STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505441	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Central Care Center	N 1812 Wall Street Spokane, WA 99205

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 provide information of potential risks and/or benefits of psychotropic (medications that affect behavior, mood, thoughts, or perception such as antidepressants) medications prior to their use for 1 of 5 sampled residents (Resident 31), reviewed for unnecessary medications. This failure placed residents and/or their representatives at risk of not being fully informed of the risks, benefits or alternative treatment options available before decisions were made regarding medications. Findings included. According to the 06/03/2025 admission assessment, Resident 31 admitted to the facility on [DATE] with diagnoses including depression and received antidepressant medication. Resident 31 was cognitively intact and able to clearly verbalize their needs. Review of the 05/28/2025 depression care plan showed Resident 31 used antidepressant medication and instructed staff to administer medication as ordered, monitor for adverse reactions to the medication, and educate the resident about the risks versus (vs) benefits and/or toxic symptoms of medications as needed. Review of provider orders showed an active 05/31/2025 order for Resident 31 to be administered Duloxetine (antidepressant medication) daily for depression. Review of May 2025 through July 2025 Medication Administration Records showed Resident 31 was administered Duloxetine 55 times. Additional record review showed no documentation a consent for Duloxetine use was obtained prior to medication administration, as required. In an interview on 07/25/2025 at 9:56 AM, Staff E, Registered Nurse, stated a consent needed to be obtained prior to administration of psychotropic medications. In an interview on 07/25/2025 at 10:29 AM, Staff D, Resident Care Manager, stated staff needed to discuss psychotropic medications with the resident when ordered and a consent with risks vs benefits obtained prior to administration of psychotropic medications. Staff D reviewed Resident 31's medical record. Staff D acknowledged they were unable to find documentation a Duloxetine consent was obtained for Resident 31 prior to medication administration, as required. In an interview on 07/28/2025 at 8:38 AM, Staff B, Director of Nursing, stated psychotropic medication consents needed to be obtained prior to medication administration. Staff B reviewed Resident 31's medical record. Staff B acknowledged the Duloxetine consent for Resident 31 was not obtained until July 2025 and expected staff to obtain psychotropic medication consents prior to medication administration, as required. Reference WAC 388-97-0300 (3)(a), 0260, 1020 (4)(a-b)

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview and record review, the facility failed to ensure an effective system to deliver mail to the residents on the days mail was delivered. This failure placed the residents at risk for feelings of isolation, loneliness, anxiety, and depression. Findings included. In a resident group meeting on 07/22/2025 at 1:30 PM, a resident stated, I was told we don't get mail on Saturday because no one is at the front desk. Another resident stated, We don't have anybody here to let them in. Six of the six residents stated they did not get mail delivered to them on Saturdays.In an interview on 07/24/2025 at 11:50 AM, Staff S, Business Office Manager, stated, Mailman doesn't come on Saturday. I don't know why it's not delivered on Saturday. In a telephone interview on 07/24/2025 at 12:04 PM, a Collateral Contact (CC) from the Post Office that handled the facility mail stated, Mail is delivered on Saturdays unless the business is closed. The address of the facility was provided to the CC who confirmed, Mail is delivered there on Saturday.In an interview on 07/24/2025 in the afternoon hours, Staff T, Medical Receptionist, stated, We don't get mail on the weekends. The front door is locked on the weekends. The mail man doesn't come on Saturday and hasn't for years. They have to ring the doorbell for assistance and then a staff from the unit will come and let them in because there's nobody here at the front desk or at the offices. The doorbell is heard at the nurses station. When asked when the facility started locking the front door on the weekends, Staff T stated, For as long as I've been working here, years, you'd have to ask [Staff A, Administrator, or Staff B, Director of Nursing] about that. In an interview on 07/24/2025 at 12:52 PM, Staff U, Activities Assistant, stated they worked at the facility on Saturdays and, I think the front doors are locked because they don't want anyone coming in because it's kind of a bad neighborhood, but someone is usually here to unlock the doors. On weekends there is no front desk receptionist. Staff U stated, Maybe a couple months ago, [mailman] came once because I was at the door. I was letting someone else in, and [they] saw me, and I said I would take it [the mail] that one time.In an interview on 07/25/2025 at 9:44 AM, an express delivery services CC stated when the front doors were locked on Saturdays and there was no staff at the front desk, Then we will treat