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	06/18/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure informed consents which explained the potential risks and benefits associated with the use of psychotropic medications and/or vaccines were accurately completed, and obtained from the resident or their representative prior to their administration, for 2 of 5 sampled residents (Residents 14 and 3) reviewed for unnecessary medications. In addition, the facility failed to ensure Resident 3 had the cognitive ability to understand the risks prior to signing the informed consent. These failures placed the residents and/or their representatives at risk of not being fully informed of the potential risks and benefits of receiving the medication and/or vaccines. Findings included . <Resident 14> The 04/15/2025 quarterly assessment documented Resident 14 had diagnoses which included depression, a mental health condition characterized by a persistent feeling of sadness that lasted over an extended period. In addition, the assessment documented that the resident received psychotropic medication. Review of the physician orders from 01/01/2025 through 06/11/2025 documented the psychotropic medication, Duloxetine, had been prescribed on 03/01/2024 to treat Resident 14's depression. Review of the Medication Administration Records (MARS) from 03/01/2025 through 06/11/2025 documented Resident 14 had received the medication daily as prescribed. Review of Resident 14's record found an informed consent that included the risks and benefits for the Duloxetine had been signed by the resident on 03/13/2024, 12 days after the resident began taking the medication. In an interview on 06/11/2025 at 12:46 PM, Staff H, Nurse Manager, stated informed consents for psychotropic medications needed to be obtained prior to the first dose of the medication being given. When informed of the Duloxetine consent being completed 12 days after Resident 14 had received the medication, Staff H stated the facility had transitioned to new ownership and a different electronic record system and would check with medical records to see if an earlier consent had been obtained. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a follow-up interview on 06/11/2025 at 1:05 PM, Staff H provided an informed consent for the Duloxetine; however, it was the same consent that was dated 03/13/2024. Staff H acknowledged an informed consent had not been done prior to Resident 14 receiving the medication as was required. <Resident 3> Review of a 05/16/2025 quarterly assessment showed Resident 3 was admitted to the facility on [DATE] with a diagnosis of dementia and bipolar disorder (a mental illness with extreme shifts in mood, energy, and activity levels). The assessment showed Resident 3 had severely impaired cognitive skills for daily decision making, unclear speech, and was sometimes able to be understood by and sometimes able to understand others. Review of the medical record showed Resident 3 had two next of kin as emergency contacts. Additionally, a 02/28/2025 cognition care plan showed the resident was no longer consistently responding to the cognitive assessment, showing signs of severely impaired cognition and the [Spouse] assists with decision making and coordination of care. The care plan informed the staff Resident 3 required supervision/assistance with all decision making. Review of a 09/11/2024 vaccine consent for pneumonia (a contagious respiratory disease) showed the staff provided vaccine information to Resident 3 and the consent was signed by the resident. The consent showed the resident understood the risks and benefits of receiving the vaccine and did not consent to receiving it. Review of 09/23/2024 vaccine consents for influenza and COVID-19 (both contagious respiratory diseases) showed the staff provided vaccine information to Resident 3 and the consents were signed by the resident. The consents showed the resident understood the risks and benefits of receiving the vaccines and consented to receiving them. Review of the June 2025 MAR showed the staff administered to Resident 3, Depakote [an anticonvulsant or seizure medication also used to treat bipolar disorder] twice a day for bipolar disorder. Review of a 09/11/2024 Informed Consent for Use of Psychotropic Medication showed the medication category chosen was Antipsychotic [a class of medications primarily used to manage symptoms of psychosis, such as hallucinations, delusions, and disorganized thinking], to include the possible side effects associated with the use of an antipsychotic. The consent showed Resident 3's legal representative consented to the use of the antipsychotic and educated to the potential side effects associated with that medication category, instead of the anticonvulsant. The above findings were shared with Staff H, Nurse Manager, on 06/13/2025 at 3:34 PM. Staff H confirmed Resident 3 signed the informed consents to the immunizations, acknowledged Resident 3's severely impaired cognition, and stated that the resident was not the appropriate person to make an informed decision about immunizations and the vaccine information should have been reviewed with the next of kin identified in the care plan. Staff H acknowledged the Depakote was placed in the wrong medication category, making the informed consent erroneous in the information provided to Resident 3's representative. Reference WAC 388-97- 0300(3)(a), -0260, -1020(4)(a-b). (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility failed to utilize their grievance process to ensure concerns and grievances expressed by members of the Resident Council were responded to and/or followed up in a timely manner for 2 of 7 sampled residents (Residents 35 and 59) reviewed for Resident Council. This failure placed the residents at risk for a diminished quality of life and loss of self-worth. Findings included . The facility Grievance policy, last reviewed 12/20/2023, documented the grievance process was available to be utilized by residents to express concerns with their care and treatment as well as other general concerns. The policy documented the facility's Grievance Official would evaluate, investigate, and take actions to resolve the concerns. In addition, the policy documented the Grievance Official would respond to the individual who expressed the concern within three working days of the concern being expressed, complete the grievance resolution forms, and follow up with the individual to inform what steps were taken to address and/or correct the concern. <Resident Council Minutes> Review of the January 2025 through April 2025 Resident Council minutes showed the following: - On 01/28/2025, Resident 35 stated their shower drained slowly after bathing and Resident 59 stated towels were not picked up after they showered, it sometimes took days and there had been times when they had placed