505411	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of July 2024 through October 2024 nursing progress notes showed no documentation Resident 23 was evaluated and/or assessed by the IDT, was safe to self-administer medications or store/keep medications at bedside. Further review of Resident 23's record showed no documentation Resident 23 was evaluated and/or assessed by the IDT, was safe to self-administer medications or store/keep medications at bedside. During observation and interview on 10/22/2024 at 9:41 AM, Resident 23 had a small clear platsic cup with nine pills sitting on the bedside table in front of them. Resident 23 stated staff usually left their medications with them so Resident 23 could take them slowly with yogurt. Review of the medication administration report showed Resident 23's medications schedule to be administered on 10/22/2024 at 6 AM, 7 AM, and 7:30 AM were documented as administered at 7:25 AM. In an interview on 10/24/2024 at 10:01 AM, Staff M, Nursing Assistant, stated most resident were administered medications by the nurse and was unsure what the process was if a resident chose to self-administer medication. Staff M further stated medications should not be left at the bedside as it could be a potential safety issue. In an interview on 10/24/2024 at 10:25 AM, Staff K, Registered Nurse, stated they were unsure of the facility process or documentation required for resident to keep medications at bedside and/or self-administer medications. Staff K further stated medications should not be left at the bedside without a provider order as it could be a potential safety issue because of residents that wander. In an interview on 10/24/2024 at 11:50 AM, Staff B, Director of Nursing, stated if residents chose to self-administer medications an assessment needed to be completed, and the provider order needed to reflect which medications could be self-administered and/or left at the bedside. Staff B acknowledged medications should not be left at the bedside without taking the appropriate steps as it could be a potential safety issue. Staff B acknowledged Resident 23 took a while to take their medications. In an interview on 10/24/2024 at 12:30 PM, Staff A, Administrator, stated residents were allowed to self-administer medications after they were properly assessed. Staff A stated they expected staff to follow the facility process when a resident chose to self-administer medications and care plan accordingly. Staff A acknowledged medications should not be left in a resident's room unattended if they had not been cleared for safe self-administration of medications. Reference WAC 388-97-0440, 1060 (3)(l), 1880 (2)(g)(i)

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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 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review the facility failed to not request or require residents to waive their rights to retain personal property including items of value to admit to the facility for 4 of 4 sampled residents (Resident 23, 76, 184, and 185), reviewed for resident rights. This failure placed all residents at risk of inability to exercise their resident rights, unmet needs, and diminished quality of life. Findings included . Review of the facility policy titled, Resident Rights revised February 2018, showed residents had the right to keep and use their personal belongings and property as long as it did not interfere with the rights, health, or safety of others. The facility was to protect resident property from theft. The policy further showed residents had the right to manage their own money, choose a trusted person to do so, or may deposit funds into a personal resident account (trust fund) with the facility. The facility must allow residents access to their bank accounts, cash, and other financial records. <Resident 23> According to the admission assessment, dated 07/13/2024, showed Resident 23 admitted to the facility on [DATE] with diagnoses including adjustment disorder with depressed mood. The assessment further showed it was very important for Resident 23 to care for their belongings and somewhat important to have a place to lock items for safety. Resident 23 was cognitively intact and able to verbalize their needs. Review of the 07/09/2024 facility admission agreement showed the resident had the following responsibilities to assist the facility protect their personal belongings: DO NOT bring valuables to the facility. This includes jewelry, money, credit cards. The admission agreement showed a resident/resident representative signature indicated the agreement was read, understood, and agreed to abide by all aspects of the agreement. The form was electronically signed by Resident 23 on 07/09/2024. Review of Resident 23's personal effect inventory sheet showed they brought in a wallet that was sent home with their child. The bottom of the form included the statement I certify that this is a correct list of my belongings which I wish to retain in my possession and for which I take ENTIRE RESPONSIBILITY and showed it was signed by the resident or their representative on 07/09/2024. Review of the 07/30/2024 resident preference evaluations showed it was very important for Resident 23 to care for their personal belongings. In an interview on 10/22/2024 at 9:43 AM, Resident 23 stated the facility told them they were not allowed to bring money or personal items into the facility because it was not safe. Resident 23 explained that prior to being at the facility they managed their own finances but since they admitted to the facility, they had to rely on their child to bring them money if or when needed. Resident 23 further stated they would prefer to have their insurance and debit cards on their person, if allowed by the facility. (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 10/24/2024 at 10:01 AM, Staff M, Nursing Assistant, stated staff filled out a resident personal possession inventory sheet upon admission. Staff M explained residents were allowed to bring personal items but if money and/or debit cards were brought into the facility, it was inventoried, removed from the resident, and secured in a facility safe. Staff M further stated the safe was in the front office and was unsure if it could be accessed after hours. In an interview on 10/24/2024 at 10:25 AM, Staff K, Registered Nurse (RN), stated the facility completed a resident possession inventory sheet upon admission. Staff K explained residents were discouraged from bringing wallets, purses, or items of value into the facility but could bring items in if adamant. Staff K further stated the facility had a safe, but they were unsure where it was located or how to access it. In an interview on 10/24/2024 at 10:42 AM, Staff D, Social Service Director, stated resident were allowed to bring personal items into the facility but discouraged items of value because the facility did not want items to get lost. Staff D explained resident could bring items of value in if they were adamant and had a safe in the front office to secure items. Staff D further stated the admissions nurse was the only staff that had a key to the safe and was unsure how the safe was accessed after business hours or on Sundays. Staff D reviewed the admission agreement and acknowledged the verbiage appeared as if residents were not allowed to bring items in. In an interview on 10/24/2024 at 11:32 AM, with Staff E, Admission RN, and Staff F, Admission RN, they explained residents were allowed to bring personal items into the building and items inventoried on a personal possession sheet. Both Staff explained that if a resident brought in a significant amount of cash, it would be inventoried, removed and stored in the office safe because residents do not need money at the facility. They further explained the safe was in a closet in their office (behind 3 closed doors), they were the only two staff with keys to access the safe and they did not work on Sundays. Both Staff acknowledged if a resident wanted to access items in the safe after hours or on Sunday, they would have to at least wait until the next day. Both Staff E and Staff F reviewed Resident 23's admission agreement. Both staff acknowledged every resident signed the admission agreement, the verbiage on the admission agreement appeared to take away a residents right to have personal possessions as a condition of admission, and safeguarding resident personal items in a place that could not be easily accessed by a resident was similar to them not being allowed to bring items in. <Resident 184> According to the admission assessment, dated 07/29/2024, showed Resident 184 admitted to the facility on , d+[DATE]/. The assessment further showed it was somewhat important for Resident 184 to care for their belongings. Resident 184 was cognitively intact and able to verbalize their needs. Review of the 07/25/2024 facility admission agreement showed the resident had the following responsibilities to assist the facility protect their personal belongings: DO NOT bring valuables to the facility. This includes jewelry, money, credit cards. The admission agreement showed a resident/resident representative signature indicated the agreement was read, understood, and agreed to abide by all aspects of the agreement. The form was electronically signed by Resident 184 on 07/25/2024. (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident 184's personal effect inventory sheet showed no items of value were brought into the facility. The bottom of the form included the statement I certify that this is a correct list of my belongings which I wish to retain in my possession and for which I take ENTIRE RESPONSIBILITY and showed it was signed by the resident's spouse on 07/25/2024. Review of the 08/05/2024 resident preference evaluation showed it was somewhat important for Resident 184 to take care of their personal belongings. <Resident 185> According to the admission assessment, dated 09/30/2024, Resident 185 admitted to the facility ion 09/26/2024. The assessment further showed it was very important for Resident 185 to care for their personal belongings. Resident 185 had severe cognitive impairment, had short term and long term memory problems, no speech, and sometimes understood others. Review of the 09/26/2024 facility admission agreement showed the resident had the following responsibilities to assist the facility protect their personal belongings: DO NOT bring valuables to the facility. This includes jewelry, money, credit cards. The admission agreement showed a resident/resident representative signature indicated the agreement was read, understood, and agreed to abide by all aspects of the agreement. The form was electronically signed by the severly cognitivley impaired Resident 185 on 09/26/2024, not the resident representative. Review of Resident 184's personal effect inventory sheet showed no items of value were brought into the facility and unable to tell me anything related to personal items written. The bottom of the form included the statement I certify that this is a correct list of my belongings which I wish to retain in my possession and for which I take ENTIRE RESPONSIBILITY and showed unable to sign written in the resident/representative signature section on 09/26/2024. <Resident 76> According to the admission assessment, dated 09/20/2024, Resident 76 admitted to the facility on [DATE]. The assessment further showed Resident 76 was cognitively intact and it was somewhat important for them to take care of their personal belongings. Review of the 09/16/2024 facility admission agreement showed the resident had the following responsibilities to assist the facility protect their personal belongings: DO NOT bring valuables to the facility. This includes jewelry, money, credit cards. The admission agreement showed a resident/resident representative signature indicated the agreement was read, understood, and agreed to abide by all aspects of the agreement. The form was electronically signed by Resident 76 on 09/16/2024. Further review of Resident 76's record showed no personal effect inventory sheet was found. In an interview on 10/24/2024 at 11:50 AM, Staff B, Director of Nursing, reviewed the facility admission agreement and acknowledged the verbiage appeared to violate a resident rights to bring personal belongings into the facility. Reference WAC 388-97- 0040 (2)(a)(b), -1080 (4)(i)(ii)

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F 0640

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47328

Based on interview and record review the facility failed to routinely encode and transmit resident assessment data to the Centers for Medicare & Medicaid Services (CMS) within the required timeframe for 7 of 7 sampled residents (Residents 6, 7, 8, 25, 48, 50, and 53), reviewed for timeliness in encoding and transmission of Minimum Data Set (MDS - an assessment tool). This failure affected federal health information data gathering and placed residents at risk for inaccurate monitoring of the residents' progress over time, untimely comprehensive review of residents' health data/information, and a diminished quality of life.