it as 'Business Closed' and move on because we do not have time to wait.In an interview on 07/25/2025 at 10:40 AM, a Postal Service CC assigned to deliver mail at the facility stated they delivered mail to the facility since before 2020, to include Saturdays. The CC stated that when the COVID-19 (a contagious disease) pandemic started, the facility locked the doors of the building on Saturdays. The CC confirmed they knew there was a sign that asked of the public to Ring the doorbell if the doors were closed but, No one's at the door. The CC stated they did not stop by the facility anymore to deliver mail on Saturdays because of the door closure and there was no one at the front desk to readily accept the mail. The CC explained the Saturday mail is returned to the designated postal station and stayed there until the postal service's return to the facility the following week. The above findings were shared with Staff B, Director of Nursing, in lieu of Staff A's absence on 07/24/2025 at 1:02 PM. Staff B stated the front doors were locked ever since their employment at the facility, For 5 years they've locked up the doors on the weekends. Staff B said the doors were locked for security reasons and the Front Desk was not staffed on weekends. When asked what was required for a resident to receive their mail on Saturdays, Staff B said, That's a good question. I don't know the entirety of the answer and did not know if locking the front doors with no Front Desk attendant created a delay or hindrance for mail delivery to the residents on Saturdays. When asked if the facility explored ways to complete mail delivery to the residents on Saturdays, Staff B said, I've never had a concern brought to my attention. In a follow up interview on 07/28/2025 at 10:27 AM, Staff B said, I checked our video cameras, and they haven't delivered mail for the past three weekends. I can't make them [mailman] ring the doorbell and wait.General observations during the survey period from 07/21/2025 to 07/28/2025 showed a plaque on the side of the exterior wall before the front entry doors that instructed the public to Ring Bell for Admittance. There were no instructions to the mailman as to what to do when they encountered locked front doors and no staff readily available to take the mail from them and no mail receptacle visible for drop off. Reference WAC 388-97-0360, -0540(1-3), -0180(2).

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review the facility failed to maintain a clean, sanitary, and homelike environment free of institutional odors for 1 of 4 sampled residents (Resident 31), reviewed for environment. This failure placed residents at risk of lack of dignity, unmet care needs, and diminished quality of life.Findings included. According to the 06/03/2025 admission assessment, Resident 31 was frequently incontinent of urine and required substantial staff assistance for toileting hygiene. The assessment further showed Resident 31 rejected care four to six days a week, but less than daily. Resident 31 was cognitively intact and able to clearly verbalize their needs. Review of the 05/27/2025 activity of daily living care plan showed Resident 31 was incontinent, a heavy wetter, wore incontinence briefs, and required extensive staff assistance for bathing, bed mobility, and toileting. Interventions instructed staff to check and change Resident 31 every 90-120 minutes and as needed. The care plan further showed Resident 31 often refused care such as brief changes, bathing, and hygiene; staff were to notify the nurse of refusals and reapproach. No documentation was found to show how strong odors secondary to care refusals were minimized or addressed. During observation on 07/21/2025 at 10:09 AM, a strong urine odor was smelled coming from Resident 31's room, into the common hallway. Similar observations were made on 07/22/2025 at 10:06 AM and on 07/24/2025 at 2:07 PM. In an interview on 07/25/2025 at 10:49 AM, Staff F, Nursing Assistant, explained housekeeping deep cleaned resident beds on their shower day. Staff F stated they would notify housekeeping if strong odors were noted. Staff F further stated Resident 31 did not like to bathe. In an interview on 07/28/2025 at 11:29 AM, Staff H, Housekeeper, explained housekeeping deep cleaned resident beds on their shower day. Staff H acknowledged Resident 31's room had a really bad urine odor and explained Resident 31's mattress was exchanged on 07/22/2025; there was a puddle of urine under the bed, it was pretty bad. Staff H further stated the new mattress helped decrease the urine odor some, but the strong urine smell returned because Resident 31 refused to be changed and/or bathed. In an interview on 07/28/2025 at 11:48 AM, Staff G, Maintenance Director, acknowledged Resident 31's room had a strong urine odor, and the mattresses was exchanged recently because it was pretty saturated. In an interview on 07/28/2025 at 12:28 PM, Staff B, Director of Nursing, stated they were unsure how often housekeeping cleaned resident rooms or if housekeeping increased the cleaning frequency of resident rooms when the resident refused care and/or bathing. Staff B acknowledged Resident 31's room was odorous, and the facility recently threw out Resident 31's soggy mattress. Staff B explained Resident 31 often refused cares and the interdisciplinary team discussed possible odor eliminating interventions to attempt but nothing had been care planned. Reference WAC 388-97-0880

