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	01/30/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview and record review the facility failed to ensure that residents, families and visitors had access to grievance forms if they wanted to file a grievance anonymously. The facility also failed to ensure residents knew the process for filing grievances for 4 of 4 residents (Resident's 61,15, 66 and 51) reviewed for the grievance process in Resident Council. Additionally, staff were unaware of the location of grievance forms in the event a resident, family member or visitor requested a form. This failure placed the residents at risk for not being able to voice concerns and have their concerns resolved in a timely manner.Findings included . Review of a facility policy dated 10/2025 titled Resident/Family Grievance Policy a Procedure showed; the facility staff will make grievance forms available to residents, family members and friends. During a Resident Council meeting on 01/28/2026 at 10:42 AM, Resident's 61, 15, 66 and 51 each stated they were unaware of the grievance process to include how to file a grievance anonymously or where the forms were located. Resident 51 stated they thought they would probably call the corporate office if they had any concerns. During an observation on 01/26/2026 at 9:36 AM, showed a bulletin board around the corner from the nurse's station. The board contained information which included the grievance process. Below the board was a plastic letter sized pocket attached to the wall designed to hold papers or forms which was empty. To the left of the plastic pocket was a locked wood box also attached to the wall with an opening on top to place papers or forms. Neither the plastic pocket or wood box were labeled or identified as to what they were used for. In an interview on 01/27/2026 at 9:42 AM, Staff J, Registered Nurse, was asked where the grievance forms were located and they stated, I'm not sure, but they are around here somewhere, maybe you should ask someone else. During an interview on 01/27/2026 at 9:45 AM, Staff G, Licensed Practical Nurse, was asked where the grievance forms were located, and they stated they were unsure but would ask someone where they were kept. Staff G thought they might be at the nurse's station. During an interview on 01/27/2026 at 9:46 AM, Staff C, Infection Preventionist, was asked where the grievance forms were located, and they stated in the file cabinet at the nurse's station. Staff C attempted to find a grievance form however they stated there were none available. I can't find them. I will go and get some because we keep them in the nurse's station. During a concurrent observation and interview on 01/27/2026 at 9:50 AM, Staff B, Director of Nursing (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Services, observed the bulletin board with the posted grievance process and the unidentified empty plastic pocket and locked wood box. Staff B stated the plastic pocket was empty but should be identified as the grievance form holder. Staff B stated the wood locked box should also be identified as the receptacle for completed grievance forms. Staff B stated they would re-fill and label the plastic pocket as that was where the grievance forms were kept. Additionally, their expectation was that residents or family members should be able to file a grievance anonymously if they chose to and not have to ask for a form at the nurses station. Reference: WAC 388-97-0460

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure 6 of 7 residents (Residents 44, 7, 64, 61, 20, and 49) were accurately assessed for activity preferences to mitigate the risk of boredom and enhance quality of life. Additionally, the facility failed to have a registered nurse ensure the activity assessments were timely and appropriately completed. This failure placed the residents at risk for unmet psycho-social needs and a diminished quality of life.Findings included.Review of the Long Term Care Facility Resident Assessment Instrument 3.0 Manual dated 10/2019 Section F: Preferences for Customary Care and Routine Activities, showed, quality of life can be greatly enhanced when care respects the residents choices regarding activities that are important to them. Information directly from the resident or representative provides specific individualized daily activity planning. Resident 44Review of the resident's medical record showed they were admitted the facility with diagnoses which included a right hip fracture with surgical repair and diabetes (too much sugar in the blood), The comprehensive assessment dated [DATE] showed the resident was cognitively intact and required substantial assistance from staff for transfers, lower body dressing and mobility. Further review of the assessment showed the area related to activity preferences was not assessed. During a concurrent observation and interview on 01/26/2026 at 11:22 AM, Resident 44 in their room looking out the window. When asked if they wanted to attend an activity they stated no as they were unsure what was available and were not sure if it would interest them. During an observation on 01/28/2026 at 10:16 AM and 01/29/2026 at 3:40 PM showed Resident 44 in their room alone, looking out the window, and not engaged in any activities. Resident 7Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including dementia (a progressive disease that destroys memory and other important mental