Findings included .

Review of the Centers for Medicare and Medicaid Services Long Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.18.11 revised October 2023, showed the RAI consisted of three basic components: the MDS, the Care Area Assessment (CAA) and the RAI utilization guidelines. The utilization of the three component of the RAI yields information about a resident's functional status, strengths, weaknesses, and preferences, as well as offered guidance on further assessment once problems were identified. Nursing homes are required to submit Omnibus Budget Reconciliation Act (OBRA) required MDS records for all residents in Medicare- or Medicaid-certified beds regardless of the payer source. All Medicare and/or Medicaid-certified nursing homes and swing beds, or agents of those facilities, must transmit required MDS data records to CMS' Internet Quality Improvement and Evaluation System (iQIES). After completion of the required assessment and/or tracking records, each provider must create electronic transmission files that meet the requirements detailed in the current MDS 3.0 Data Submission Specifications. When the transmission file was received by iQIES, the system performs a series of validation edits to evaluate whether or not the data submitted met the required standards. MDS records were verified to ensure clinical responses were within valid ranges and were consistent, dates were reasonable, and records were in the proper order with regard to records that were previously accepted by iQIES for the same resident. The provider was notified of the results of this evaluation by error and warning messages on a Final Validation Report.

<Resident 6>

Review of the discharge assessment, dated 08/15/2024, showed Resident 6 admitted to the facility on [DATE] and discharged to the community on 08/15/2024. The assessment further showed the assessment observation end date was 08/15/2024 and was signed as completed on 10/23/2024.

Review of August 2024 through October 2024 nursing progress notes showed Resident 6 discharged the facility on 08/15/2024.

<Resident 7>

Review of the discharge assessment, dated 08/30/2024, showed Resident 7 admitted to the facility on [DATE] and discharged to the community on 08/30/2024. The assessment further showed the assessment observation end date was 08/30/2024 and was signed as completed on 10/22/2024.

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of August 2024 through October 2024 nursing progress notes showed Resident 7 discharged the facility on 08/30/2024. <Resident 8> Review of the discharge assessment, dated 08/06/2024, showed Resident 8 admitted to the facility on [DATE] and discharged to the community on 08/06/2024. The assessment further showed the assessment observation end date was 08/06/2024 and was signed as completed on 10/23/2024. Review of August 2024 through October 2024 nursing progress notes showed Resident 8 discharged the facility on 08/06/2024. <Resident 25> Review of the discharge assessment, dated 08/07/2024, showed Resident 25 admitted to the facility on [DATE] and discharged home with services on 08/07/2024. The assessment further showed the assessment observation end date was 08/07/2024 and was signed as completed on 10/23/2024. Review of August 2024 through October 2024 nursing progress notes showed Resident 25 discharged home on 08/07/2024. <Resident 48> Review of the discharge assessment, dated 09/11/2024, showed Resident 48 admitted to the facility on [DATE] and discharged to an unknown location on 09/11/2024. The assessment further showed the assessment observation end date was 09/11/2024 and was not signed as completed as of 10/29/2024. Review of September 2024 through October 2024 nursing progress notes showed Resident 48 discharged home on 09/11/2024. <Resident 50> Review of the discharge assessment, dated 08/13/2024, showed Resident 50 admitted to the facility on [DATE] and discharged to the community on 08/13/2024. The assessment further showed the assessment observation end date was 08/13/2024 and was signed as completed on 10/23/2024. Review of August 2024 through September 2024 nursing progress notes showed Resident 50 discharged the facility on 08/13/2024. <Resident 53> Review of the discharge assessment, dated 08/06/2024, showed Resident 53 admitted to the facility on [DATE] and discharged home with services on 08/06/2024. The assessment further showed the assessment observation end date was 08/06/2024 and was signed as completed on 10/23/2024. Review of August 2024 through October 2024 nursing progress notes showed Resident 53 discharged the facility on 08/06/2024. (continued on next page)

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility MDS batch report #1032 showed 62 assessment were accepted on 10/28/2024. The batch included assessments dated 07/24/2024 through 10/23/2024, including a 07/24/2024 and a 08/13/2024 assessment for Resident 50. Review of the 10/28/2024 iQIES MDS validation report showed 62 files were submitted and accepted with 49 warning messages. The warning messages showed the following: - Resident 8, 08/06/2024 MDS assessment completed late and was more than 14 days after the assessment reference dated. - Resident 50, 07/24/2024 MDS assessment completed late and was more than 14 days after the assessment reference dated. The 08/13/2024 MDS assessment completed late and was more than 14 days after the assessment reference dated. - Resident 25, 08/07/2024 MDS assessment completed late and was more than 14 days after the assessment reference dated. - Resident 53, 08/06/2024 MDS assessment completed late and was more than 14 days after the assessment reference dated. - Resident 6, 08/15/2024 MDS assessment completed late and was more than 14 days after the assessment reference dated. - Resident 7, 08/30/2024 MDS assessment completed late and was more than 14 days after the assessment reference dated. Review of the facility resident discharge list from 08/22/2024 through 10/21/2024 showed 97 residents discharged the facility in 60 days. Review of the 10/21/2024 facility Matrix (used to identify pertinent care categories) for new admissions showed 30 residents admitted the facility in the last 30 days. In an interview on 10/29/2024 at 11:04 AM, Staff G, MDS Coordinator, explained the MDS process. Staff G stated MDSs needed to be completed and submitted to CMS per the required time frames, discharge MDS should be completed with 14 days of the event occurring. Staff G further stated a MDS validation report would be received when a MDS was submitted that would flag errors to fix and/or warnings including late submissions. Staff G acknowledged as the only MDS coordinator, they struggled to keep up with the MDS workload and had late MDS submissions, including the batch that was submitted on 10/28/2024. In an interview on 10/29/2024 at 11:22 AM, Staff A, Administrator, stated they expected MDS to be completed within the required time frames according to the RAI manual. Staff A acknowledged some MDSs were submitted late. Reference WAC 388-97- 1000 (4)(b), (5)(b)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50027 Based on observation, interview and record review, the facility failed to consistently provide bathing for 2 of 4 sampled residents (Resident 28 and 234), reviewed for activities of daily living (ADLs). This failure placed residents at risk for poor personal hygiene, unmet care needs, and diminished quality of life. Findings included . Review of the facility policy titled, Activities of Daily Living reviewed October 2024, showed the facility would ensure a resident's abilities in ADLs did not deteriorate unless deterioration was unavoidable. The policy further showed care, and services would be provided to include bathing, dressing, grooming, and oral care. A resident who was unable to carry out ADLs would receive the necessary services to maintain good nutrition, grooming, personal and oral hygiene. <Resident 28> According to the comprehensive assessment, dated 10/05/2024, Resident 28 admitted to the facility on [DATE] with diagnoses including heart failure, malnutrition and anxiety disorder. The assessment further showed Resident 28 required substantial/max assistance from staff to complete showering and/or bathing. Resident 28 was cognitively intact. Review of the 10/01/2024 care plan showed Resident 28 needed assistance with showers and instructed staff to provide showers (including shampoo and nail care) per the resident's schedule. During an interview on 10/22/2024 at 9:27 AM, Resident 28 stated they had only received showers once a week and did not like the facility's organizational approach for providing showering/bathing. In a follow-up interview on 10/23/2024 at 3:58 PM, Resident 28 stated that they had not received a shower that week. Review of the shower schedule book showed Resident 28 was to receive showers twice a week on Tuesdays during the day and Friday evenings. Review of the bathing documentation from 10/1/2024 through 10/22/2024, showed Resident 28 received 2 out of 7 scheduled showers, one on 10/8/2024 and the second on 10/15/24. The record further showed N/A documented 35 times. In an interview on 10/28/2024 at 10:01 AM, Staff Y, Nursing Assistant, stated residents were scheduled for showers twice a week according to the schedule in the shower book. Staff Y further stated residents scheduled showers were heavily missed due to the lack of staff. Staff Y explained when staff was unable to perform resident baths due to staffing it was documented as N/A in their record. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/28/2024 at 3:33 PM, Staff B, Director of Nursing (DON), stated that staff should reapproach/reattempt to provide showers if initially refused. Staff B stated that bathing refusals were documented in the resident's electronic health record and on a shower refusal form submitted to the DON. Staff B acknowledged residents may not get showered if/when the assigned shower aide was reassigned to provide care on the unit. Staff B reviewed the shower refusal forms. Staff B acknowledged Resident 28 did not receive showers as scheduled and should have. <Resident 234> According to the admission assessment, dated 10/07/2024, Resident 234 admitted to the facility on [DATE]. Review of October 2024 nursing progress notes showed Resident 234 had diagnoses including knee fracture, required assistance with transfers, was cooperative with cares, and was occasionally incontinent. The notes further showed showers were very important to Resident 234. During an interview on 10/21/24 at 10:30 AM, Resident 234's child stated Resident 234 had not been bathed since 10/13/2024, eight days, and was instructed by staff to bathe Resident 234 themselves. Resident 234's child further stated when a scheduled shower was missed it was not guaranteed to be given at a later day or time. During an interview on 10/22/2024 at 10:22 AM, Resident 234 stated they still had not had a shower since 10/13/2024 and was still waiting to receive one as requested. Review of the shower schedule book showed Resident 234 was to receive showers twice weekly on Sunday and Wednesday evenings. Review of the shower record from 10/7/2024 through 10/23/2024 showed Resident 234 received 2 out of 5 scheduled showers. The record further showed N/A documented 27 times. No documentation was found to show Resident 234 refused to bathe or alternative bathing was offered. In an interview on 10/28/2024 at 3:33 PM, Staff B, stated the facility did not staff a bathe aide for evening shift even though residents were scheduled to bathe on evening shift and the bathe aide was often pulled to provide direct resident care on the floor. Staff B reviewed the bathing refusal documentation forms. Staff B acknowledged Resident 234 had no shower refusals and should have received showers as scheduled. Reference : (WAC) 388-97-1060 (1)(2)(a)(i)