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the staff documented the information conveyed to the hospital at the time of 4 of 5 hospital transfers for 1 of 3 sampled residents (Resident 6) whose closed records were reviewed. Additionally, the staff failed to ensure bed hold notices were offered to Resident 6 or their representative in 4 of 5 hospital transfers and failed to notify the Office of the State Long-Term Care Ombudsman (an advocate for residents of nursing homes, adult family homes, and assisted living facilities who protect and promote the resident rights under federal and state law and regulations) of 5 of 5 hospital transfers. These failures placed the resident at risk for delayed services and a lack of knowledge regarding the right to a bed-hold while they were hospitalized , and detracted from the residents' rights being protected, the opportunity to explore other options, or provide them with support and advocacy during a potentially stressful and confusing time.Findings included. Review of an undated facility policy and procedure titled Room and Bed Hold Letter showed that when a resident transferred to the hospital, the nurse presented a Room and Bed Hold Letter to the resident, family, or responsible party upon transfer of the resident. If a resident could not participate in the transfer process, the nurse sent a copy of the Room and Bed Hold Letter with the resident to the hospital and made a copy of the letter and left it for the medical records staff to mail it on the next business day. The medical records staff attempted to contact the resident's family or responsible party by phone on the first business day following the transfer, explained the bed hold notice policy and informed them a copy was placed in the mail.On 07/24/2025 at 5:48 PM, Staff B, Director of Nursing Services, communicated to the Survey Team via e-mail that the facility did not have specific policies regarding Sending a resident to the hospital but the procedure was, an SBAR [Situation, Background, Assessment, and Recommendation, a structured tool used to facilitate clear and concise communication between healthcare professionals when reporting patient information] will be completed and sent with the ambulance team, along with MAR [Medication Administration Record], POLST [Physician Orders for Life-Sustaining Treatment, a document that outlines a person's wishes for medical treatment, particularly at the end of life], face sheet [details about a resident's identity, contact information, medical background], notice of transfer, and bed-hold information. This was sent in a print format with [the ambulance team]. Review of a 06/11/2025 admission assessment showed Resident 6 admitted to the facility on [DATE] with weakness, diabetes, and several heart conditions. The assessment showed Resident 6's cognition was intact and they required physical assistance from the staff to complete their Activities of Daily Living.<1st Transfer>Review of a 04/29/2025 progress note written at 9:07 AM showed Resident 6 required a hospital transfer due to abnormal blood work results. The progress note showed the staff called the hospital to give report. Review of the medical record showed no documentation of what information the facility communicated to the hospital, for example the SBAR, contact information for their provider, family or representative, POLST and/or advanced directives, plan of care and treatment, current medications and the reason for the hospital transfer. Additionally, review of the medical record showed no documentation the staff offered or provided a bed hold notice to Resident 6 or their representative. <2nd Transfer>Review of a 06/23/2025 progress note written at 1:01 PM showed Resident 6 was insisting to go to the ER [Emergency Room] because [they were] in excruciating pain and Paperwork given to resident to take to the ER. The note showed, Resident called 911 and left about [3:45 PM]. Review of the medical record showed no documentation of what information the staff conveyed to the hospital at the time of the transfer or that a bed hold notice was offered or provided to Resident 6 or their representative. <3rd Transfer>Review of a 07/01/2025 progress note written at 8:01 PM showed the staff was unable to flush Resident 6's urinary catheter (a flexible tube inserted inside the urinary canal to drain urine from the bladder) and assessed some blood in urine. The staff reported the change in condition to the provider who ordered a transfer to the hospital. Record review showed the staff conveyed information to the hospital using an SBAR form. Record review showed no documentation the staff provided or offered a bed hold notice to Resident 6 or their representative.<4th Transfer>Review of 07/04/2025 progress notes showed the provider was in the facility and assessed Resident 6, who appeared pale. After their assessment, the provider ordered a transfer to the ER for evaluation and blood transfusion. The notes showed, All paperwork along with order to transfer and recent labs sent with resident. Review of the medical record showed no documentation of what information staff conveyed to the hospital in all paperwork sent at the time of transfer or that a bed hold