the towels outside in the hallway by their room door in order to have them picked up. In addition, the meeting minutes documented many of the residents in attendance stated their bed linens were not being changed timely. - On 02/25/2025, no documentation was found in the meeting minutes that showed the concerns that were expressed in the 01/28/2025 meeting as stated above had been addressed and/or followed up on by the Grievance Official. - The 03/25/2025 meeting minutes were not provided, the documentation received only included the meeting agenda and the attendance roster of staff and residents. - On 04/29/2025, Resident 59 stated the issue with bath towels not being picked up and bed linens not being changed timely was still a problem. No documentation was found in the meeting minutes that showed the issue was addressed, what actions were taken, or what if any, follow-up occurred. Review of the facility's grievance log and grievance binder from January 2025 through April 2025, found no entries were made related to the above concerns that were expressed in the Resident Council meetings, nor were any grievance forms completed as per the facility's grievance policy. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/13/2025 from 3:16 PM through 3:42 PM, Staff Q, Activity Director, stated the Grievance Official was Staff A, Administrator, until about a month ago, and now it was Staff K, Social Services. After reviewing the Resident Council meeting minutes and a discussion about the grievance process and concerns that residents voiced during Resident Council had not been addressed and/or followed-up timely, Staff Q stated the grievance forms were filled out by the Grievance Official. When asked if the grievance forms were completed for issues expressed during Resident Council meetings, Staff Q stated they had not been, but using them would make it easier and helpful to ensure concerns were addressed and followed-up on. In an interview on 06/13/2025 at 11:54 AM, after discussion about the grievance process, lack of logging grievance concerns in the facility log, and lack of timely follow up for resident's concerns, Staff A acknowledged the facility grievance process was not utilized consistently and addressing and following up on resident's concerns was not timely. Reference WAC 388-97-0920 (1-6)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the development of adequate baseline care plans within the required timeframe to ensure continuity of care for 4 of 7 sampled residents (Resident 183, 180, 52 and 17) recently admitted to the facility. This failure placed the residents at risk for unmet needs and possible complications. Findings included . <Resident 183> Review of the medical record showed Resident 183 was admitted to the facility on [DATE] with diagnoses that included a recent stroke that affected the right side of their body, diabetes, chronic kidney disease, and heart failure [where the heart can't pump enough blood to meet the body's needs]. An observation on 06/09/2025 at 10:04 AM showed Resident 183 in their room sitting in a wheelchair (WC) with their representative present. The resident's right arm was elevated with a stack of towels about 4 inches thick. On their wardrobe door was signage that instructed the staff to keep their arm elevated 30 degrees while in bed and WC. Resident 183's hand was slightly swollen or puffy. A black forearm/hand brace was observed on the bedside table and the resident's representative stated the resident did not like to wear it. An observation on 06/11/2025 at 10:21 AM showed Resident 183 in their room, seated in a WC, and their representative present. The resident had their right forearm supported on a stack of washcloths, with fingers curled around the washcloths. Observed on the right forearm was a black brace. Resident 183's hand was slightly swollen or puffy. An observation on 06/13/2025 at 10:22 AM showed Resident 183 seated in a WC in their room, watching the television. A stack of towels supported the right forearm which had a black brace applied. The resident's hand was less swollen. Review of the June 2025 Medication Administration Record (MAR) showed Resident 183 received Torsemide (a water pill, used to remove excess water and salt from the body through increased urine production; helps to lower blood pressure and reduce fluid buildup in the body and commonly used to treat conditions like high blood pressure, heart failure, and swelling). Review of the June 2025 Treatment Administration Record (TAR) showed a 06/05/2025 order (the day of Resident 183's admission) that instructed the nurses to, Monitor skin under brace to R [right] wrist. Notify provider if any breakdown is noted. In an interview on 06/13/2025 at 9:54 AM, Staff M, Nursing Assistant, said Resident 183 wore a brace to their right hand because it was softer than a cast, kept their hand in place and from hurting, and the caregivers applied the brace. Staff M said the resident wore the brace whenever they were up and came off at bedtime, That's what I know at least off hand. Staff M said they found specifics about the brace management in the Kardex, an abbreviated form of a care plan for nursing assistants. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/13/2025 at 10:43 AM, Staff L, Licensed Practical Nurse, said, Resident 183 wore the brace because, That's [their] weak side so were keeping the fingers open and preventing a contracture [a condition where muscles, tendons, or skin shorten and tighten, restricting joint movement and causing stiffness]. Staff L stated the nurses or nursing assistants could apply the brace and would know for how long the brace should be on by verifying its order in the TAR. Staff L said if the order was in the TAR, then it would become consistent with the brace application and helped identify concerns, like refusals. Staff L confirmed there were no orders in the TAR to show who was responsible for brace application and how long to keep the brace on once applied. Review of Resident 183's medical record and Kardex showed no indication of the presence of a brace to the right wrist, its purpose, who was responsible for ensuring it was applied, and for how long the brace should be left on the resident's wrist. Additionally, it did not identify or address the primary physical problems and functional limitations associated with heart failure, the resident's goals or desired response, and interventions to help achieve those goals. The above findings were shared with Staff E, Nurse Manager, on 06/13/2025 at 2:34 PM. Staff E acknowledged Resident 183's baseline care plan should have but did not adequately address potential resident response to the diagnosis of heart failure. Staff E stated Resident 183 wore the brace to the right wrist, for comfort and based off of the patient's wishes, and could be applied by the nurses and aides, the