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	505411	A. Building B. Wing	10/29/2024

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47328 Based on observation, interview, and record review the facility failed to routinely implement a system with sufficient detail to enable an accurate reconciliation of all controlled drugs, including the facilities emergency medication supply in 1 of 1 sampled medication rooms (Victorian Rose) reviewed for medication storage. This failure placed the facility at increased risk for potential controlled substance drug diversion and detracted from the facility's ability to promptly identify drug diversion. Findings included . Review of the facility policy titled, Medication Storage in the Facility reviewed January 2020, showed medication storage conditions were monitored on a monthly basis by the consultant pharmacist or the pharmacy designee. Controlled substances that required refrigeration were to be stored within a locked box, attached to the inside of the refrigerator. The policy further showed controlled substances were subject to special handling, storage, disposal and record keeping. Medications subject to abuse or diversion were to be stored in permanently affixed, double locked compartments separate from all other medications. At each shift change, or when keys were transferred, a physical inventory of all controlled substances, including refrigerated items was to be conducted by two licensed nurses and documented. During observation and interview on 10/23/2024 at 2:30 PM, with Staff Q, Registered Nurse (RN), the Victorian [NAME] medication room refrigerator was observed. The refrigerator contained a clear removable box with three separate locking compartments. The first compartment was empty, the middle compartment contained two 30 milliliter (ml) bottles of liquid Ativan (controlled substance typically used to treat anxiety or symptoms of air hunger, the feeling of being unable to breathe deep enough or running out of air, during end of life) and three different vials of insulin, the third compartment contained suppositories, a vial of insulin, and an enzyme used to break up clogs in intravenous catheters. Staff Q stated the liquid Ativan was part of the facility's emergency medication supply and tracked in the electronic medication dispensing machine. Staff Q explained that if Ativan was removed from the emergency medication supply for a specific resident the Ativan would then be logging into a controlled substance book, counted and tracked there. Staff Q further stated they were unsure how often the pharmacy checked or tracked the Ativan in the refrigerator. During observation and interview on 10/23/2024 at 2:44 PM, Staff R, RN, the Victorian [NAME] medication room refrigerator was observed. Staff R stated the liquid Ativan was part of the facility's emergency medication supply and tracked in the electronic medication dispensing machine. Staff R was unable to access the electronic medication dispensing machine to verify the Ativan count or balance. Staff R acknowledged facility nursing staff would not be aware if the Ativan count was accurate or not because it was tracked by the pharmacy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation and interview on 10/23/2024 at 2:58 PM, Staff B, Director of Nursing, the Victorian [NAME] medication room refrigerator was observed. Staff B removed the clear removable box containing Ativan and other medications out of the refrigerator. Staff B stated the Ativan was part of the emergency medication supply and tracked via the electronic medication dispensing machine at least twice monthly by pharmacy staff. Staff B acknowledged they would have no knowledge of potential medication drug diversion if the Ativan was not stored in a permanently affixed compartment or routinely tracked. During observation and interview on 10/23/2024 at 3:45 PM, with Staff S, Pharmacist, and Staff B, Director of Nursing. Staff S stated insulin was placed in the same locking compartment as the emergency Ativan supply to help minimize or prevent potential insulin errors. Staff B told Staff S that staff could log into the electronic medication dispensing machine to access insulin and remove Ativan without facility or pharmacy knowledge. The State Survey Agency requested documentation that showed when the emergency Ativan supply was stocked and tracked. Review of the 10/24/2024 activity transaction report, the 10/24/2024 inventory replenishment report, and an undated transaction log did not show sufficient detail to enable an accurate reconciliation of the facility's emergency Ativan medication supply. During an interview on 10/28/2024 at 3:17 PM, Staff A, Administrator, stated they expected staff to store controlled drugs in a manner that would prevent potential drug diversion and maintain records for all controlled drugs in sufficient detail to enable an accurate reconciliation. Reference WAC 388-97-1300 (1)(b)(ii), (c)(ii-iv)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 42802 Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than five percent. Specifically, two medication errors were identified during 26 medication administration opportunities. This resulted in an error rate of 7.69 %. This failure placed residents at risk of receiving subtherapeutic effects of their medications, possible adverse side effects, and diminished quality of life. Findings included . According to progress notes dated 10/21/2024, Resident 141 was admitted to the facility that day with diagnoses that included Gastroesophageal Reflux Disease (GERD, a gastrointestinal disorder causing a backup of stomach contents back into the esophagus) and Irritable Bowel Syndrome (IBS, a bowel disorder characterized by abdominal pain, discomfort and bloating). The resident was alert and made their needs known. On 10/24/2024 at 8:38 AM, observed as Staff N, Registered Nurse, prepared and gave Resident 141 their medications. The resident was sitting up with a finished breakfast tray in front of them. Metoclopramide 5mg (an anti-nausea medication) and Pantoprazole 40 mg (a medication to treat GERD) were 2 of the medications administered. While dispensing the medications, Staff N said that those medications were late and were supposed to be given before breakfast, and the resident had already eaten. A review of the resident's October 2024 Medication Administration Record (MAR) documented current orders for Pantoprazole 40 mg in the morning for GERD, to take on an empty stomach. The medication was scheduled for 7:30 AM. The Metoclopramide 5mg was ordered 3 times a day, before meals for nausea. The morning dose was scheduled for 7:30 AM. During an interview on 10/24/2024 at 10:08 AM, Staff N stated that they were at fault for the late medications for Resident 141, and they could have possibly given the Pantoprazole later and before lunch, so it would have been on an empty stomach. During an interview on 10/29/2024 at 1:36 PM, Staff B, Director of Nursing, was informed of the above observation and interview. Staff B acknowledged that the 2 medications given late were considered medication errors. Reference: WAC 388-97-1060(3)(k)(iii)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 42802 F801 Based on interview and record review the facility failed to employ a dietician that had the licensure and/or certification to practice as a Registered Dietician in Washington State, as required for 1 of 1 staff (Staff U), reviewed for Registered Dietician qualifications. This failure placed all residents at risk for unmet nutritional needs and diminished quality of life. Findings included . Review of the facility's undated policy titled, Professional Licenses showed all professional licenses were tracked using an online human resources management system. The policy further showed if a license lapsed, the employee would be removed from the schedule and not allowed to work until resolved. Review of the Academy of Nutrition of Dietetics Scope of Practice for Registered Dietician Nutritionist revised 2024, showed RDNs operated within applicable federal and state laws and regulations and accreditation organization standards. When the practitioner and patient/client were located in different states, the practitioner must be licensed in the state where the patient/client is located and/or meet all applicable standards of both states. Review of the 10/21/2024 facility staff list identified Staff U as the facility ' s Corporate Dietician since 04/19/2024. Review of staff credentials showed Staff U successfully completed the requirements for national dietetic registration through the Academy of Nutrition and Dietetics Commission on Dietetic Registration, with a registration valid from 09/01/2024 through 08/31/2025. The State Survey Agency requested a copy of Staff U's Washington State Dietician licensure or certification to practice in Washington State was requested on 10/28/2024 at 9:48 AM. No documentation was provided. A search of the Washington State Department of Health Provider Credential database showed no documentation Staff U had a Dietitian Certification or Licensure to practice in Washington State, as required. In an interview on 10/28/2024 at 9:48 AM, Staff U, acknowledged they were registered nationally with the Commission on Dietetics Registration but did not have a Washington State license or certification. Reference: WAC 388-97-1160(1)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50027 Based on observation, interview, and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food safety for 1 of 1 facility kitchens, reviewed. This failure placed residents at risk for food borne illness and diminished quality of life. Findings included . Review of the undated facility policy titled, Record of Food Temperatures showed the dietary department would check food temperatures on all items prepared by the dietary department, hot foods should be held at 135 degrees Fahrenheit (F), and potentially hazardous cold food kept at or below 41 degrees F. The policy instructed staff to measure and record food temperature on a temperature log every meal. Hot food temperature should be checked when placed on the steam table. Food that did not meet food code standard temperature were not to be served. Cold menu items were to be placed in an ice bath pan for holding until served. The policy instructed staff to clean, sanitize and calibrate the food thermometer used to verify food temperatures. Review of the U.S. Food and Drug Administration (FDA) Food Code 2022 revised [DATE], showed hot foods should be kept at 135 F or above and cold foods should be kept at 41 F or below prior to serving. Food Preparation and Service During observation of tray line service on [DATE] at 11:35 AM, Staff CC, Dietary Cook, began to serve the lunch meal (Swiss steak, baked potato, Normany vegetables, roll, apple walnut chicken salad with gorgonzola, sweet onion dressing, fruit cup) at the steam table. Staff CC placed a baked potato on the plate, sliced it open and then added the Swiss steak on the plate. Staff CC passed the plate to their right side to Staff DD, Dietary Cook, to add more food items. Prior to serving. No staff checked the food temperatures of the food resting in the steam table. This surveyor prompted Staff CC and Staff DD to check the temperatures of all food items at the steam table. Both Staff CC and Staff DD stated they were unsure food temperature ranges that food items were required to be at prior to serving and had to ask another staff member. At 11:42 AM, Staff CC began to temp all food items with a digital food thermometer at the steam table, except the salads, which were placed in the holding fridge located underneath the steam table. During an observation on [DATE] at 11:43 AM, Staff CC used the digital food thermometer to check the temperature of the soup being served. The soup being served was stored in cardboard cups with a lid (approximately 20) stacked against the end of the right side of the steam table. The temperature for the soup was 154 F. During observation and interview on [DATE] at 11:50 AM, Staff EE, Dietary Aide, was placing cold items including fruit cups on the trays and putting them in the meal carts. Staff EE was prompted to temp the diced peaches in hard plastic cups after Staff EE stated they had not checked the temperature of the fruit being served. The regular texture fruit temperature was 54.3 F and the pureed fruit temperature was 54.5 F. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 11:58 AM, Staff EE, acknowledged cold food items needed to be at a temperature of at least 41 F and should have been kept in an ice bucket to keep the items cold to keep bacteria from growing. During observation during tray line on [DATE] at 12:10 PM, Staff CC did not temp two salads prior to serving and placed the salads on the steam table shelf for Staff EE to receive it on the opposite side. They stated that they did not temp the salads and were prompted again to provide the temperatures. The following temperatures were noted: the first salad at 50.2 F and the second salad at 50 F. In an interview on [DATE] at 12:35 PM, Staff U, Registered Dietician, confirmed line staff should have temped the food prior to serving during tray line and the temperature of the cold food items should have been at least 41 F. Staff U stated that this was important for food palatability and to reduce foodborne illness. In an interview on [DATE] at 12:39 PM, Staff T, Dietary Services Director, stated the soup should have been served at 160 F prior to being placed on a meal tray. Review of the kitchen temperature logs from [DATE] through [DATE] only showed the final cooking and holding temperatures, did not include temperature checks before tray line or mid service. There was no documentation on final holding temperatures for breakfast items served on [DATE]. In an interview on [DATE] at 11:05 AM, Staff T, stated the temperatures of food should be checked and monitored at the following times: final cooking, before tray line starts, mid service break and at the end of tray line. Staff T stated temperatures should have been checked throughout the meal servicing process and is important to make sure safe food temperatures are maintained. Food Storage During a kitchen observation on [DATE] at 8:50 AM, the walk-in refrigerator had one metal pan of uncovered and undated cooked bacon. The bacon was on the middle rack of the cooling shelf directly in front of the refrigerator entrance door with pans above and next to. At 9:16 AM, the bacon was still uncovered and undated. In an observation and interview on [DATE] at 2:37 PM, Staff T, acknowledge that the bacon cooling in the refrigerator should have been covered. During a kitchen observation on [DATE] at 9:34 AM, the walk-in freezer had a package of frozen shrimp sliced open at the top with an expiration date of [DATE] and an opened resealable bag of chicken wings (, d+[DATE] full) with an expiration date of ,d+[DATE]. In an observation and interview on [DATE] at 2:34 PM, Staff T was shown the expired food items in the walk-in freezer. More food items on the shelf were discovered and determined to be expired, chicken strips in a resealable plastic bag labeled with an expiration date of ,d+[DATE] and potato wedges in a resealable plastic bag labeled with an expiration date of ,d+[DATE]. Staff T acknowledged that all expired freezer items should have been discarded due to food safety regulations. Reference: WAC [DATE] (2) (3); [DATE]