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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 interview and record review, the facility failed to ensure a Pre-admission Screening and Resident Review (PASRR, a screening that occurred prior to facility admission that determined if one met nursing home level of care and potentially required services for mental health needs once a resident. If one was expected to be at the facility less than 30 days, they were exempt. After 30 days, if still at the facility, a new referral and screening was required) was completed timely after an exempted hospital stay expired for 2 of 5 sampled residents (Residents 2 and 3) reviewed. This failure placed residents at risk for not receiving timely and necessary services to support their mental health care needs.Findings included.<Resident 3> A review of the record documented Resident 3 was admitted to the facility on [DATE] and had diagnoses that included end stage renal (kidney) disease and depression. The [DATE] PASRR documented Resident 3 had mood and anxiety disorders. Section III of the Screening form documented the resident did not require further behavioral health screenings; they had an exempted hospital discharge per the requirements listed in Section IIA of the form. However, Section IIA was not completed. A review of Resident 3’s census data documented the resident was discharged to the hospital on [DATE] and was readmitted to the facility on [DATE]. On [DATE], a second PASRR was completed that documented Resident 3 had been a resident of the facility since [DATE], had diagnoses that included mood disorders, and the resident required further level II PASRR evaluations to determine their need for behavioral health services. During an interview on [DATE] at 11:57 AM, Staff L, Social Services Director, stated the admission Coordinator received initial admission paperwork and Staff L reviewed the PASRRs to ensure they were complete. Staff L stated initially, the plan was that Resident 3 was to reside at the facility for less than 30 days, but this changed after the resident returned to the hospital. Staff L stated they kept a list of those residents that had an exempted hospital stay so they ensured that another PASRR was completed timely when a resident remained at the facility longer than 30 days. Staff L stated a new PASRR should have been completed when the resident re-admitted to the facility on [DATE]. <Resident 2> The [DATE] quarterly assessment documented Resident 2 admitted to the facility from the hospital on [DATE], and had diagnoses which included medically complex conditions, depression, and dementia. On [DATE] at 10:04 AM, Resident 2 was observed sitting on the edge of the bed in their room. When asked how they were doing, Resident 2, laughed and stated, “Just fine”. Review of Resident 2’s record documented the hospital had completed a Level I PASRR on [DATE], prior to the resident’s arrival at the facility. The PASRR documented a Level II PASRR was not required since Resident 2 met the guidelines for an exempted hospital stay. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes from [DATE] through [DATE] documented ongoing conversations and discussions related to discharge planning occurred with the resident, their representative and the facility; the resident wished to remain at the facility. Additional record review found an updated Level I PASRR was completed on [DATE], two months past the time frame for the exempted hospital stay, and not within the 30 days as required. In an interview on [DATE] at 2:37 PM, Staff L stated an updated Level I PASRR needed to be completed when a resident with an exempted hospital stay did not discharge within the 30-day time frame. When informed an updated Level I was not found prior to [DATE] for Resident 2, Staff L stated they would review the resident records and follow-up. In a follow-up interview on [DATE] at 8:23 AM, Staff L stated they were unable to locate any documentation that showed an updated Level I was completed prior to [DATE] and acknowledged one should have been completed when Resident 2 did not discharge within 30 days of being admitted . Reference: WAC 388-97-1915(1)(2)(a-c)

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	505441	A. Building B. Wing	07/28/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to consistently provide shaving and nail care for 2 of 2 sampled residents (Residents 19 and13) reviewed for activities of daily living (ADLS). This failure placed the residents at risk for poor personal hygiene, unmet care needs, and a diminished quality of life.Findings included . <Resident 19> The 06/18/2025 quarterly assessment documented Resident 19 needed assistance from nursing staff to complete ADLS for personal hygiene such as shaving. In addition, the assessment showed Resident 19 had severe cognitive impairment and unclear speech. On 07/21/2025 at 9:14 AM, Resident 19 was observed standing in the hallway by the ward entrance doors. The resident’s face was clean and there was facial stubble present on the cheeks, chin and upper lip. Additional observations of Resident 19 with facial stubble were