resident, and the resident's spouse. Staff E acknowledged the baseline care plan did not show the potential resident response to the brace, the intent of the brace, the resident goals for the brace, and interventions to achieve those goals. Staff E stated the use of the brace should have reflected on the care plan, when it was given to the resident. <Resident 180> Review of the medical record showed Resident 180 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease, heart failure, ventricular fibrillation (a life-threatening heart rhythm where the heart quivers irregularly instead of beating effectively), and the presence of a defibrillator (a small battery-powered device placed in the chest that detects and stops irregular heartbeats). The medical record showed orders for the staff to administer Eliquis, an anticoagulant (blood thinner), twice a day for DVT (deep venous thrombosis, a blood clot that forms in a deep vein, most commonly in the legs) prevention. Review of Resident 180's medical record and Kardex showed no care plan that identified or addressed the primary physical problems and functional limitations associated with the treatment of DVT prevention or ventricular fibrillation, to include the presence of a defibrillator, the resident's goals or desired response, and interventions to help achieve those goals. The above findings were shared with Staff E on 06/13/2025 at 2:16 PM. Staff E reviewed Resident 180's care plan and confirmed, I don't see this on here but normally it would be. <Resident 52> According to a comprehensive admission assessment, dated 02/06/2025, Resident 52 was admitted on [DATE] with end-stage renal disease (the kidneys can no longer meet the body's needs) which required dialysis (a medical procedure that uses a machine to filter wastes and fluids from the blood). (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 52's electronic medical record (EMR) showed the following dialysis-related orders: - on 01/30/2025, dialysis scheduled to occur on Monday, Wednesday and Friday. Details of the order included details of the transport company, pick-up and drop-off times, and the name of the kidney center with their address and phone number. - on 01/30/2025, orders instructed the nursing staff to complete the dialysis communication sheet prior to dialysis, send the form with the resident to dialysis, and complete the form upon the resident's return to the facility. - on 03/01/2025, orders instricted the nurses to monitor the Permcath (a small flexible tube inserted in the right upper chest that facilitated dialysis treatment) every shift. A review of the 03/01/2025 care plan documented a focus of end-stage renal disease. Interventions included to elevate feet, give medications as ordered and monitor for signs of complications. There was no documentation in the care plan that the resident received dialysis services, their dialysis schedule or the name and contact information of the dialysis center, as required. <Resident 17> According to a comprehensive admission assessment dated [DATE], Resident 17 was admitted on [DATE] with diagnoses of a hip fracture and irritable bowel syndrome (IBS, a bowel disorder, symptoms included abdominal pain, bloating and changes in the consistency of bowel movements) with constipation (hard, dry or difficult to pass stools). The resident was alert and able to make their needs known. During an interview on 06/10/2025 at 10:23 AM, Resident 17 stated that they occasionally had abdominal discomfort, and were unsure of the cause. They further reported problems with hard bowel movements, which changed to diarrhea after taking suppositories and enemas. A review of the medical record showed Resident 17 received both scheduled and as needed medications to regulate their bowels. From 05/18/2025 through 06/16/2025, the resident had four formed/normal stools, fourteen diarrhea/loose stools and five constipated/hard stools. A review the 05/09/2025 care plan showed no mention of the presence of an actively treated diagnosis of IBS, any focus on monitoring their bowels, the resident's goals or desired response, and interventions to help achieve those goals. During an interview on 06/18/2025 at 10:08 AM, Staff L, Licensed Practical Nurse (LPN), stated that staff monitored Resident 17's bowel habits and they could give medications for either constipation or diarrhea. They stated that IBS and symptoms should be on their care plan and expressed surprise that it was not. During an interview on 06/18/2025 at 2:50 PM, Staff O, Nurse Manager, reviewed the care plans for Resident 17 and Resident 52. They acknowledged that information on Resident 17's IBS and Resident 52's dialysis treatment should have been on their care plans and were not. Reference WAC 388-97-1020(3) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure controlled medications were adequately accounted for, following accepted standards of practice in 3 of 3 controlled medication ledgers reviewed. This failure placed residents at risk of misappropriation of controlled substances and a decreased quality of care. Findings included . According to the 2025 article titled Narcotic Drugs: Handling and Documentation, Controlled Drug Policy and Procedure, written by [NAME], a nationally recognized Registered Nurse (RN) and online educator, for the publication RN.org, the traditional method of accounting for narcotic medications in long-term care facilities included an end-of-shift narcotics count with the oncoming nurse counting the medications, the outgoing nurse verifying the count, and both nurses signing off in the ledger that the count was correct. <Controlled Substance Ledger Books> Record reviews and interviews of the controlled substance ledger books showed the following: - On 06/18/2025 at 1:35 PM, the ledger showed that 37 out of 75 signature lines were blank from 05/24/2025 through 06/18/2025 for Medication Cart 1 on the first floor. In an interview at that time, Staff R, Licensed Practical Nurse (LPN), confirmed the signatures were missing. - On 06/18/2025 at 01:45 PM, the ledger showed that 93 out of 189 signature lines were blank from 05/17/2025 through 06/18/2025 for Medication Cart 1 on the second floor. In an interview at that time, Staff S, LPN, confirmed the signatures were missing. - On 06/18/2025 at 01:55 PM, the ledger showed that 93 out of 189 signature lines from 03/17/2025 through 06/18/2025 for Medication Cart 2 on the second floor. In an interview at that time, Staff T, RN, confirmed the signatures were missing and acknowledged the facility process to account for controlled substances was the same as described in the 2025 article referenced above. In an interview on 06/18/2025 at 2:16 PM, Staff B, Director of Nursing, acknowledged the inconsistent accounting of controlled substances. Reference WAC: 388-97-1620(2)(b)(i)(ii),(6)(b)(i)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the