functions), malnutrition and kidney complications. The 10/29/2025 comprehensive assessment showed the resident had a severe cognitive impairment, but the activity preferences were not assessed. Resident 64Review of Resident 64's medical record showed they were admitted to the facility on [DATE] with diagnoses including a fracture of the lower spine, long term pain, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety (a feeling of unease, worry, or fear about something that might happen in the future). The 01/16/2026 comprehensive assessment showed the resident's cognition was intact and they were able to make their needs known, but the activity preference had not been assessed. Resident 61Record review of Resident 61's medical record showed they were admitted to the facility on [DATE] with diagnoses including kidney failure, diabetes, and a right below the knee amputation. Review of the 01/17/2026 resident assessment showed the resident required set-up/moderate assistance of one staff member for activities of daily living (ADLs) and had an intact cognition. Further review of the assessment showed the area related to activity preferences was not assessed. Resident 20Record review of Resident 20's medical record showed they were admitted to the facility on [DATE] with diagnoses including history of bladder cancer, anemia and depression. Review of the 01/09/2026 resident assessment showed the resident required moderate assistance of one to two (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff members for ADLs and had an intact cognition. Further review of the assessment showed the area related to activity preferences was not assessed. Resident 49Review of the medical record showed the resident was admitted to the facility with diagnoses including right hip fracture, dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and diabetes (a condition that happens when your blood sugar is too high). The 11/11/2025 comprehensive assessment showed Resident 49's cognition was intact and required the assistance of one staff member for ADLs. Further review showed Resident 49 was not assessed for daily and activity preferences. During an interview on 01/27/2026 at 2:49 PM Staff S, Activities Assistant, stated they were responsible for completing the activities assessments with residents who were admitted to the facility. The assessments included resident preferences and a plan to accommodate the identified preferences for activities. Staff S stated they were not always able to complete the assessment as they did not have enough time and realized they were currently behind on the resident activity assessments. During an interview on 01/27/2026 at 4:04 PM, Staff D, Registered Nurse, Minimum Data Set (MDS, a comprehensive assessment tool) Coordinator, stated they were aware that the activities assessments were not consistently being completed and had to mark the activity portion of the assessment as not assessed to be able to transmit it. Staff D stated the incomplete activity assessments had been an ongoing issue which had improved for a while but had gotten worse again. In an interview on 01/29/2026 at 3:46 PM, Staff B, Director of Nursing Services, stated they expected resident activity assessments to be completed timely as required. Staff B stated they would re-visit the issue of incomplete activity assessments as it had been a previous concern. Reference: WAC 388-97-1000(1)(b)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than five percent. Four medication errors were identified for 3 of 8 residents (Residents 31, 61 and 75) observed during 25 medication administration opportunities that resulted in an error rate of 16%. This failure placed residents at risk for not receiving the full therapeutic effect of the medication and possible adverse side effects.Findings included. Review of the Instructions for use (IFU) by the U.S. Food and Drug Administration (USFDA) revised 07/2023, stated to prime the insulin (a medication used to manage blood sugar levels in the blood) pen (a pre-filled disposable device containing insulin) with a new needle prior to each injection administration. Priming was meant to remove air from the needle and the cartridge that may collect during usages. In addition, the IFU stated to insert the needle into the skin, press plunger all the way down, and continue to hold the plunger and slowly count to five prior to removing the needle. These steps were to ensure the insulin pen worked correctly and the proper dosage of medication was administered. Resident 31Review of the medical record showed Resident 31 was admitted with diagnoses including diabetes (a group of diseases that result in too much sugar in the blood), chronic obstructive pulmonary disease (COPD-a group of lung diseases that block airflow and make it difficult to breathe), and hypertension (high blood pressure). The 12/16/2025 comprehensive assessment showed Resident 31 required supervision/substantial assistance of one staff member for activities of daily living (ADLs) and had an intact cognition. Review of Resident 31's December 2025 and January 2026 physician orders, showed the resident had four orders for insulin. One order dated 12/19/2025, showed the resident's insulin was to be administered on a sliding scale based on the resident's current blood glucose (sugar) result. The sliding scale showed that based on blood glucose of 201-250 milligram (mg)/deciliter (dL), the resident was to have six units (unit of measure) of insulin. Resident 31's blood glucose result was 248 mg/dL. A second physician order dated 12/30/2025 showed Resident 31 was to have 15 units administered every morning. The third physician order dated 01/05/2026 showed Resident 31 was to have six units of insulin administered every morning. The fourth physician order dated 01/05/2026 showed Resident 31 was to have four units of insulin administered twice a day. During an observation and concurrent interview on 01/27/2026 at 8:37 AM, showed Staff J, Registered Nurse, (RN), prepare the insulin pen by cleaning both insulin pen tips with an alcohol swab then attached a disposable needle to administer the insulins. Staff J dialed one insulin pen to 12 units and the other insulin pen to 15 units. Staff J did not prime either of the insulin pen needles prior to the administration. Staff J stated they did not know they were to prime the needle of the insulin pens. During an observation on 01/28/2026 at 12:52 PM, showed Staff K, Licensed Practical Nurse, prepared one dose of insulin. Resident 31's blood glucose level was 371 mg/dL. Based on the sliding scale of insulin the resident was to be administered 14 units, in addition to the four units for a total administration of 18 units of insulin. Staff K obtained two insulin pens as one pen did not contain 18 units of insulin. Staff K swabbed the tops of the insulin pens, dialed them each to two units and pressed the plunger, then attached the disposable insulin needles. (This did not allow for the insulin to prime the needles). Staff K dialed one insulin pen to 10 units and the second insulin pen to eight units. Staff K then inserted one insulin pen needle into Resident 31's abdomen, pressed the insulin pen plunger and held for two seconds, then pressed the second insulin pen needle into the other side of (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	their abdomen, pressed the insulin pen plunger and held for two seconds. Resident 61Review of the medical record showed Resident 61 was admitted with diagnoses including diabetes, kidney disease and hypertension. The 01/17/2026 comprehensive assessment showed Resident 61 required set-up/moderate assistance of one staff member for ADLs and had an intact cognition. Review of Resident 61's physician orders showed they had orders for insulin. One insulin order dated 01/19/2026 showed the resident's insulin was to be administered on a sliding scale based on the resident's current blood glucose result. The sliding scale showed that based on blood glucose of 131-150 mg/dL, the resident was to have three units of insulin. Resident 61's blood glucose level was 142 mg/dL. In addition, Resident 61 had another insulin order that showed they were to be administered 10 units of insulin with meals. During an observation on 01/27/2026 at 9:08 AM, showed Staff J prepared Resident 61's insulin pen by swabbing the top of the insulin pen with an alcohol swab, attached a disposable needle, dialed the insulin pen to 13 units, and administered to Resident 61's abdomen. Staff J did not prime the insulin pen needle. Resident 75Review of Resident 75's medical record showed they were admitted with diagnoses including diabetes, kidney disease and COPD. Resident 75's admission care plan showed they required dependent/moderate assistance of one to two staff for ADLs and had an impaired cognition. Review of Resident 75's physician orders dated 01/26/2026, showed the resident's insulin was to be administered on a sliding scale based on the resident's current blood glucose result. The sliding scale showed that based on blood glucose of 131-150 mg/dL, the resident was to have two units of insulin. The resident's blood glucose level was 142 mg/dL. During an observation on 01/28/2026 at 12:52 PM, showed Staff K, prepared Resident 75's two units of insulin by swabbing the top of the insulin pen with an alcohol swab, dialed the insulin pen to two units and pressed the plunger, then attached the disposable insulin needle (This did not allow for the insulin to prime the needle). Staff K then dialed the insulin pen to two units, inserted into the resident's abdomen and pressed the plunger and immediately removed from the skin (Staff K did not hold into the resident's skin and count to five seconds). During an interview on 01/28/2026 at 2:55 PM, Staff B, Director of Nursing Services, stated the process for administering insulin using an insulin pen was to swab the top of the insulin pen with an alcohol swab, attach a new disposable insulin needle, dial the insulin pen to two units and press the plunger to allow the insulin to prime the needle. Staff B stated, following priming of the needle the nurse was to dial the insulin pen to the ordered dose of insulin and inject into the resident's skin for the required time. Staff B further stated they should hold in the skin for 10 seconds or the required time and these processes were to ensure the residents received the entire prescribed dose of insulin and the process was not followed. Reference: WAC 388-97-1060(3)(k)(ii)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff followed infection control measures, including Personal Protective Equipment [(PPE) protective garments and gear used to minimize exposure to hazards that can cause injury or illness], intended to mitigate the transmission of shingles (a viral infection that causes a painful, burning rash with blisters) were followed for transmission-based