made on the following: 07/22/2025 at 9:02 AM, 07/23/2025 at 8:59 AM, 9:36 AM, and 11:52 AM, and on 07/24/2025 at 7:10 AM. Review of the ADL care plan included interventions that informed nursing staff of Resident 19’s care needs related to bathing, toileting, oral care and dressing, but no interventions or instructions related to Resident 19’s grooming/shaving needs, preferences or assistance required were included. Review of the personal hygiene/grooming records from 06/24/2025 through 07/22/2025 documented the type of assistance Resident 19 needed to maintain personal hygiene (shaving, combing hair, applying makeup, and washing/drying face and hands), but did not include what type of personal hygiene the resident received. In addition, the documentation indicated Resident 19 had refused assistance nine times but did not specify which type of personal hygiene was refused. In an interview on 07/23/2025 at 3:24 PM, Staff F, Nursing Assistant, stated the resident’s care plans informed them of the specific care needs for the resident. When asked when shaving was completed, Staff F stated it was done when the nursing staff got residents ready for the day, and when residents were bathed. In an interview on 07/23/2025 at 3:43 PM, Staff B, Director of Nursing, was informed of the observations of the resident with facial stubble, and the lack of interventions/instructions related to grooming/shaving in Resident 19’s care plan. Staff B stated the expectation was that shaving and personal hygiene were done with morning cares and the resident’s care plan was to include information that informed the staff of the resident’s specific care needs. <Resident 13> (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 05/22/2025 quarterly assessment showed Resident 13 admitted to the facility on [DATE] with medically complex conditions, to include a stroke and related weakness or paralysis (the loss of muscle function in part of the body, resulting in the inability to move or feel that area) to their left side, and had moderately impaired cognition. The assessment showed Resident 13 required partial to moderate assistance from the staff to complete personal hygiene (e.g., combing hair, shaving, applying makeup, washing/drying face and hands) and did not reject care. An observation and interview on 07/21/2025 at 10:35 AM showed Resident 13 in bed. The right hand had black matter under the fingernails that were visibly long and required trimming. The left-hand fingernails were unable to be properly visualized as the hand curled inward in a fist. When asked, Resident 13 said the staff did not clean their fingernails when they gave the resident their weekly evening shower. Subsequent observations of 07/21/2025 at 11:50 AM and 07/22/2025 at 8:53 AM showed similar findings. Review of the 05/17/2024 care plan showed the resident had “paralysis/deficits” to their left hand, arm, and shoulder due to a stroke, and staff were instructed to allow the resident time during tasks of dressing and grooming. Another care plan intervention instructed the staff to keep the resident’s fingernails short. Review of a July 2025 Treatment Administration Record showed an order that instructed the nurses to check Resident 13’s nails every two weeks on Thursdays and was signed by a nurse as completed on 07/10/2025. Review of a 07/13/2025 progress note showed the staff, “Trimmed fingernails on resident's contracted hand [left hand] without incident. Palm washed and dry washcloth placed for drying and separation of skin. Resident tolerated well.” Progress notes from 07/13/2025 to 07/23/2025 showed no documentation of staff attempts to provide nail care to Resident 13’s right hand. On 07/23/2025 at 12:32 PM, Resident 13 said they had a shower, “Two days ago”. The right-hand still showed black matter under the nails. Staff R, the Nursing Assistant who served Resident 13 their lunch and present during the observation stated, Yeah, they need to be cleaned and trimmed” and would let the nurse know. Staff R said that usually the nurse trimmed the nails to the left hand and then the nursing assistants completed nail care to the right hand on shower days. Resident 13 then interjected they preferred the nurse to trim the fingernails of both hands. The above findings were shared with Staff K, Resident Care Manager, on 07/25/2025 at 12:33 PM. Staff K stated that because of “behaviors” Resident 13 required two people for care provision. Staff K said that if a resident did not have diabetes or took an anticoagulant (blood thinner), the Nursing Assistants provided nail care, cleaned with an orange stick and trimmed the nails. Staff K said they expected staff to provide nail care in between shower days if the resident nails were long or had build-up noticeable under the nails. Reference: WAC 388-97-1060 (2)(c)

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	505441	A. Building B. Wing	07/28/2025