medical record showed an accurate account of a resident's fluid intake while on a fluid restriction for 1 of 3 sampled residents (Resident 180) reviewed for nutrition and hydration. This failure placed the resident at risk of dehydration, fluid overload, and rehospitalization. Findings included . Review of the medical record showed Resident 180 was admitted to the facility on [DATE] after being hospitalized for an episode of congestive heart failure [CHF, where the heart can't pump enough blood to meet the body's needs] and septic shock [a severe medical condition characterized by dangerously low blood pressure and organ failure, resulting from the body's overwhelming response to an infection] secondary to cellulitis [a bacterial infection of the skin and underlying tissues]. The medical record showed that at the hospital, almost 4.8 liters (a measurement and over a gallon) of fluid were removed. The resident received a diuretic, or water pill (a medication that helped the body get rid of excess water and salt through increased urination). An observation on 06/09/2025 at 9:25 AM showed laminated signage with a blue drop of water on Resident 180's room door. The signage showed, Day 450, Eve [Evening] 450 and NOC [Night] 100. Entry into the resident's room showed Resident 180 sitting in a wheelchair (WC) in their room next to their bed. When asked, Resident 180 stated they were no longer on fluid restriction and the reason it was started was because, lungs were failing. The resident said they now had a water pitcher brought to them by the staff, which started two days ago, and refreshed with ice whenever they asked for it. On 06/10/2025 at 10:31 AM, a water pitcher was observed on Resident 180's bedside table. Resident 180 was not in their room. On 06/12/2025 at 10:10 AM, a clear plastic glass filled partially with water and a water pitcher sat on the over-the-bed table. Resident 180 sat in their WC and stated the staff brought them the water pitcher, Every time I ask. It's the first one for today, and I didn't ask for it. It's fresh today. It's got ice in there. A bottle of Boost [oral nutrition] supplement also sat on the over-the-bed table to which the resident said they received, Every meal. The amount in the bottle was 237 milliliters (mL, a measurement). On 06/13/2025 at 10:31 AM, the laminated signage with the blue drop of water and integers by shift remained on Resident 180's door. Review of 06/02/2025 hospital transfer documents showed orders for a salt-restricted diet with a fluid restriction of 2000 ml. Review of the facility provider orders showed no instruction to the nurses Resident 180 was on a fluid restriction. Review of the care plan and Kardex (abbreviated care instructions for nursing assistants derived from the general care plan) showed it informed the staff Resident 180 was on a Fluid restriction of 2000mL per day. The care plan or Kardex showed no clarity to how much fluid was allowed per shift, specifically the amount sent with meal trays by the kitchen department and how much the staff was allowed to give the resident between meals and per shift apart from the meal trays. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record showed no documentation the staff monitored or reconciled Resident 180's fluid intake between shifts to ensure they maintained the ordered fluid restriction. In an interview on 06/13/2025 at 10:08 AM, Staff M, Nursing Assistant, stated they knew a resident was on fluid restriction by the water drop signage on doors and by checking the Kardex. Staff M stated they documented fluids in the electronic medical record (EMR) under the Tasks section and included fluids from a water pitcher, at mealtimes and in between meals. Staff M stated the nurses were responsible for documenting how much of the Boost supplement a resident drank. Staff M stated that a water pitcher held 800 to 1000 mL, and they would calculate how much the resident drank at the end of the shift by pouring out and deducting the remaining water from the 800 to 1000 mL adding, I can do an estimate of what was consumed. In an interview on 06/13/2025 at 10:33 AM, Staff L, Licensed Practical Nurse, stated a resident ran the risk of becoming dehydrated, constipated, or running a low blood pressure when on a fluid restriction. Staff L was asked what the facility process was to ensure the staff provided fluids that did not exceed fluid restriction and stated, I believe kitchen gives a certain amount on each tray and there is usually a little sign on the door [of what] nursing gives. Staff L explained that the nursing assistants did not give the resident fluids apart from what was sent on the meal trays and were responsible for documenting that amount under the Tasks section of the EMR. Staff L stated that residents on fluid restriction are generally not provided water pitchers but if they really want one we will fill it with what they can have for their shift. Staff L stated that before the end of their shift, they checked the amount of fluid a resident consumed, tallied and then documented it either in the Medication Administration Record (MAR) or the progress notes. Staff L stated they believed Resident 180 was on a fluid restriction secondary to CHF. Staff L confirmed nurses were responsible for including the amount of Boost supplement consumed and counted it towards the fluid restriction. Staff L stated a provider order showed how much fluid the kitchen department would send at meal trays and how much the staff could give per shift so that the fluid restriction would not be exceeded. Staff L checked Resident 180's medical record and could not find an order for the fluid restriction and added, [The resident] does have heart failure and kidney disease, especially [now] that he also has IV [by vein] fluids. That's something that needs to be clarified. Staff L acknowledged there was no documentation in the medical record that showed how much fluid the nurses gave Resident 180 shift by shift, or the nurses reviewed and tallied the entire daily amount of fluid to ensure Resident 180 met the fluid restriction ordered at the time of admission to the facility and mentioned in the care plan. The above findings were shared with Staff N, Registered Dietitian, on 06/13/2025 at 11:18 AM. Staff N stated they expected fluid restriction to show in the provider order. Staff N reviewed Resident 180's medical record and confirmed, I don't see that order in, and we would want to see and delegate who's responsible for how much to give per shift. Staff N reviewed Resident 180's meal tray slip delivered with each meal, which would include the type of diet, allergies, preferences, and fluid restriction. Staff N confirmed it did not show instructions to the kitchen staff on Resident 180's fluid restriction and stated, I'm not sure what happened. Reference WAC 388-97-1060 (3)(i). .