precautionsˆ[(TBP) additional precautions used with residents that are suspected or confirmed to have an infection]ˆfor 7 of 7 staff members (Staff L, M, N, O, P, Q, K); Additionally the facility failed to ensure medical supplies were maintained in a manner to prevent healthcare-associated infections by failing to remove expired sterile and non-sterile clinical supplies from 1 of 1 treatment storage rooms, reviewed for infection control. The facility's failure to remove expired medical supplies from the clinical environment placed the residents at an increased risk for communicable diseases along with an introduction of pathogens (tiny organisms that can make you sick if they get inside your body into the urinary tract), potentially leading to urinary tract infections (UTI) or urosepsis (a life-threatening, severe medical emergency where a UTI usually in the kidneys spreads to the bloodstream and triggers a body wide, dangerous immune response).Findings included.Review of the facility posted Washington State Hospital Association, Contact Precautions, (precautions used for infections that can be spread through direct or indirect contact with a person or their environment. This included wearing gowns/gloves when interacting with a person or handling their belongings), revised 2019, showed everyone must clean hands when entering and leaving the room, staff must gown and glove at the door. PPEDuring an observation and concurrent interview on [DATE] at 2:41 PM, showed a resident room with a contact precaution sign posted outside their door on the right side. The contact precaution sign instructed all staff to perform hand hygiene and put on a gown and gloves prior to entering the resident room. Staff L, Nursing Assistant, (NA), was inside the resident room and was standing next to the resident on the right side of the room, without a gown or gloves and was obtaining the residents vital signs. When Staff L finished, they exited the room and stated they did not wear a gown or gloves and they should have, as the resident room was posted as contact precautions. During an interview on [DATE] at 12:27 PM, Staff M, NA, stated the resident room with the contact precaution sign was for the resident who had shingles. Staff M stated they were not required to wear a gown when they entered the room. Staff M stated they just wore a mask and gloves. During an observation and concurrent interview on [DATE] at 11:38 AM, showed the resident being wheeled into their room by Staff N, Physical Therapy Assistant. Upon entering the resident room, Staff N removed a gait belt (an assistive device used to help safely transfer and support individuals with mobility challenges) from the resident's waist, removed the resident's oxygen tubing from the portable oxygen on their wheelchair and connected the oxygen tubing to the room oxygen. Staff N placed the resident's call light on their bed and then exited the room. Staff N stated they did not know why the contact precaution sign was posted. Staff N stated the sign would be for staff who would toilet the resident. During an observation on [DATE] at 8:30 AM, showed Staff O, NA, and Staff P, NA, entered the resident's room without performing hand hygiene and did not put on a gown. Staff O and Staff P then put on gloves and transferred the resident's roommate on the left side of the room from their wheelchair and placed them into their bed. Staff O proceeded to the resident on the right side of the room and assisted their feet to the floor and then wheeled them into the bathroom. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up observation on [DATE] at 8:47 AM, showed Staff P entered the contact isolation resident room without a gown. Staff P put on gloves and assisted the resident from the bathroom and wheeled the resident back to the left side of the room. During an observation on [DATE] at 12:05 PM, showed Staff Q, NA, wheeled the resident from the contact isolation room and placed them on the scale in their wheelchair to be weighed, then returned with the resident and entered the contact isolation room after obtaining the resident's weight. Staff Q did not put on gown or gloves upon entering and adjusted the residents breaks on their wheelchair, moved the resident's bedside table to an area they wanted, obtained the resident's oxygen tubing and handed it to the resident and placed their call light on their bed. During an observation on [DATE] at 12:40 PM, showed Staff K, Licensed Practical Nurse, wheeled a resident into the contact isolation room, entered the room without putting on a gown or gloves. Staff K exited the room, obtained blood glucose (sugar) testing supplies from the medication cart and re-entered the contact isolation room, and did not put on all required PPE, and performed a blood glucose fingerstick (a quick test for blood sugar levels). During an interview on [DATE] at 2:29 PM, Staff C, Infection Preventionist, stated the contact precautions sign was dedicated for the room and not a resident and staff should have been following the instructions posted on the contact precautions sign. Treatment RoomReview of the Centers for Disease Control and Prevention (CDC) document titled, Guideline for Prevention of Catheter-Associated Urinary Tract Infections, dated [DATE], showed Because the manufacturer's expiration date represents the final date for which the device's sterile (completely free from all living germs) and material integrity are