STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505414	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence St Joseph Care Center	17 East 8th Avenue Spokane, WA 99202

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 38527 Based on interview and record review, the facility failed to investigate resident-reported concerns (grievances) and to provide timely follow-up for 1 of 5 sampled residents (Resident 2), reviewed for grievances. This failure placed the resident at risk of having unresolved grievances and a diminished quality of life. Findings included . Review of the policy titled, Safeguarding Residents' Belongings, revised December 2023, showed the facility would promptly respond to and investigate complaints of missing property, and the Administrator or their designee would notify the resident of the results of the investigation and corrective action taken within 10 working days. In an interview on 03/29/2024 at 1:18 PM, Resident 2 stated during their admission to the facility they had reported to multiple unidentified nursing assistants and one unidentified charge nurse a concern about missing property (a notebook) and missing money (stored inside the notebook). The resident stated they were told by the charge nurse that facility administration was aware of the concern and were investigating. Review of the 2024 grievance log and incident logs showed no entries for Resident 2. In an interview on 04/09/2024, Staff C, Charge Nurse, confirmed Resident 2 had mentioned missing property and money to them, and they had notified the resident that facility administration was investigating the complaint. Staff C stated they did not recall the date(s) of the investigation and/or the outcome. In an interview on 04/12/2024 at 11:10 AM Staff D, Social Services, stated resident concerns regarding missing property were typically reported by residents to nursing staff, then submitted on a grievance form. Staff D stated Resident 2's concern regarding their missing book and money was written on a scrap of paper, and upon a search the book had been found. Staff D stated no money was found inside the book and since the resident did not bring up the missing money again, they assumed it had been found. Per Staff D, facility administration was responsible for following up with residents on grievances, but Resident 2's concern had not been properly documented so there was no closure. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/15/2024 at 12:51 PM, Staff A, Administrator, confirmed that resident concerns of missing property or money began as a grievance, then were escalated to the incident log if unable to be found. Staff A stated since the resident and staff did not bring up further concerns with missing property and/or money for Resident 2 they believed the resident's concern had been resolved. Staff A confirmed no documentation regarding the investigation for Resident 2 was available and stated assumptions regarding the outcome should not be made. Reference WAC 388-97-0460

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 38527 Based on interview and record review, the facility failed to ensure an allegation of potential misappropriation was reported to the State Agency as required, for one of five sampled residents (Resident 2) reviewed for abuse. This failure placed residents at risk for possible abuse. Findings included . In an interview on 03/29/2024 at 1:18 PM, Resident 2 stated during their admission to the facility they had reported to multiple unidentified nursing assistants and one unidentified charge nurse a complainant about missing property (a notebook) and missing money (stored inside the notebook). The resident stated they were told by the charge nurse that facility administration was aware of the concern and were investigating. Review of the January to April 2024 incident logs showed no entries for Resident 2. In an interview on 04/09/2024, Staff C, Charge Nurse, confirmed Resident 2 had mentioned missing property and money to them, and they had notified the resident that facility administration was investigating the complaint. Staff C stated they were not involved in the investigation and had no further information, but an entry should have been on the incident log. In an interview on 04/09/2024 at 3:52 PM, Staff A, Administrator, stated Resident 2 had submitted a complaint to social services staff about missing items and thought that included a concern about a missing debit card. In an interview on 04/12/2024 at 11:10 AM Staff D, Social Services, confirmed Resident 2 had complained about missing money inside of a book, and after a search facility staff had found and returned the resident's book, but no money was inside of it. Staff D stated missing money complaints should be reported to facility administration, but since the resident did not bring up the missing money again, they thought the complaint had been resolved. In a follow up interview with Staff A at 12:51 PM on 04/15/2024, Staff A confirmed Resident 2's complaint of missing money was not reported as required. Reference: (WAC) 388-97-0640(5)(a)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 38527 Based on interview and record review, the facility failed to care plan and implement an identified intervention for 1 of 5 sampled residents (Resident 3) reviewed for care planning. This failure placed the resident at risk of unmet needs and diminished quality of life. Findings included . Review of a facility investigation dated 03/15/2024 showed Resident 3 made a statement about trauma from their past that was triggered