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	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Hill Rehabilitation and Care Center	17 East 8th Avenue Spokane, WA 99202

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 1 of 2 sampled residents (Resident 77) reviewed for tube feeding (TF, the delivery of nutrients through a tube directly inserted into the stomach) received their nutrition according to provider orders. This failure placed the resident at risk of nutritional complications, dehydration, or fluid overload. Findings included . Review of a 06/02/2025 admission assessment showed Resident 77 was admitted to the facility on [DATE] with diagnoses that included a progressive neurological condition and severe malnutrition. The staff assessed the resident as cognitively intact and depended on TF for nutrition. An observation on 06/11/2025 at 12:50 PM showed Resident 77 in bed with the head of the bed up. A dressing was observed to their left abdomen and TF tubing extending out. A pole was observed with a pump for the delivery of enteral nutrition. Resident 77 was unable to be interviewed secondary to their desire to conserve physical energy. Review of the May 2025 Medication Administration Record (MAR) showed a 05/28/2025 order that instructed the nurses to administer Jevita [sic, a nutrition formula] 1.2 at 50 cc (cubic centimeter, a measurement) every hour and continuously, for a total administration of 1,200 cc in a 24-hour period, or 400 cc every eight-hour shift. The nurses documented the amount administered on their shift as 50/hr on 05/29/2025, 05/30/2025, and 05/31/2025, not showing the approximate or complete amount of nutrition provided each shift. Review of the June 2025 MAR showed an order that instructed the nurses to administer Jevity 1.2 at 60 ml (milliliter, a measurement also equivalent to a cc) every hour and continuously, totaling 1,440 cc in a 24-hour period, or 480 cc every eight-hour shift. On 06/02/2025, 06/03/3025 and 06/04/2025, the nurses showed no documentation of how much enteral nutrition was provided to Resident 77. Review of the June 2025 MAR showed an order dated 06/03/2025 that instructed the nurses to administer FiberSource (a nutrition formula) 1.2 at 60 cc/hr in a 24-hour period for a total of 1,440 cc, or 480 cc every eight-hour shift. The MAR showed the nurses documented 60 or 60cc instead of the expected or approximate amount of 480 cc per shift from 06/03/2025 to 06/10/2025. Review of the June 2025 MAR showed an order dated 06/10/2025 that instructed the nurses to provide Resident 77 IsoSource (a nutrition formula) at 50 cc/hr continuously, for a total of 1,200 cc in a 24-hour period, or 400 cc every eight-hour shift. Review of the MAR showed the nurses administered nutrition more than what was ordered by the physician on: 06/10/2025 Night Shift - 795 cc, an excess of 395 cc 06/11/2025 Day Shift - 890 cc, an excess of 490 cc 06/11/2025 Afternoon Shift - 1202 cc, an excess of 802 cc (continued on next page)