guaranteed, the use of an expired catheter constitutes a breach of aseptic technique (a set of strict procedures used by healthcare professionals to prevent transfer of germs). Review of the Treatment Supply room located on the Lilac Hallway on [DATE] at 10:24 AM, showed these items to be expired: Four sterile, urinary catheters, (a thin, flexible, hollow tube inserted into the bladder to drain urine into a collection bag when a person cannot urinate on their own) 22 French (Fr- a unit of measure) expired on [DATE]. One sterile urinary catheter 18 Fr expired on [DATE]. Two self-catheter kits (a pre-packaged, single-use set of medical supplies designed for individuals to safely empty their bladder at home or on the go) expired on [DATE]. One 18-inch (in- a unit of measure) catheter extension tube (a flexible, hollow piece of plastic tubing that acts as an extension cord for a medical catheter) expired on 09/2016. Ostomy (a discreet, odor-proof, and waterproof bag worn on the outside of the body to collect bodily waste stool or urine) pouch care supplies with one drainable ostomy pouch 2 1/4 in, expired on 01/2021 and four drainable ostomy pouches 2 1/4 in, expired on 10/2023. During an interview on [DATE] at 1:53 PM, Staff B, Director of Nursing Services, stated that Central Supply Assistants were expected to check for expired items weekly. Staff B stated that the current assistant was a new employee who was unaware of this task and requires additional training/education. A follow up interview at 3:33 PM, Staff B stated the resident room was placed on contact precautions and all staff should be performing hand hygiene, putting on a gown and gloves when they entered the room and upon exiting the room, staff were to remove all PPE and perform hand hygiene. Reference: WAC 388-97-1320(1)(a)(5)(b)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that resident dignity was maintained for 2 of 3 residents (Resident's 32 and 58) reviewed for resident rights to privacy and a dignified existence. Residents 32 and 58 had their medical information discussed and were assessed in front of other residents and visitors while in the common area. This failure placed them at risk for embarrassment and lack of confidentiality related to their medical care. Findings included .Record review of an undated facility policy titled [Resident Rights showed; as a nursing home resident you have certain rights and protections under federal and state law.including the right to have your personal information kept private. Resident 32 Review of the resident's record showed they were admitted with diagnoses which included Parkinson's (a movement disorder of the nervous system that worsen' s over time) and dementia. Review of the comprehensive assessment dated [DATE] showed the resident was cognitively intact and required substantial assistance from staff for dressing, toileting and transfers. During an observation on 01/26/2026 at 12:08 PM, showed Resident 32 sitting at a table in the common area waiting for lunch. Two visitors and two residents were sitting at the table with Resident 32. Additionally other residents were seated at tables waiting for their lunch trays near Resident 32. Several minutes later at 12:10 PM, Staff T, Nurse Practitioner, approached Resident 32 while they were waiting for their lunch and placed a stethoscope (an acoustic medical device typically used for listening to the heart or lungs) on the resident's chest and back to listen to their lungs and heart. Staff T discussed the assessment with the resident including their medications. The discussion of Resident 32's medical care could be overheard by visitors and other residents in the area. Additionally, Staff T discussed concerns related to Resident 32's body rash and possible causative factors prior to leaving the room. Resident 58Review of the resident's medical record showed they were admitted to the facility with diagnoses which included pancreatitis (a gland behind the stomach for digestion and hormones which becomes inflamed and swollen) and dementia. Review of the care plan dated 01/23/2026 showed the resident required substantial assistance from staff for dressing, toileting and transfers. During an observation on 01/28/2026 at 11:37 AM, Staff U, Licensed Practical Nurse, was standing at their medication cart across the room from Resident 58 who was in the common room sitting at a table with other residents. In a loud voice Staff U stated to Resident 58 I've got your MiraLAX (a medication to relieve constipation) it should help. The common area had six other residents sitting in the area and one visitor who could overhear the conversation about Resident 58's bowel medication. During an interview on 01/29/2026 at 2:29 PM, Staff B, Director of Nursing Services, stated their expectation was that staff respected resident privacy and dignity and that all medical care or discussions related to medical care should be done in a private area such as the resident room. Reference: WAC 388-97-0180(1)-(4)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to review, and validate the Preadmission Screening and Resident Reviews (PASARR, an assessment to ensure individuals with serious mental illness [SMI] or intellectual/developmental disabilities [ID/DD] are not inappropriately placed in nursing homes for long term care) were correct on admission or updated for 1 of 5 residents (Resident 64) reviewed for PASARR. This failure placed the residents at