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on observation, interview, and record review the facility failed to review policies and/or procedures yearly as required, perform hand hygiene when indicated, and store soiled laundry in a manner to prevent the spread of infection. In addition, the facility failed to implement, follow, and discontinue transmission-based precautions when indicated for 2 of 3 sampled residents (Resident 23 and 135), reviewed for infection control. This failure placed all residents, staff, and visitors at risk of development of a multi-drug-resistant organisms (MDRO), communicable diseases, and diminished quality of life Findings included . POLICIES Review of the facility policy titled, Vaccination of Residents, showed the policy was revised November 2012. No documentation was found to show the policy had been reviewed yearly as required. Review of the facility policy titled, Influenza Vaccine, showed the policy was revised November 2012. No documentation was found to show the policy had been reviewed yearly as required. Review of the facility policy titled, Pneumococcal Vaccine, showed the policy was revised October 2014. No documentation was found to show the policy had been reviewed yearly as required. Review of the facility policy titled, Antibiotic Stewardship, showed the policy was revised July 2016. No documentation was found to show the policy had been reviewed yearly as required. Review of the facility policy titled, COVID-19, showed the policy was reviewed/revised March 2022. No documentation was found to show the policy had been reviewed yearly as required. Review of the facility policy titled, COVID-19 Vaccine Policy showed the policy was implemented December 2020. No documentation was found to show the policy had been reviewed yearly as required. Review of the undated facility policy titled, Transmission Based Precautions showed no documentation the policy had been reviewed yearly as required. In an interview on 10/28/2024 at 10:57 AM, Staff H, Charge Nurse, was unsure what the facility process was for reviewing policies, how often policies were reviewed, or where documentation on policies reviewed was located. In an interview on 10/28/2024 at 11:26 AM, with Staff C, Infection Preventionist (IP), and Staff B, Director of Nursing (DNS). Staff C was unsure what the facility process was for reviewing policies, how often policies were reviewed, or where documentation on policies reviewed was located. Staff B stated policies were to be reviewed yearly and documented on the policy itself when it was reviewed. Staff B acknowledged policies were being reviewed and/or updated as needed and some policies might not be up to date. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 10/28/2024 at 3:17 PM, Staff A, Administrator, stated policies were reviewed yearly and documented through the facility's quality assurance and performance improvement program. The State Survey Agency requested documentation that showed policies were reviewed yearly as required, at that time and again on 10/29/2024 at 3:04 PM. No documentation was provided. HAND HYGIENE Review of the facility policy titled, Handwashing/Hand Hygiene revised August 2015, showed hand hygiene was the primary means to prevent the spread of infections. The policy instructed staff to perform hand hygiene by using alcohol-based hand rub (ABHR) or wash their hands with soap and water before and after direct contact with residents, before preparing or handling medication, before and after handling an invasive medical device, before handling clean or soiled dressings, before moving from a contaminated body site to a clean body site, after contact with a resident's intact skin, after handling used dressings or contaminated equipment, after contact with objects in the immediate vicinity of a resident, after removing gloves, before and after entering an isolation precaution setting, and after removal of personal protective equipment (PPE). The policy specified staff were to wash their hands with soap and water when visibly soiled and after contact with a resident with infectious stools. Glove use and routine hand hygiene was the best practice for preventing healthcare-associated infections. The policy further showed all staff were to perform hand hygiene when indicated to help prevent the spread of infections to other personnel, residents, and visitors. The website CDC.gov - in which CDC refers to Centers for Disease Control and Prevention- with regard to hand hygiene showed, hand hygiene protects both healthcare personnel and patients. Hand hygiene means handwashing with water and soap or antiseptic hand rub (alcohol-based foam or gel hand sanitizer) . gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene before donning [applying] gloves and touching the patient or the patient's surroundings recommendations for hand hygiene in healthcare settings . immediately before touching a patient, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal cleaning hands at key times with soap and water or hand sanitizer that contains at least 60% alcohol is one of the most important steps you can take to avoid getting sick and spreading germs to those around you. The website CDC.gov - with regard to standard precautions showed, standard precautions are based on the principle that all blood, body fluids, secretions, excretions except sweat, nonintact skin, and mucous membranes may contain transmissible infectious agents. Standard precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered. These include: hand hygiene, use of gloves, gown, masks, eye protection, or face shield, depending on the anticipated exposure The application of Standard Precautions during patient care is determined by the nature of the HCW [health care worker]-patient interaction and the extent of anticipated blood, body fluid, or pathogen exposure. During observation on 10/22/2024 at 8:40 AM, Staff I, Nursing Assistant (NA), assisted a resident reposition in bed, exited the room without performing hand hygiene, pushed a black rolling cart down the hall that contained black cups with lids and straws, then delivered a cup to a resident in a different room, without performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observation on 10/22/2024 at 8:47 AM, Staff I, NA, exited a resident room while actively removing a pair of green gloves, did not perform hand hygiene, walked down the hall to the clean linen cart to obtain a pair of yellow socks, and returned to the resident room, without performing hand hygiene. During observation on 10/22/2024 at 9:31 AM, Staff I, entered a resident room without performing hand hygiene, adjusted the resident's bedside table and privacy curtain, and exited the room without performing hand hygiene. During observation on 10/23/2024 at 1:45 PM, Staff J, NA, put on a pair of green gloves without performing hand hygiene. During observation on 10/24/2024 at 8:11 AM, Staff K, Registered Nurse (RN), dispensed medications for a resident, did not perform hand hygiene prior to entering the resident room, placed items on the resident's bedside table, adjusted the bedside table, and administered an injection without performing hand hygiene or applying a pair of gloves. In an interview on 10/24/2024 at 8:19 AM, Staff K, stated they never wore gloves when administering injections. Staff K acknowledged they should have used ABHR prior to entering the resident room. In an interview on 10/25/2024 at 2:35 PM, Staff L, NA, stated hand hygiene should be performed when entering and exiting a resident room, before applying and after removal of PPE. Staff L was unable to specify other instances when hand hygiene was indicated. In an interview on 10/25/2024 at 3:00 PM, Staff N, Licensed Practical Nurse, stated staff should perform hand hygiene when indicated to prevent the spread of germs. In an interview on 10/28/2024 at 10:57 AM, Staff H, Charge Nurse, stated staff should wear gloves when administering injections. Staff H further stated staff should perform hand hygiene when indicated to prevent the spread of germs or infection and prevent others from getting sick. In an interview on 10/28/2024 at 1:31 PM, Staff C, IP, explained hand hygiene was cleansing hands with ABHR or washing with soap and water when visibly soiled or after contact with a resident with infectious stools. Staff C stated hand hygiene should be performed when entering and exiting a resident room, before and after removal of PPE, and after staff ate or used the restroom. Staff C was unable to specify other instances when hand hygiene was indicated. Staff C stated staff were expected to perform hand hygiene when indicated to prevent the spread of germs and/or infection. Staff C further stated staff should wear gloves when administering injections because of the potential risk of contact with blood. In an interview on 10/28/2024 at 3:17 PM, Staff A, Administrator, stated they expected staff to perform hand hygiene when indicated. <Resident 135> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to a 10/04/2024 admission assessment, Resident 135 was alert and made their needs known. The document further showed Resident 135 had diagnoses which included diabetes, heart failure (an impairment of the hearts ability to fill and pump blood, which can cause swollen legs) and peripheral vascular disease (a disorder of the blood vessels, that can cause impaired circulation to the legs and feet.) On 10/21/2024 at 11:50 AM, observed as Staff X, Registered Nurse (RN) changed the dressing on Resident 135's right lower leg. The resident had a bulky dressing wrapped from below their knee to just above the ankle. Staff X wore a gown and gloves into the room when they brought in the new dressing supplies. They set the unopened supplies on the resident's bed. The resident then moved their wheelchair so they could prop their right foot on the bed, leaving the right calf free. Staff X unwound the fluffy gauze roll (kerlex) and absorbent pads (ABD pads), which were saturated and heavy with clear drainage, and discarded them in the trash. Staff X then pressed around on the resident's leg, to evaluate the extent of the swelling and where all the drainage was coming from. Staff X did not change their gloves or perform hand hygiene, after handling the soiled dressing or touching the resident's skin. Staff X then opened the new kerlex roll packaging and ABD package, and set the opened ABD's on their lap (covered with a gown) and redressed the leg, used bandage scissors, all while wearing the same gloves they removed the soiled dressings with. When asked how often the dressing changes were done, Staff X responded that it was ordered as needed. Staff X removed their gown and gloves, and used hand sanitizer when they left the room. During an interview on 10/25/2024 at 2:41 PM, Staff N, LPN, stated that they should clean your hands and put on clean gloves, after removing an old dressing during wound care. So basically, when you went from a dirty task to a clean. During an interview on 10/25/2024 at 3:04 PM, Staff Q, RN, stated should change gloves after they removed the old dressing and cleansed the wound and before they put the new dressing on. They further stated it could cause an infection, if hand hygiene not done. During an interview on 10/25/2024 at 3:35 PM, Staff B, Director of Nursing stated their expectation of staff performing a dressing change was to do hand hygiene and change gloves after removing soiled dressing, anytime they went from a dirty task to a clean task. Not doing so was an infection control issue. Staff B acknowledged the description of the dressing change for Resident 135 did not meet their expectations. SOILED LINEN STORAGE During observation on 10/21/2024 at 9:10 AM, two large waist high barrels were observed in the common milieu area, one barrel lid was labeled as soiled linen with biohazards stickers, the second was labeled as garbage. Similar observations were made on 10/22/2024 at 9:31 AM, 10/23/2024 at 8:44 AM, and on 10/28/2024 at 10:27 AM. In an interview on 10/28/2024 at 10:33 AM, Staff O, NA, stated the soiled linen and trash barrels were always stored in the common milieu instead of behind closed doors and acknowledged it could be a potential infection control issue. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 10/28/2024 at 10:57 AM, Staff H, Charge Nurse, stated soiled linen and garbage was stored in different locations on the units based on NA preference and had seen them stored in the common milieu area. Staff H further stated storing soil linen and garbage in the common milieu area could be a potential infection control issue if residents tried to access them. In an interview on 10/28/2024 at 1:31 PM, Staff C, IP, stated the large soiled linen and garbage barrels should be stored in the shower room, not in the common milieu area, because that could be a potential infection control issue. TRANSMISSION BASED PRECAUTIONS Review of the undated facility policy titled, Transmission Based Precautions showed transmission of infection required a source of infection, a mode of transmission, and a vulnerable host. The policy categorized transmission-based precautions (TBP) into contact precautions, droplet precautions, airborne precautions, and enhanced barrier precautions (EBP). Clear signage would be posted on the resident door or wall outside of the resident room indicating the type of precaution implemented and required PPE. Contact precautions were designed to reduce the transmission of microorganisms by direct or indirect contact. Direct contact transmission involved the physical transfer of microorganisms to a susceptible host from an infected person and indirect contact transmission involved contact of a susceptible host with contaminated hands, objects, or surfaces. The website CDC.gov - with regard to TBP showed, Transmission-Based Precautions are the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. Use contact precautions for patient with known or suspected infections that represent an increased risk for contact transmission. Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning [applying] PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens. Review of the undated facility policy titled, Enhanced Barrier Precautions showed EBP referred to the use gloves and gown during high-contact resident care activities for residents know to be colonized or infected with a MDRO or at increased risk of MDRO acquisition. The policy showed a provider order would be obtained for EBP for resident with chronic wounds and/or indwelling medical devices. High-contact care activities included dressing, bathing, transferring, providing hygiene, changing linens, and indwelling medical device care. The policy showed staff were expected to know which residents should be placed on EBP, appropriate PPE to wear and when to wear it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The website CDC.gov - with regard to EBP showed, Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities . Examples of high-contact resident care activities requiring gown and glove use include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line [venous catheter inserted into the neck, chest, or groin to provide access to the bloodstream], urinary catheter [flexible tube that drains urine from the bladder into a collection bag], feeding tube [flexible tube that provides nutrition, fluids, and medicine when unable to eat or drink safely], tracheostomy [surgical opening that creates an opening into the neck to provide alternative airway for breathing]/ventilator [machine that assists with breathing when unable to do so independently]), and wound care for any skin opening requiring a dressing . EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status and infection or colonization with an MDRO. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care. Standard Precautions, which are a group of infection prevention practices, continue to apply to the care of all residents, regardless of suspected or confirmed infection or colonization status. <Resident 23> According to the admission assessment, dated 07/13/2024, showed Resident 23 admitted to the facility on [DATE]. The assessment further showed Resident 23 had a colostomy, had surgical wounds, did not require isolation or quarantine for active infectious disease, did not have intravenous (IV) access or a MDRO infection. Resident 23 was cognitively intact and able to verbalize their needs. Review of the 07/09/2024 clinical admission assessment showed Resident 23 had a colostomy, had an abdominal surgical incision, was not on isolation precautions for active infections, and did not have IV access. Review of the 07/10/2024 care plan showed Resident 23 was on EBP related to having a colostomy and instructed staff to follow precaution signage, perform hand hygiene per protocol, monitor for signs and/or symptoms of infection, and notify the provider of changes of condition. The 07/10/2024 care plan showed Resident 23 was at risk for impairment to skin integrity related to bruising, moisture associated skin damage and fungal skin conditions. The care plan instructed staff to perform treatments per provider orders, float heels, and therapy for positioning and mobility. Review of August 2024 through October 2024 weekly head to toe assessments showed Resident 23 had a small skin tear to their right wrist, no chronic skin issues were documented. Review of September 2024 through October 2024 nursing progress notes showed Resident 23's abdominal surgical incision healed on 09/28/2024. During observation on 10/21/2024 at 8:47 AM, EBP signage was posted right outside Resident 23's room with a plastic tote full of PPE supplies. Similar observations were made on 10/21/2024 at 9:41 AM and 2:37 PM, on 10/22/2024 at 8:50 AM and 3:36 PM. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of provider orders as of 10/22/2024 showed no order for Resident 23 to be on EBP for their colostomy. During an interview on 10/23/2024 at 2:18 PM, Resident 23 stated their surgical incisions were healed but they still had a colostomy. In an interview on 10/24/2024 at 10:01 AM, Staff M, NA, stated Resident 23 had a colostomy but no other wounds or indwelling medical devices. In an interview on 10/24/2024 at 10:25 AM, Staff K, RN, stated Resident 23's surgical incisions had healed, did not have chronic wounds or indwelling medical devices. In an interview on 10/24/2024 at 11:50 AM, Staff B, DNS, reviewed Resident 23's medical record. Staff B stated Resident 23 did not have wounds or indwelling medical devices. In an interview on 10/28/2024 at 11:51 AM, Staff C, IP, and Staff B, DNS. Staff C stated EBP required the use of gloves and a gown when providing resident care. Staff B stated if staff were entering an EBP room they were not required to put on PPE if they were not coming into contact with the resident or their environment. Staff B explained EBP were implemented to protect the resident from potential MDRO acquisition because they were at higher risk compared to contact precautions that protected staff from MDROs. Staff B further stated EBP should be removed as soon as the indwelling medical device was removed or if discontinuation was ordered by the provider. Both Staff B and C reviewed Resident 23's medical record. Staff C stated Resident 23 was on EBP because they had a colostomy. Staff C further stated Resident 23 did not have wounds or long-term IV access. <Resident 135> According to the admission assessment, dated 10/04/2024, showed Resident 135 admitted to the facility on [DATE] with diagnoses including a MDRO infection. The assessment further showed Resident 135 had surgical wounds, had IV access, and was not on isolation or quarantine for active infectious diseases. Resident 135 was cognitively intact and able to verbalize their needs. Review of 09/30/2024 hospital discharge paperwork showed Resident 135 was to be on contact precautions for an active MDRO infection. Review of the 09/30/2024 clinical admission assessment showed Resident 135 had a surgical incision to their chest and long-term IV access. The assessment further showed Resident 135 was to be on contact isolation precautions related to a MDRO bladder infection. Review of the 10/03/2024 care plan showed Resident 135 was at risk for infection related to long-term IV access and instructed staff to completed dressing changes weekly, monitor lung sounds, and inspect the insertion site for signs and/or symptoms of infection. The 10/03/2024 urinary care plan showed Resident 135 had a MDRO bladder infection and instructed staff to administer medications per provider orders, encourage fluids, and monitor urine. Special instructions on the care plan showed Resident 135 was on contact precautions for a MDRO bladder infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observation on 10/21/2024 at 10:59 AM, a Contact Precaution sign was posted outside Resident 135's room. The sign instructed persons entering the room to perform hand hygiene and wear a gown and gloves prior to entering. Similar observation was made on 10/22/2024 at 8:38 AM. During observation on 10/21/2024 at 12:47 PM, Staff M, NA, entered Resident 135's room without putting on a gown or gloves, moved a breathing machine and placed it on a chair, placed a meal tray on the bedside table, adjusted the table and opened up the tray, then used ABHR when exiting the room. At 12:49 PM, Staff M returned to Resident 135's room, did not perform hand hygiene, did not put on gloves or a gown, entered the room to hand Resident 135 butter, moved the call light within reach, and used ABHR when exiting the room. At 12:54 PM, a male visitor was sitting on Resident 135's bed without wearing a gown or gloves. At 12:56 PM, the male visitor exited Resident 135's room without performing hand hygiene. In an interview on 10/28/2024 at 11:51 AM, Staff C, IP, stated if TBP were not followed it could cause the spread of infection and cause an infection outbreak. Staff C further stated they expected staff to follow TBP when implemented. In an interview on 10/28/2024 at 3:17 PM, Staff A, Administrator, stated they expected staff to follow TBP when implemented. Reference WAC 388-97-1320 (1)(a), (2)(b), (1)(c), (3) Refer to F882 for additional information. 42802