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	505414	A. Building B. Wing	06/18/2025

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/12/2025 Day Shift - 600 cc, an excess of 200 cc 06/12/2025 Evening Shift - 600 cc, an excess of 200 cc The above findings were shared with Staff N, Registered Dietitian, on 06/13/2025 at 10:57 AM. Staff N stated the facility ensured a resident with orders for enteral nutrition received the prescribed rate by review of documentation in the MAR. Staff N acknowledged the medical record did not show the staff consistently provided Resident 77 with the prescribed rate of enteral nutrition daily and stated, It would be good to have the total amount [administered]. Looks like there is some miscommunication as to what is supposed to be in the MAR. I don't have an answer for you on that. Am not sure what was going on there. Reference: WAC 388-97-1060 (3)(f). .

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	505414	A. Building B. Wing	06/18/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on interview and observation, the facility failed to ensure medications carts were locked/secured in the absence of a nurse, expired medications were discarded timely, and injectable medications were dated/timed when opened. These failures placed the residents at risk of unauthorized access to medications and their potential adverse effects, theft or diversion of medications, and decreased potency and safety of the medications. Findings included . <Unsecured Medication Cart> An observation on the second floor on 06/09/2025 at 9:06 AM showed an unlocked and unattended medication cart stationed at the beginning of Unit B - Transitional Care Unit. In this continuous observation, Staff C, Licensed Practical Nurse (LPN) approached the medication cart. At 9:30 AM, the medication cart was again observed unlocked and unattended, and Staff C was coming from Unit B, Long Term Care Unit. Staff C acknowledged the medication cart was opened and that it should have been locked, and stated it should be secured, When we are away. <Expired Medications> On 06/18/2025 at 01:45 PM, during an inspection of medication cart 2 on the first floor, an eight-ounce bottle of Hibiclens (a skin cleanser that helps reduce bacteria) with an expiration date of 11/2024 was observed in the cart with other medications and supplies. Staff S, LPN, acknowledged the expiration date and stated the Hibiclens should have been discarded. Staff S stated all the medication cart nurses are responsible for checking for and disposing of expired medications and supplies in the medication carts. <Injectable Medications> On 06/18/2025 at 1:10 PM, during an inspection of the second floor medication room, an open, undated bottle of Tubersol solution (used to help diagnose tuberculosis infection) was observed in the medication refrigerator. Staff O, Nurse Manager, acknowledged the Tubersol was opened and undated and stated it should have been disposed of because it expired 30 days after being opened and there was no way to know when it was opened. In an interview on 06/18/2025 at 02:16 PM , Staff B, Director of Nursing, stated Tubersol was only good for 30 days after being opened and if it was not dated when opened it should be thrown away. Reference WAC 388-97-1300 (2), -2340. .

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	505414	A. Building B. Wing	06/18/2025

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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. <Second Floor Dining Room> Observations of the meal showed the following on 06/09/2025: At 12:01 PM, Staff D, Speech Therapist, touched the back of a female resident seated at a dining room (DR) table. Staff D completed HH then grabbed a pair of gloves and put them on. Staff D approached another female resident, touched their wheelchair (WC) with the gloved hand, walked to the serving area to get a bowl of soup, and brought it to the female resident. Staff D then touched another resident's WC with the same gloves on, went to get ketchup at the serving area. Staff D returned to the resident with the same gloved hands, opened the burger bun, poured the ketchup on the burger, and moved it closer to the resident. At 12:05 PM, Staff D went to get a plate of food with the same gloved hands and brought it to Resident 183, touched the table surface, then the resident's right chest, and then the table surface again with gloved hands. A staff approached Staff D with a plate, Staff D touched the plate of food and gave instructions to the staff. Staff D then assisted a male resident in their WC out of the DR with the same gloved hands. At 12:10 PM, Staff D returned to the DR, put on gloves, went to talk to a male resident, got a cola for another male resident, opened the cola can, touched their pants at the hip area, then sat down on the resident's walker seat. Staff D then returned to Resident 183, placed the same gloved hands on the table surface where Resident 183 was seated at. Staff D then stepped away and went to a male resident who requested a baked apple for dessert. En route to getting the male resident the baked apple, Staff D went to Resident 71, adjusted their napkin, and went to the serving cart to ask for the baked apple. Staff D took the baked apple and brought it to the male resident. With the same gloved hands, Staff D then went to another male resident and touched their WC with their left hand. Staff D then touched their own front thighs and was called by another male resident who also requested a baked apple. Staff D went to the serving area, obtained the baked apple, and brought the baked apple to the male resident with the same gloved hands. Staff D then announced, I have to go now downstairs, removed their gloves, and exited the DR. The above findings were shared in an interview with Staff F, Infection Preventionist, on 06/16/2025 at 11:03 AM. Staff F stated, You need to take gloves off and wash your hands when making in-between contact with residents and anything that's a personal surface. Reference WAC 388-97-1100 (3), -2980. Based on observation, interview and record review, the facility failed to ensure the staff performed hand hygiene (HH) and changed gloves when required for 2 of the 2 dining rooms observed. This failure placed the residents at risk for foodborne illnesses. Findings included . <First Floor Dining Room> (continued on next page)