risk for not receiving the care and services appropriate for their needs.Findings included.Review of Resident 64's medical record showed they were admitted to the facility on [DATE] with diagnoses including a fracture of the lower spine, long term pain, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety (a feeling of unease, worry, or fear about something that might happen in the future). The 01/16/2026 comprehensive assessment showed the resident's cognition was intact and they were able to make their needs known.Review of the facility's Level I PASARR assessment, dated 01/12/2025 (one year prior to Resident 64's admission to the facility), showed the resident had no SMIs documented and was marked as not requiring a Level II PASARR referral.During an interview on 01/27/2026 at 2:40 PM, Staff E, Social Service Director, stated they received Level I PASARR assessments prior to residents being admitted , would review the assessments for accuracy and whether the resident had the required Level II referral sent when needed. After reviewing Resident 64's PASARR, Staff E stated that Resident 64's diagnosis of depression and anxiety were not documented under the SMIs section, and the resident required a Level II PASARR referral. Staff E stated the correct process was not followed and Resident 64's PASARR was not accurate or sent for a Level II referral prior to the resident's admission to the facility.During an interview on 01/29/2026 at 3:14 PM, Staff B, Director of Nursing Services, stated that all residents with diagnoses of SMIs required a PASARR Level II referral sent prior to admission into the facility.Reference: WAC 388-97-1915(1)(2)(a-c)

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	505411	A. Building B. Wing	01/30/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility failed to: A) establish a Quality Assurance Performance Improvement (QAPI) policy for the inclusion/utilization of information from all resident care departments, including residents/resident representatives (RR) feedback/input data that would be used to identify high risk, problem prone areas or opportunities for improvement and, B) implement an effective QAPI program that incorporated a thorough collection/analysis of resident/RR feedback data and information from all departments/staff involved in 1 of 1 QAPI Program. This failure placed residents at an increased risk for unidentified complications, prompted corrective action towards high-risk/problem prone areas and unmet care needs.Findings included .Review of the facility's policy titled, QAPI Policy and Procedure, dated January 2023 showed, the facility's QAPI committee programs purpose was to take a systematic, interdisciplinary, Comprehensive, data driven approach (refers to actions , decisions, or processes that are guided by data rather than personal experience, and the importance of using collected information) to maintaining and improving safety and quality within the facility. The policy showed the QAPI program focused on .indicators of the outcome of care and quality of life, and would collect/obtain data from .several areas including but not limited to, trends, staff and resident input, critical incidents and citations ., which would then be reviewed by the QAPI committee to .identify problems. The policy did not include the systems to obtain resident/RR feedback data or input nor how the information would be used to identify high risk, problem prone areas or opportunities for improvement. Additionally, the policy did not include systems to identify, collect, and use data and information from all departments as required.Review of the facility's policy titled, QAA- QAPI Plan, revised January 2020 showed that QAPI activities would be .data driven . with using the Centers for Medicare and Medicaid Services (CMS) facility resident reports, rehospitalization reports and data from resident medical records. The policy showed the facility's QAPI process shall include review of any formal grievances (complaints or concerns documented) expressed by residents or family member ., and that they .may include input . from residents/RR. The policy showed the facility's resident incident reporting log would be used to guide investigations. The policy did not show resident/RR feedback data or inclusion of input if not documented in a formal grievance nor how the information was to be used to identify high risk, problem prone areas or opportunities for improvement. Additionally, the policy did not show how the facility identified, collected, and utilized information from all department like infection control, pharmacy, or nursing staff data.During an interview on 01/29/2026 at 4:55 PM, Staff B, Director of Nursing Services (DNS), stated they were the QAPI coordinator for the facility and conducted the quarterly meetings with the required members and documented the meeting information. Record review of the quarterly QAPI meeting documents, from December 2024 through January 2026, showed the facility had meetings in March 2025 and November 2025. On 03/24/2025, the QAPI committee records showed they discussed current process improvement projects (PIPs) that had been in place and the facility's five-star report (a CMS facility resident report). The records did not show documentation of what data/information had been brought in from all departments or Staff attending the meeting, resident/RR grievances or feedback data/input and how the information was