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review the facility failed to implement antibiotic protocols to ensure antibiotics were appropriately prescribed for 1 of 6 sampled residents (Resident 4), reviewed for antibiotic stewardship. This failure placed residents at risk of development of [NAME]-drug-resistant organisms (MDRO), adverse side effects, and diminished quality of life. Findings included . Review of the facility policy titled, Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes revised July 2016, showed antibiotic usage and outcome data would be collected, documented on the antibiotic surveillance tracking form, information used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility wide antibiotic stewardship. The policy showed all clinical infections treated with antibiotics would undergo review by the infection preventionist or designee within 48 hours of antibiotic start to determine if continued therapy was justified. The policy showed antibiotic therapy was not justified if the organisms was not susceptible to the antibiotic chosen, antibiotic therapy was ordered for prolonged surgical prophylaxis or antibiotics were started awaiting culture, but no organisms was isolated after 72 hours. The policy further showed the provider would be notified of the antibiotic stewardship review findings and recommendations and the provider response documented as follows: agrees to make change, needs to discuss with the team prior to making changes, or will not make changes because they do not agree with recommendations and/or team does not agree with recommendations. The website CDC.gov - in which CDC refers to Centers for Disease Control and Prevention - with regard to antibiotic stewardship showed antibiotic stewardship is the effort to measure and improve how antibiotics are prescribed by clinicians and used by patients improving antibiotic prescribing and use is critical to effectively treat infections, protect patients from harms caused by unnecessary antibiotic use, and combat antibiotic resistance. The website CDC.gov - with regard to urinary tract infection (UTI) showed urinary tract includes the bladder [organ in pelvis that stores urine], urethra [tube which urine leaves the body] and kidneys [remove waste and extra water from the blood as urine]. UTIs are common infections that happen when bacteria, often form the skin or rectum, enter the urethra and infect the urinary tract any time you take antibiotic, they can cause side effects. Side effects can include rash, dizziness, nausea, diarrhea, and yeast infections. More serious side effects can include antimicrobial-resistant infections (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of McGeer Criteria revised 04/2024, with regard to UTI, showed residents without an indwelling catheter (tube left in the bladder that drains urine into a drainage bag) must meet criteria 1 and criteria 2 for symptomatic UTI infection. Criteria 1- At least one symptom acute dysuria (burning sensation during urination) OR acute pain, swelling, or testicular tenderness; fever OR leukocytosis (high white blood cell count) AND at least one of the following localized urinary tract sub-criteria: acute back pain or tenderness, suprapubic tenderness, gross hematuria, new or marked increased incontinence, urinary urgency or frequency. In the absence of fever or leukocytosis, then at least 2 or more localizing urinary symptoms need to be met. Criteria 2- culture identified no more than 2 species of microorganisms >100,000 colony count (number of microorganisms grown) in a voided urine OR >10,000 colony count of any number of organisms in a specimen collected by in-and-out catheter. UTI should be diagnosed when there are localizing signs and/or symptoms AND a positive urinary culture . pyuria [pus in urine] does not differentiate symptomatic UTI from asymptomatic bacteriuria [high bacterial count with one or more organisms in the urine specimen without symptoms or infection]. Review of McGeer Criteria revised 04/2024, with regard to skin, soft tissue, and mucosal infections, showed at least one of the following criteria must be present 1) pus present at a wound, skin, or soft tissue site, 2) new or increased presence of at least 4 of the following signs or symptom sub-criteria: a) heat at the affected site, b) redness at the affected site, c) swelling at the affected site, d) tenderness or pain at the affected site, e) serous (clear, thin, watery fluid) drainage at the affected site, and/or f) fever, leukocytosis, acute change in mental status, or acute functional decline. According to the admission assessment, dated 09/13/2024, Resident 4 admitted to the facility on [DATE] with diagnoses including bladder infection and was always incontinent of bladder. The assessment further showed Resident 4 had recent major surgery involving the abdominal contents and had surgical wounds. Resident 4 was cognitively intact and able to make their needs known. Review of 09/09/2024 hospital discharge orders showed Resident 4 did not have a urinary catheter. Resident 4 was discharged with an abdominal drain and instructed staff to strip (squeezing and moving drain tubing to prevent obstructions) daily and empty as needed. The orders further showed Resident 4 had an abdominal incision closed with staples and instructed staff to remove staples on or around 09/19/2024, change dressing as needed, notify the surgeon of drainage, and contact the surgeon prior to starting antibiotics or sending Resident 4 to the emergency department for a suspected infected incision. Review of the 09/10/2024 care plan showed Resident 4 was at risk for potential impairment to skin integrity and instructed staff to completed treatments as ordered, encourage meals, monitor skin weekly, and report skin redness/breakdown to the nurse. The care plan further showed Resident 4 had a drain, but no documentation was found to show Resident 4 had surgical wounds. Review of 09/18/2024 urologist (specialist in the urinary system) progress notes showed Resident 4 was ordered an antibiotic twice daily for five days (09/18/2024 through 09/23/2024) then dose decreased to once daily (without an end date) for UTI prevention. A urine sample was to be sent out for culture if any UTI symptoms were noted. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of September 2024 through October 2024 nursing progress notes showed on 09/09/2024 Resident 4 admitted to the facility with a 16.5 centimeter (cm) surgical incision closed with 19 staples and an abdominal drain. On 09/18/2024 Resident 4's drain was removed. On 09/19/2024 Resident 4 was started on antibiotics for a UTI without signs and/or symptoms of UTI. On 09/22/2024 Resident 4 denied urinary symptoms related to a UTI. On 09/25/2024 Resident 4 was tired with an elevated temperature earlier in the day, denied urinary infection symptoms, and a urine sample was obtained via catheter. On 09/26/2024 Resident 4 experienced a fever and moderate amount of lose stools possibly related to the antibiotic administered for UTI. On 09/28/2024 Resident 4's abdominal incision split open, and a massive amount of pus drained. The notes further showed minimal monitoring/assessment documentation of the large abdominal surgical incision closed with staples. Review of the antibiotic stewardship surveillance spreadsheet showed Resident 4 was started on antibiotics on 09/25/2024 for a bladder infection and McGeer criteria met was marked as N/A. Review of the September 2024 Medication Administration Record showed Resident 4 was administered antibiotics twice daily for five days 09/19/2024 through 09/24/2024 and 09/25/20241 through 09/30/2024 for a UTI. Review of the urine culture sample collected via straight catheter on 09/25/2024 with 09/28/2024 results showed <10,000 colony forming units of mixed urogenital flora. No organisms were identified or grown to show medication sensitivity, the culture did not meet McGeer Criteria. The website CDC.gov - with regard to catheter-associated urinary tract infection, non-catheter-associated urinary tract infection (UTI) and other urinary system infection showed, the medical definition of flora is a group of organisms. Any type of mixed flora makes a positive urine culture ineligible for use to meet NHSN [National Healthcare Safety Network] UTI criteria, because mixed flora implies that at least 2 organisms are present in addition to the identified organism. The urine culture does not meet the criteria for a positive urine culture with 2 organisms or less and cannot be used to meet the NHSN UTI criteria. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of September 2024 provider progress notes showed on 09/13/2024 Resident 4's abdominal incision was healing without signs and/or symptoms of infection but complained of muscle spasms and pain that affected their ability to sit up in their wheelchair. Resident 4 was started on medications to help manage muscle spasms and pain. On 09/16/2024 Resident 4 was tired/fatigued, confusion, had an altered mental status, experienced recent hallucinations, declining condition, experienced intermittent abdominal pain, but had no fever, chills or other notable symptoms including urinary symptoms. Medications stated on 09/13/2024 were discontinued. On 09/20/2024 Resident 4's blood work was reviewed, mild elevated potassium levels were noted, and Resident 4 was ordered a medication to help reduce elevated potassium levels. On 09/25/2024 Resident 4 again began to hallucinate with no other identifiable signs and/or symptoms but had a reduction in antibiotic to treat a bladder infection from twice daily to once daily. Resident 4 was again ordered a medication to help reduce elevated potassium levels and medication to help rid the body of excess fluid was changed. On 09/26/2024 Resident 4 experienced hallucinations the previous day, orders were given to increase antibiotic for UTI back to twice daily, urine was sent for analysis, blood work showed very mild elevation in white blood cells. On 09/27/2024 Resident 4 experienced intermittent fevers over the past few days, slightly elevated white blood cells, and mildly elevated potassium levels. Resident 4's abdominal incision had opened up, drained pus, and a wound culture was collected. Resident 4 was started on a different antibiotic twice daily for an abscess (painful pus-filled pocket) near the surgical incision site, was referred to wound specialist, surgeon was to be notified of infection, fever, fatigue, and starting of antibiotics. On 10/02/2024 Resident 4's confusion had improved. Resident 4's surgical incision was assessed by the surgeon, wound care and antibiotics were to continue. Review of 10/01/2024 surgical specialist progress notes showed Resident 4 had surgical incision infection and wound was assessed. Wound care and antibiotics to treat the wound infection were to be continued. In an interview on 10/28/2024 at 10:57 AM, Staff H, Charge Nurse, stated the facility tool, criteria, or protocol for prescribing antibiotics depended on the type of infection but was up to the prescribing provider. Staff H further stated they typically just processed provider orders, double checked allergies, and place the resident on alert charting for monitoring, they did not review antibiotics to ensure they met criteria for appropriate usage. Staff H acknowledged if antibiotics were inappropriately prescribed it could lead to a resistant infection. In an interview on 10/28/2024 at 11:47 AM, with Staff C, Infection Preventionist, and Staff B, Director of Nursing. Staff C stated the facility used McGreer criteria to determine if an antibiotic was needed but when antibiotics did not meet McGeer criteria it is discussed with the provider. Staff B stated the provider did not always follow McGeer criteria. Staff B acknowledged if antibiotics were inappropriately prescribed it could cause MDRO infection or adverse side effects. In a follow-up interview on 10/28/2024 at 1:40 PM, with Staff C, IP, and Staff B, DNS, both staff reviewed Resident 4's medical record. Staff C was asked if Resident 4's antibiotic orders written on 09/25/2024 met McGeers criteria for a UTI. Staff C was unsure and requested assistance for answering the question from Staff B. Staff B stated staff did not fill out McGeer criteria forms when antibiotics were prescribed. Staff B reviewed McGeers criteria and stated a urine culture should be considered along with urinary symptoms to meet McGeers criteria. Staff B reviewed Resident 4's urine culture results for the sample collected on 09/25/2024 and acknowledged the culture results did not meet McGeers criteria for antibiotic use. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/28/2024 at 3:17 PM, Staff A, Administrator, stated they expected staff to follow antibiotic stewardship and ensure antibiotics were appropriately prescribed. No associated WAC. Refer to F882 for additional information.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 47328 Based on interview and record review, the facility failed to ensure the designated Infection Preventionist met the qualifications for experience, education, training and/or certification for the role to assume responsibility of the facility's Infection Prevention and Control Program for 1 of 1 sampled staff (Staff C), reviewed for infection preventionist qualifications. This failure placed all residents, staff, and visitors at risk of contracting communicable diseases, unmet infection control issues, and lack of oversite of the facility staff's infection control practices. Findings included . In an interview on 10/21/2024 at 9:03 AM, Staff A, Administrator, stated Staff C was the facility's infection preventionist. Documentation of Staff C's completion of specialized infection prevention and control training was requested at that time. No documentation was provided. Review of the 10/21/2024 staff list showed Staff C was identified as the facility's only infection prevention and control staff. In an interview on 10/24/2024 at 4:06 PM, Staff B, Director of Nursing, stated Staff C was the facility's infection preventionist since March 2024 but Staff C was still in the process of completing the infection preventionist training. In an interview on 10/25/2024 at 10:19 AM, Staff E, Admissions Registered Nurse, stated Staff C was the facility's infection preventionist, and should refer infection control questions to them. In an interview on 10/28/2024 at 11:26 AM, Staff C, Infection Preventionist, stated they were new to the infection preventionist role and were still learning. In an interview on 10/28/2024 at 3:17 PM, Staff A, Administrator, stated Staff C was the facility's infection preventionist but was still in the process of completing the infection prevention and control training. Staff A further stated they expected the infection preventionist to have sufficient training in infection prevention and control to perform the role. No associated WAC. Refer to F880, F881, F883, F887, and WAC 1480 for additional information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505411	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER: Sunshine Health & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE: 10410 East Ninth Avenue Spokane, WA 99206	