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	505414	A. Building B. Wing	06/18/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations of the meal showed the following on 06/09/2025: - At 12:31 PM, Staff U, Nursing Assistant (NA), touched a resident's arm, then proceeded to touch a sink faucet. Staff U opened the refrigerator door, retrieved a can of soda, opened it, then poured it into a cup. Without performing hand hygiene, Staff U held onto the cup at the rim where the resident's mouth would touch, and gave it to a resident who proceeded to drink from the cup. In an interview on 06/09/2025 at 12:40 PM, when asked when they should perform hand hygiene during meal service, Staff U stated, when changing glove and after providing care for a resident. Staff U stated they did not realize they hadn't performed hand hygiene, and when asked if they should have performed hand hygiene, the staff stated they definitely should have. Observations of the meal showed the following on 06/16/2025: - At 11:45 AM, Staff V, NA, touched a resident's wheelchair handle with gloved hands, then opened the refrigerator and removed juice and two cans of soda. Staff V then poured the juice into a cup and without changing gloves or performing hand hygiene picked up the cup by the rim where the resident's mouth would touch and placed it in front of a resident. Staff V then proceeded to open the cans of soda pop for two different residents and place them in front of the residents. Staff V, still wearing the same gloves, removed a straw from its wrapper, touching it where it would come in contact with the resident's mouth and placed it in front of a resident, then, without changing gloves or performing hand hygiene, picked up two cups by the rims, where a resident's mouth would touch, and filled the cups with ice and placed them in front of residents. Staff V, still wearing the same gloves, then proceeded to touch a tabletop, assisted a resident to put on a clothing protector, then touched a wheelchair handle of another resident, then without changing gloves or performing hand hygiene prepared a drink and gave it to a resident. In an interview on 06/16/2025 at 11:54 AM when asked when glove change and hand hygiene should be performed when working the dining room, Staff V stated between touching residents, when starting meal trays, and if touched a dirty surface. When asked why they did not perform hand hygiene and glove changes at the appropriate times they stated it was because they were only serving drinks and only touching the bottom of the cups. When Staff V was informed they were observed touching the rims of cups and touching the straw they stated they should have performed hand hygiene and glove changes, and stated it was important to prevent cross contamination.

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	505414	A. Building B. Wing	06/18/2025

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on interview and record review, the facility failed to identify a designated interdisciplinary team member, to act as a liaison for coordinating care and communication with the hospice provider, for 1 of 1 sampled residents (Resident 37), reviewed for hospice services. This failure placed the resident at risk for unmet care needs. Findings included The 05/05/2025 significant change assessment documented Resident 37 was able to make decisions regarding their care, had diagnoses which included malnutrition, asthma, and respiratory failure. In addition, the assessment documented the resident received hospice services. Review of Resident 37's record showed a referral was made on 04/16/2025 for hospice services, and serv ices were started on 05/01/2025. Review of the facility's 05/01/2025 hospice agreement documented the services and responsibilities for care that would be provided by both the facility and the hospice provider; however, the policy did not include and/or document who the designated facility liaison to hospice was that was responsible for collaborating in the development and care of the resident. In an interview on 06/11/2025 at 2:11 PM, Staff A, stated the facility was in the process of updating and renewing contracts due to transitioning to new owners. When asked if the facility had a designated hospice liaison, Staff A stated when hospice services were desired, Staff K, Social Services made the arrangements, but a designated hospice liaison had not been appointed. No associated WAC

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	505414	A. Building B. Wing	06/18/2025

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South Hill Rehabilitation and Care Center	17 East 8th Avenue Spokane, WA 99202