used to identify high risk, problem prone areas or opportunities for improvement. On 11/03/2025, the QAPI committee records showed they discussed PIPs that had been completed and that had been completed and what PIP would be next. The QAPI meeting reviewed data from the facility's CMS reports. The records did not show documentation of what data/information had been brought in from all departments or Staff attending the meeting, resident/RR grievances or feedback data/input and how the information was used to identify high risk, problem prone areas or opportunities for improvement.Review of the facility grievance log (a document of formal grievances expressed by resident/RR) from December 2024 through January 2026, showed a total of five formal grievances were filed in the year 2025. The document showed that (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no formal resident/RR grievance had been logged from 07/15/2025 to 01/29/2026 (six months and 17 days).During an interview on 01/30/2026 at 7:59 AM, Staff E, Social Service Director, stated they were in charge of collecting and documenting all the resident/RR grievances and grievance forms filled out by staff on a resident's behalf. Staff E stated that sometimes residents would not fill out a formal grievance form and that sometimes resident concerns were able to be handled quickly, which did not require staff to document it as a formal grievance or on the grievance log. Staff E stated they were involved/attended QAPI meetings and did not have any information that they would bring into QAPI, because there had been no grievances since July 2025. Staff E stated that during the QAPI meeting they would discuss stuff about their department but did not bring in data or information from their department unless there was information the staff member noted on the grievance log. Additionally, Staff E stated they have daily care meetings that went over staff concerns/incidents and Staff V, Therapy Director, had that documentation. During an interview on 01/30/2026 at 8:14 AM, Staff V stated they had documentation of the daily care meetings, which would sometimes include resident and family concerns, but that it was not information that was brought into QAPI. Staff V stated they were involved in QAPI and attended the meetings, but they did not bring in data or information into QAPI from their department unless it was part of the PIP they were focusing on. Staff V stated the data that was gone over in QAPI was the CMS reports and that was the information utilized to develop the facility PIPs.During an interview on 01/30/2026 at 8:39 AM, Staff C, Infection Preventionist (IP), stated they were involved in QAPI and attended the meeting. Staff C stated that during the meetings CMS reports data was reviewed. Staff C stated they did not bring infection control data into the QAPI meetings. Staff C stated they did not bring in or present information on trends/patterns regarding antibiotics or the facility's surveillance listing of infections throughout the facility.During an interview on 01/30/2026 at 9:04 AM, Staff B stated they were not able to show how the facility incorporated a thorough collection/analysis of resident/RR feedback data and information from all departments was brought into QAPI. Staff B stated that CMS data reports were reviewed during the QAPI meeting and previous PIPs. Staff B stated the facility had multiple avenues of data and information collection within the facility, like resident/RR feedback data. The information was not brought into or discussed during QAPI meetings, since the data or information was previously talked about within other facility meetings. Staff B stated that different department heads attended QAPI but did not bring in data or information from their department. Staff B stated the IP used to bring in and discuss infection control data and trends but was no longer completing that. Staff B stated the correct process was not being followed for QAPI and the meetings should have included information from all resident care departments, including resident/RR feedback information. During an interview on 01/30/2026 at 10:20 AM, Staff A, Administrator, stated they would attend the QAPI meetings and bring in data/information on CMS reports. Staff A stated they reviewed the QAPI meeting documentation and that it did not incorporate a thorough collection/analysis of resident data and information from all departments which was not the correct process for QAPI. Reference: WAC 388-97-1760(1)(2)Cross Reference: F868, F585 for more information.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to ensure the Quality Assessment and Assurance (QAA) committee included the required members and met at least quarterly (once every quarter of the year or every three months) for 2 of 4 quarters (Q2 and Q3) reviewed for QAA. The failure to meet quarterly increased the facility's risk of unrecognized quality deficiencies, the facility's ability to effectively correct identified issues and ongoing unmet care needs regarding residents' quality of life.Findings included .Review of the facility's policy titled, Quality Assurance Performance Improvement (QAPI) Policy and Procedure, dated January 2023 showed, the facility's QAA committee would collect and obtain data from several areas including staff/resident input, critical incidents and patterns which would then be reviewed to .identify problems. Additionally, the policy stated the committee would conduct a meeting at least quarterly.Review of the facility's policy titled, QAA- Quality Assurance Performance Improvement Plan, dated January 2020 showed, the committee member would include the facility's Administrator, Director of Nursing Services (DNS), a physician, three other staff members and the Infection Preventionist (IP).Record review of the quarterly QAPI meeting documents, from the facility's last annual recertification survey on 10/29/2024 through to 01/29/2026, showed the facility conducted quarterly QAA/QAPI meetings on: 03/24/2025, which included the Administrator, Medical Director, DNS and at least three other members (one from a leadership role) from the facility's staff. No documentation of the IP attending the committee meeting for March 2025. 