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review the facility failed to routinely provide education on benefits and potential side effects of vaccinations, offer pneumococcal (bacteria that could cause respiratory infections) and influenza (flu, contagious viral respiratory illness) vaccinations when indicated, and document in the resident's medical record accordingly for 3 of 5 sampled residents (Resident 4, 52 and 78), reviewed for immunizations. These failures placed residents at risk of being unable to make informed decisions regarding immunizations, acquiring communicable diseases, and diminished quality of life. Findings included . Review of the facility policy titled, Vaccination of Residents revised November 2012, showed all residents would be offered vaccinations to aid in the prevention of infectious diseases. Residents and/or their representatives would be provided information and education regarding benefits and potential side effects of vaccinations. The policy further showed education provided would be documented in the resident's medical record. Residents and/or their representatives could refuse vaccinations for any reason, vaccine refusals would also be documented in the resident's medical record. Review of the facility policy titled, Influenza Vaccine revised November 2012, showed all residents and staff without medical contraindications would be offered the influenza vaccine annually between October 1 and March 31. The policy showed the facility would provide pertinent information about the significant risks and benefits of vaccines to staff and residents/representatives prior to vaccination with documentation of education in the resident and/or employee's record. The policy further showed a resident and/or staff vaccination refusal would be documented on the influenza informed consent form. Review of the facility policy titled, Pneumococcal Vaccine revised October 2014, showed all residents would be offered pneumococcal vaccines within 30 days of admission unless medically contraindicated or if the resident had already been vaccinated. The policy showed the facility would provide information and education regarding the benefits and potential side effects of pneumococcal vaccine prior to vaccination with documentation of education in the resident's record. The policy further showed a residents and/or their representatives could refuse vaccination and vaccine refusals would be documented in the resident's medical record. <Resident 4> According to the admission assessment, dated 09/13/2024, Resident 4 admitted to the facility on [DATE] with diagnoses including respiratory failure (serious condition that made it difficult for a person to breathe on their own). The assessment further showed Resident 4 received the influenza vaccination outside of the facility and was offered and declined the pneumococcal vaccination. Resident 4 was cognitively intact and able to clearly verbalize their needs. (continued on next page)