by cares provided by a (male) nurse the previous night. Per the investigation, the resident's care plan was updated to include female-only care for personal care. Review of Resident 3's care plan, effective 03/11/2024 to 04/20/2024, showed no interventions for female-only care for personal care. The Kardex (summarized version of the care plan) for the same timeframe also showed no interventions for female-only personal care. In an interview on 04/09/2024 at 12:39 PM a representative for Resident 3 stated they were told Resident 3 would have female-only staff provide personal care after 03/15/2024, but the resident continued have male staff provide personal care such as toileting and dressing/undressing for bed. In an interview at 1:14 PM the same day, Staff E, Social Services, confirmed Resident 3 was to have female-only staff provide personal care after 03/15/2024, which was listed in their care plan. After reviewing the care plan and Kardex, Staff E stated there was no intervention listed on either for female-only care. Per Staff E, the care plan and Kardex was the method of communicating interventions (such as female-only care) to staff members. In an interview at 4:10 PM the same day, Staff A, Administrator stated identified interventions for resident care should be added to the care plan. Reference: (WAC) 388-97-1020(1), (2)(a)(b)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 38527 Based on observation, interview, and record review, the facility failed to thoroughly investigate the cause(s) of falls and assess the need for additional effective interventions for 1 of 3 sampled residents (Resident 1), reviewed for accident hazards. This failed practice placed the resident at risk for additional falls, injury secondary to falls, and diminished quality of life. Findings included . Review of the 03/06/2024 significant change assessment showed Resident 1 was severely cognitively impaired and had a history of falls. Additionally, the resident required moderate staff assistance for transfers, toileting, and walking, and supervision in their wheelchair. Review of Resident 1's care plan for falls, initiated 04/27/2023, showed staff were to offer toileting assistance every two hours and assess for unmet needs, ensure the resident's floor was clean and free of clutter, encourage appropriate footwear, ensure the bed was at an appropriate height to allow for safe transfers, and provide a room in a highly trafficked area to facilitate frequent observation. Review of the March 2024 incident log showed two non-injury falls for Resident 1 were listed on 03/22/2024 and 03/26/2024. In an interview on 03/29/2024 at 3:20 PM a representative for Resident 1 stated on a recent visit with the resident they had noticed a large amount of bruising on the resident's face and was told by the resident that they had a recent fall. The representative stated they were concerned about fall prevention as the resident was high risk to fall and had previously had significant injuries due to falls. Observation at 3:38 PM the same day showed Resident 1 still had a healing bruise next to their right eye. The resident was sitting up in their wheelchair in their room, leaning far forward in their wheelchair attempting to pick up a crumbled-up piece of garbage from the floor next to their garbage can. Review of the March 2024 progress notes for Resident 1 showed the resident was found lying face down on the floor in their room by nursing staff after attempting to self-transfer on 03/13/2024. The note did not contain additional details regarding the fall, including whether care planned interventions to prevent falls were in place at the time. Review of a facility fall report dated 03/22/2024 showed the resident was found on the floor at approximately 7:00PM. Per the note, the resident had no injury other than a healing bruise from a previous fall. Per the report the resident's call light and fluids were in reach but the report did not indicate if the call light was utilized at the time of the fall. Assessment of additional factors that may have contributed to the fall were not included. No new interventions to prevent further falls were listed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility fall report dated 03/26/2024 showed the resident had an unwitnessed fall at approximately 3:21 PM that day, after attempting to walk to the bathroom. The report did not show when the resident had last been assisted to the bathroom and/or seen by staff. No new interventions to prevent further falls were listed. In an interview on 03/29/2024 at 3:54 PM, Staff F, Nursing Assistant, stated they tried to encourage Resident 1 to attend activities during the day and they tried to monitor the resident when they were in their room. Staff F stated Resident 1 was care planned for assistance with toileting every two hours, but the resident would try to go the bathroom more frequently than that. Per Staff F, the resident thought they could walk but they were very unsteady. In an interview at 4:35 PM the same day, Staff B, Director of Nursing, stated they were not aware of Resident 1's fall on 03/13/2024 and the fall was not investigated. When asked about root causes for the falls on 03/22/2024 and 03/26/2024 Staff B stated there was no additional information available and the investigation reports should have been reviewed for completeness by the charge nurse on duty at the time. Staff B acknowledged no additional interventions to prevent falls were developed due to the lack of information available regarding the falls. Reference: (WAC) 388-97-1060 (3)(g)