11/03/2025, which included the required members.During an interview on 01/29/2026 at 4:55 PM, Staff B, DNS, stated they were the QAA/QAPI coordinator for the facility and conducted the quarterly meeting with the required members and Staff A, Administrator, oversaw them. During an interview on 01/29/2026 at 5:09 PM, Staff A stated the DNS headed up the QAA/QAPI committee meetings, arranged the quarterly meetings and had the QAPI meeting information/documents. During an interview on 01/30/2026 at 9:04 AM, Staff B stated the facility's process was to have QAA/QAPI meeting quarterly and included the Administrator, Medical Director, IP, other facility staff and a representative of the facility's governing body (a group or entity with the authority to make decision, establish policies and oversee operations) and themself. When reviewing the QAA/QAPI meeting documentation with the surveyor, Staff B stated they had documentation of two quarterly QAA/QAPI meetings, sign in sheets for two out of the four quarters in 2025 and the 03/04/2025 meeting did not show the IP attending the meeting. Staff B stated they had thought another meeting had been conducted but was unable to present additional documentation. Staff B stated they were not following the correct process, the committee meeting should have been conducted quarterly and included the required members. During an interview on 01/30/2026 at 10:20 AM, Staff A stated they had reviewed the QAA/QAPI information/documentation that was presented to the surveyor and the committee meetings did not have the required members along with not being conducted quarterly. Staff A stated the correct process was not being followed regarding QAA/QAPI. Reference: WAC 388-97-1760(1)(2)Cross Reference: F865

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview the facility failed to provide a safe and sanitary (relating to the conditions that affect hygiene and health) environment for 1 of 1 Laundry room (LR 1), reviewed for a functional environment. This failure placed residents and staff at an increased risk of cross-contamination (the harmful spread of diseases). Findings included.Observations of LR 1, accompanied by Staff R, Environmental/Maintenance Director, on 01/28/2026 from 2:05 PM to 2:44 PM showed:Washing machine (WM) number one was positioned next to a wall within LR 1, and behind the WM was a one foot (ft, a unit of measure) long by 1/2 ft wide puddle of water, directly underneath the machine, on the concrete floor. The water was noted to be coming from a metal plate attached to the bottom of the WM, with the leak somewhere inside the WM, dripping down to the bottom floor and wall (Staff R stated the WM's would sometime get clogged up with lint during the laundered cycle and water had been known to leak out before). The bottom of the white drywall (a name for a type of board, made from plaster and other materials, used to cover walls) by the WM was noted to have a brown discoloration/cracking, from prior exposure to water, and the puddled water was in contact with a 1/2 inch (a unit of measure) of gap filling material (a type of foam that can be used to fill gaps and cracks) in-between the drywall/concrete floor. Surveyor noted the foam was wet to the touch and water had been seeping (a slow flow of a liquid through a material's small holes) through the foam material. The puddle of water had a black sludge (a soft, wet mixture of liquid), resembling mold, noted within the water and within the foam in between the drywall and concrete floor. WM number 2 had one ft long, by 1/2 ft wide, by three-inch-tall pile of rubbery black shavings underneath, that were likely from the grinding of a rubber belt that was part of the WM used during its operation. During a concurrent interview with LR 1's observations on 01/28/2026 from 2:05 PM to 2:44 PM, Staff R stated they were unaware of water dripping or leaking from behind WM number 1. Staff R stated the bottom of the wall/foam material was wet and they would be spraying a disinfectant chemical, in the water and around the wall/concrete in case the black sludge, resembling mold, was spreading. Staff R stated the leak needed to be fixed and cleaned up. When Staff R noted the pile of rubbery black shavings, they stated the WM belt was likely torn up and the pile was from the rubber belt, which needed to be replaced. During an interview on 01/28/2026 at 3:23 PM, Staff A, Administrator, reviewed photographic documentation of LR 1 environment and stated the water leak/possible broken WM belt needed to be fixed. Staff A stated they agreed the Staff R and the water leak needed to be cleaned and disinfected. Reference: WAC 388-97-3220(1)