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	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Hill Rehabilitation and 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 of 3 sampled residents (Resident 2) reviewed for quality of care, received timely notification to the medical provider of a change in condition. This failure placed the resident at risk of delayed access to care, inability to participate in care planning, and diminished quality of life. Findings included . Review of the skilled nursing facility transfer orders dated [DATE] for Resident 2 showed they were discharged from the hospital in stable condition following an episode of respiratory failure. The oxygen therapy orders showed the resident was to receive oxygen at 2-3 liters per min (LPM; a unit of measure) via a nasal cannula (thin flexible tube with prongs that go inside the nostrils), and the resident had adamantly declined non-invasive positive pressure ventilation (respiratory support where air and oxygen is given through a mask under positive pressure). Per Resident 2's Portable Orders for Life-Sustaining Treatment (POLST) dated [DATE], the resident was to receive comfort-focused treatment and was not to be transported to the hospital. Review of the [DATE] progress notes for Resident 2 showed on [DATE] the medical provider saw the resident for complaints of vertigo (sensation of motion or spinning that is often described as dizziness). The resident's heart rate and blood pressure were stable, and the resident had no respiratory symptoms. Per the provider note staff were to monitor the resident's orthostatic blood pressure (test to measure the way blood pressure changes when a person shifts from a lying down or sitting position to standing) once daily and to continue to provide oxygen at 2-4 LPM. Further review of the progress notes showed at 5:30 PM the same day the resident was receiving oxygen via a mask at 8 LPM. There was no information regarding updates to the medical provider on the resident's increased oxygen need. An entry dated [DATE] showed Resident 2 was found unresponsive at 0350, was pronounced deceased at 0352, and the medical provider was aware of the resident's status. In an interview on [DATE] at 4:00 PM Staff B, Resident Care Manager, stated they would expect staff to notify the medical provider of a change in a resident's respiratory status, including increased oxygen need. Staff B reviewed Resident 2's medical record and stated based on their POLST status they would not expect new orders besides increased oxygen and resident monitoring. Staff B was unable to state whether the medical provider was notified of the resident's change in condition on [DATE] after the provider's visit. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505414	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Hill Rehabilitation and 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 3:46 PM Staff A, Director of Nursing, stated they spoke with the medical provider group and were not able to find any notifications regarding Resident 2's increased oxygen needs on [DATE]. Per Staff A, the nurse who worked with Resident 2 on [DATE] believed the provider had already been notified of the resident's condition. Staff A stated they would expect staff to notify the provider of the resident's change in condition and obtain any needed orders for additional supportive/comfort care. Reference: (WAC) 388-97-0320 (1)(b)(d)