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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 signage was placed to inform the staff of residents (Resident 7, 77, 180, 182, 183, and 191) who required Enhanced Barrier Precautions (EBP, infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO, germs that are resistant to many antibiotics]). Additionally, the facility failed to ensure hand hygiene was implemented as required during medication administration. These failures placed the residents at risk for the spread of infections, illnesses and unintended health consequences. Findings included . According to a 06/28/2024 Centers for Disease Control article, EBP are used in conjunction with standard precautions and expanded the use of putting on gown and gloves during high-contact resident care activities (e.g., dressing, bathing/showering, transferring, changing linens, providing hygiene, wound care and assisting with toileting) for residents known to be colonized or infected with a MDRO when Contact Precautions did not otherwise apply, as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). <Resident 183> Review of the medical record showed Resident 183 admitted to the facility on [DATE] after they experienced a stroke. The medical record showed Resident 183 admitted with the use of an indwelling urinary catheter that helped empty their bladder. An observation on 06/09/2025 at 10:09 AM showed Resident 183 sitting in a wheelchair and the tubing of the urinary catheter drained to a collection bag and secured to the wheelchair. No EBP signage was observed to instruct the staff of the required PPE after four days of admission. <Resident 77> Review of the progress notes showed Resident 77 admitted to the facility on [DATE] with a feeding tube (a flexible tube used to provide liquid nutrition, fluids, and medications directly to the stomach or small intestine when someone is unable to eat or drink adequately). The medical record showed the staff used the feeding tube to provide continuous nutrition, hydration and administer medication to the resident. An observation on 06/09/2025 at 12:34 PM showed Resident 77 in bed. A dressing was observed to the left side of their stomach and a feeding tube coming out of it and connected to a bag of nutrition formula run by a pump on a pole. No EBP signage was observed to instruct the staff of the required PPE after six days of admission. <Resident 7> Review of the medical record showed Resident 7 admitted to the facility on [DATE] with orders to administer antibiotics ([NAME]) intravenously (IV, by vein). The medical record showed the staff currently administered two [NAME] by IV. (continued on next page)

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	505414	A. Building B. Wing	06/18/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 06/09/2025 at 9:49 AM showed Resident 7 sitting in a wheelchair in their room with an IV line to their right inner arm. No EBP signage was observed to instruct the staff of the required PPE after 31 days of admission. <Resident 180> Review of the medical record showed Resident 180 was admitted to the facility on [DATE] with orders to administer an ABT by IV. The medical record showed the staff currently administered an ABT by IV. An observation on 06/09/2025 at 9:28 AM showed Resident 180 sitting in a wheelchair in their room with an IV line to their right arm. No EBP signage was observed to instruct the staff of the required PPE after seven days of admission. <Resident 191> Review of the medical record showed Resident 191 admitted to the facility on [DATE] with IV [NAME] for a bloodstream infection. The medical record showed the staff currently administered the [NAME] three times a day. An observation on 06/10/2025 at 1:25 PM showed Resident 191 sitting in a recliner. Staff D, Speech Therapist, sat directly on the resident's bed with no gown on and wore a surgical mask required by the facility for a COVID-19 (a contagious disease) outbreak. Staff D talked with the resident during their visit. An IV pole was observed with a pump and an IV bag connected to it. No EBP signage was observed to instruct the staff of the required PPE. Another observation on 06/11/2025 at 9:10 AM showed no EBP signage in use after nine days of admission. <Resident 182> Review of a medical record showed Resident 182 admitted to the facility on [DATE] with IV ABT. An observation on 06/09/2025 at 10:21 AM showed Resident 182 in bed. An IV line was observed to their right arm. No EBP signage was observed to instruct the staff of the required PPE after five days of admission. In an interview on 06/12/2025 at 8:44 AM, Staff G, Nursing Assistant, stated that they knew when a resident required EBP by, We have it [signage] posted right outside their door. (continued on next page)

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	505414	A. Building B. Wing	06/18/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The above findings were shared with Staff E, Nurse Manager, in an interview and observation on 06/12/2025 at 9:25 AM. Staff E stated that they informed the staff of the requirement for EBP via use of a laminated sign placed outside and by the resident's door on admission. Staff E stated any resident with wounds, IV lines, urinary catheters and feeding tubes required EBP signage. Staff E stated that the staff should wear a gown if they sat on the bed of a resident who met the criteria for EBP. Staff E acknowledged Resident 191 still did not have the signage to show certain cares required EBP and should have been in place eight days ago upon admission to the facility. Staff E stated that when a resident was admitted to the facility, the Admissions Nurse placed EBP signage as required and the reason the signage was not up for the above residents during the observations of 06/09/2025 was because the Admissions Nurse, just took a week's vacation and it [the admission process] was very broken. The above findings were shared with Staff F, Infection Preventionist, on 06/16/2025 at 11:05 AM. No further information was provided. <Hand Hygiene during Medication Administration> On 06/16/2025 at 8:39 AM, observed the administration of medications for Resident 283. Staff P, Nursing Technician, placed their pills into a medication cup and the pain ointment into another cup at the medication cart. Staff P then entered the resident's room, placed the pill cup on the bedside table and watched as the resident took the pills. Staff P put on gloves and applied the ointment, then discarded the gloves. They did not use hand sanitizer after removing the gloves or upon entering or leaving the resident's room. Staff P then went to the medication cart, documented the medications on the computer and began preparing medications for the next resident, without performing hand hygiene. During a concurrent interview, Staff P stated they should use hand sanitizer whenever entering or leaving a resident room, and after removing their gloves. They acknowledged they had forgotten to do so. During an interview on 06/18/2025 at 3:17 PM, informed Staff A, Administrator and Staff B, Director of Nursing of observations during medication pass with Staff P. Staff B stated they expected staff to perform hand hygiene after removing gloves and between each resident. Reference WAC 388-97-1320 (2)(b); -1320 (1)(c).