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	10/29/2024

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

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 4's immunization record showed no documentation Resident 4 was educated, offered, or administered an influenza vaccine for the October 2024-May 2025 flu season. The immunization record further showed Resident 4 refused the pneumococcal vaccination on 09/10/2024 and immunization education provided was documented as no. Review of September 2024 through October 2024 nursing progress notes showed no documentation Resident 4 was educated, offered, or administered influenza or pneumococcal vaccinations. <Resident 78> According to the admission assessment, dated 09/24/2024, Resident 78 admitted to the facility on [DATE] with diagnoses including cancer, malnutrition, and failure to thrive. The assessment further showed Resident 78 received the influenza vaccine outside of the facility and pneumococcal vaccine was up to date. Resident 78 was cognitively intact and able to clearly verbalize their needs. Review of Resident 78's immunization record showed no documentation Resident 78 was educated, offered, or administered an influenza vaccine for the October 2024-May 2025 flu season. Review of September 2024 through October 2024 nursing progress notes showed no documentation Resident 78 was educated on, offered, or administered an influenza vaccine for the October 2024-May 2025 flu season. <Resident 52> According to the admission assessment, dated 10/17/2024, Resident 52 admitted to the facility on [DATE]. Review of Resident 52's immunization record showed no documentation Resident 52 was educated or offered an influenza vaccine for the October 2024-May 2025 flu season. Review of October 2024 nursing progress notes showed no documentation Resident 52 was educated or offered an influenza vaccination for the October 2024-May 2025 flu season. In an interview on 10/28/2024 at 1:17 PM, Staff C, Infection Preventionist, stated they reviewed resident immunization records to determine which vaccinations were needed. Staff C further stated the facility offered residents pneumococcal vaccinations if they qualified and influenza vaccines during the flu season. Staff C acknowledged they did not document education on risks versus benefits of vaccinations when vaccines were offered and refused. In an interview on 10/28/2024 at 3:17 PM, Staff A, Administrator, stated they expected residents to be educated on vaccinations offered. Reference WAC 388-97-1340 (1),(2),(3) Refer to F641 and F882 for additional information

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

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 42802 Based on interview and record review, the facility failed to provide documented evidence of the required annual 12-hours of in-service training, which included dementia training for 5 of 5 nursing assistants (I, L, M, O, V), reviewed for nursing assistant continuing education and abuse prevention for 2 of 5 staff (I, V), as required. This deficient practice placed the residents at risk of being cared for by inadequately trained staff, and unmet care needs. Findings included . According to the Facility Assessment Tool, dated 07/23/2024, the facility required in-service nurse assistants (NA) trainings must be at least 12 hours per year, and include dementia management and resident abuse prevention training. Sunshine Health Facilities, Inc. Employee Handbook, 2024, page 32, documented Many of the in-services offered to staff are required by state law. Participation in in-services are reflected in your performance evaluations and required as part of your employment. During an interview on 10/28/2024 at 2:37 PM, Staff B, Director of Nursing, stated that the staff trainings for NA's included orientation when hired, education in mandatory all-staff meetings and access to Relias, an on-line education program. Staff B stated that Staff C, Infection Preventionist was also involved with the NA trainings. Staff B stated they had a sign-in attendance sheet for the meetings. For staff that did not attend the mandatory meeting, they tried to catch them and train individually, but admitted that the individual trainings were not written down. When asked about how the mandatory 12 hours of NA training was tracked, Staff B stated that since it was a requirement for their certification, the individual NA was responsible and they were not always given those records by the employee. On 10/28/2024 at 3:31 PM, requested documentation from Staff B and Staff C of all trainings, which included dementia care, abuse prevention and infection control for sampled Staff I, L, M, O, and V. According to the staff list provided by the facility: - Staff I, NA, was hired on 08/26/2024 - Staff L, NA, was hired on 06/02/2016 - Staff M, NA, was hired on 12/31/2019 - Staff O, NA, was hired on 12/29/2010 - Staff V, NA, was hired on 03/28/2024 (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Skills Fair itinerary, dated 08/28/2024, showed abuse and neglect, and infection control listed as topics included in the training. Dementia management was not included. A review of the corresponding sign-in attendance sheet showed that Staff I and V of the sampled NA's, did not attend the training. A comparison of the staff list provided by the facility to the skills fair sign-in log documented that eight of the nineteen NA's attended the mandatory skills fair. During an interview on 10/29/2024 at 1:14 PM, Staff B stated that they could not verify that all NA's got the training from the skills fair, that were not signed off on the attendance sheet. Staff B stated that they posted reminders of mandatory trainings, emailed and texted the staff. Staff B said they could not force staff to come to the trainings, or fire them because they did not. Staff B stated they did not have verification of 12 hours of continuing education yearly for the NA's. No further documents were provided. Reference: WAC 388-97-1680(2)(a-c)