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview and record review, the facility failed to ensure care plan goals and interventions were developed and monitoring occurred for 2 of 2 sampled residents (Residents 11 and 22) reviewed for edema (swelling) management. This failure placed the residents at risk for worsening edema, unrecognized changes to their skin, and decreased quality of life. Findings included. <Resident 11> The 06/17/2025 Significant Change assessment documented Resident 11 had diagnoses that included lymphedema (swelling and fluid buildup caused by blockage in the lymphatic system, part of the immune and circulatory system) and osteomyelitis (infection of the bone). The resident was cognitively intact and made their needs known. The 03/11/2025 admission skin assessment documented Resident 11 had a surgical incision on their left heel and 4+ edema (a deep indentation of the skin that occurred when pressure was applied that required two to three minutes to fill back in once pressure was relieved) to both lower legs. The 03/11/2025 care plan documented Resident 11 had actual skin impairment to the left heel related to an incision and drainage (I&D), and edema. Staff were to keep body parts from excessive moisture, keep the resident’s fingernails short to avoid scratching, keep skin clean and dry, use lotion on dry skin, encourage good nutrition, and encourage and assist to turn and reposition every two to three hours and as needed. The care plan did not have a care area, goals or interventions developed related to Resident 11’s lymphedema and lower leg edema. A 03/17/2025 Nurse Practitioner progress note documented nursing reported concerns of lower leg edema. An order was given to apply Tubi-grips (special garments that applied compression to the affected areas that helped reduce swelling and edema) to both lower extremities for edema, on in the morning, off at bedtime. There were no other provider or nursing orders given related to the management or monitoring of Resident 11’s edema. Review of the medication administration records (MARS) for April, May and June 2025 documented the resident refused the Tubi-grips daily. On 07/21/2025 at 2:31 PM, Resident 11 was observed in their room seated in their wheelchair. The resident was dressed in a hospital gown, and their lower legs were visible. Resident 11 wore non-skid socks, and their calves were edematous and had purple/red discoloration, the left more-so than the right. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505441	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/22/2025 at 2:38 PM, Resident 11 rested in bed. The resident’s legs were positioned straight out in front of them resting on the mattress and not in an elevated position. Resident 11 stated when they were home, they wore a compression stocking on their left leg because after they had a stroke, that leg was the one that had worse edema. Resident 11 stated they were given Tubi-grips to wear at the facility, but stopped wearing them because when they did, the wound on their left heel reopened. They were unaware of any other things being done to reduce swelling. The resident stated they just kept their leg out in front of them when they were in bed. A policy for lymphedema and edema management was requested. On 07/28/2025 at 11:10 AM, Staff B, Director of Nursing, responded by email that the facility had no specific policies for lymphedema and edema management. They used standard practices and procedures. During an interview on 07/28/2025 at 12:10 PM, Staff B stated they created initial care plans based on admission orders. Then, specific diagnoses were reviewed and if needed, care areas were created, but not every diagnosis had a care area developed in the care plan. Staff B stated a lymphedema care plan might or might not be created, it depended on what the resident’s assessments looked like. Staff B stated they understood Resident 11 was not wearing their Tubi-grips, so expected there would need to be other interventions to monitor and manage their edema instead. <Resident 22> The 05/19/2025 admission assessment documented Resident 22 admitted with diagnoses that included high blood pressure and irregular heartbeat. The resident had severe cognitive impairment and was able to make their needs known. In an observation on 07/21/2025 at 10:29 AM, Resident 22 was lying in bed and pulled the sheet off their legs. Their lower extremities were edematous, red in color and dressings were in place to several different areas on their legs. The resident was not wearing any compression hose, and their legs were not elevated. Review of the provider orders showed Resident 22 received Lasix (a medication used to rid the body of fluid) from 05/13/2025 through 07/02/2025. A 07/02/2025 progress note documented the provider assessed Resident 22 with orders to discontinue the Lasix. The note stated the resident needed to be monitored for changes in their blood pressure and fluid status for three days. The only progress note made during those three days was on 07/03/2025. Review of the May, June and July 2025 MARs showed there was no edema monitoring. The care plan did not have a care area, goals or interventions developed related to Resident 22's lower extremity edema. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 07/22/2025 at 10:07 AM, Resident 22 was sitting on their bed. The resident’s lower extremities were edematous, and their sheets were wet at the end of the bed. Resident 22 stated it was from their legs oozing fluid. At 1:33 PM, Resident 22 was lying in bed, and both legs were resting flat on the mattress. The resident wanted the nurse to be notified because they felt they were drowning in fluid. The nurse entered the room and explained the resident was going to restart their Lasix. In an observation on 07/24/2025 at 9:12 AM, Resident 22 was lying in bed. Their feet were edematous, red and lying flat on the mattress. Similar observations were made on 07/24/2025 at 12:33 PM and 3:59 PM, and 07/25/2025 at 12:26 PM. In an interview on 07/24/2025 at 9:28 AM, Staff X, Nursing Assistant, stated when a resident had edema they reported it to the nurse. Staff X stated residents with edema received Lasix, wore compression stockings, and their legs were elevated. In an interview on 07/24/2025 at 1:23 PM, Staff V, Licensed Practical Nurse, stated edema was monitored daily and documented in the MAR or TAR. Staff V added it was important to monitor edema because that could indicate a sudden change in medical condition and if the edema decreased the medication might need to be adjusted. In an interview on 07/24/2025 at 10:19 AM, Staff D, Resident Care Manager, stated Resident 22 should have had a care plan in place with interventions to include compression stockings, edema monitoring, and elevation of their lower extremities. In an interview on 07/25/2025 at 8:50 AM, Staff B, Director of Nursing, stated Resident 22 should have had a care plan in place for edema and their edema should have been monitored. Staff B stated it was important to monitor edema for fluctuations so the provider could be notified. Reference: WAC 388-97-1060 (1)

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	505441	A. Building B. Wing	07/28/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the staff provided required splints and positioning devices and adequately followed up with resident refusals of Restorative Nursing Programs for 3 of 3 sampled residents (Residents 12, 13, and 71) reviewed for Limited Range of Motion (ROM, the full movement potential of a joint) and positioning. These failures placed the residents at risk for worsening contractures (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) and a diminished quality of life.Findings included.Review of the October 2024 Resident Assessment Instrument User Manual (a comprehensive guide used in nursing homes and other long-term care facilities to assess residents' needs and develop individualized care plans) showed, Restorative nursing program [RNP] refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. Measurable goals and interventions were documented in the care plan and in the medical record. When the care plan was revised, the resident's progress with the RNP, goals, and duration/frequency were reassessed and the results of the reassessment documented in the resident's medical record. Evidence of periodic evaluation by a licensed nurse (LN) was present in the resident's medical record. A progress note written by the restorative aide (RA) and countersigned by a LN was sufficient to document the RNP once the purpose and objectives were established.Review of the April 2025 Facility Assessment showed the facility offered services to the residents that included walking, contracture prevention/care, and management of braces and splints. Review of an 11/15/2023 facility policy titled Restorative Nursing Policy and Procedure showed the facility provided RNP as needed to help promote optimal safety and independence. Restorative goals and objectives were individualized, resident-centered, and outlined in the resident's plan of care. The policy showed the facility was responsible for a monthly summary note completed by a LN.Review of an undated facility policy titled Resident Mobility and Range of Motion showed the facility provided the residents with the required treatment, services, equipment and assistance to increase and/or prevent a further decrease in ROM and maintain or improve mobility unless it was unavoidable. The care plan included specific interventions, exercises and therapies to maintain, prevent avoidable decline in, and/or improve mobility and ROM, to include the type, frequency, and duration of interventions, as well as measurable goals and objectives. Documentation of the resident's progress toward the goals and objectives included attempts to address any changes or decline in the resident's condition or needs.<Resident 12>Review of a 04/30/2025 Significant Change Assessment showed Resident 12 admitted to the facility on [DATE] with medically complex conditions, which included dementia and schizophrenia (a chronic and severe mental health disorder that affected how a person thinks, feels, and behaves). The assessment showed Resident 12's cognitive skills were moderately impaired for daily decision making, was dependent on the staff for completion of most Activities of Daily Living (ADLs), had limitations to both legs' range of motion, received no RNP in the last seven days of the assessment reference date period, and did not reject care.Review of a 07/09/2021 care plan showed Resident 12 was on a Restorative Program for Grooming. The goal of the RNP was to maintain or increase the ability to brush hair, wash hand/face and the ability [to] maintain oral care with cueing and setup. To achieve this goal, the care plan instructed the staff to, Provide all necessary items and Provide cuing or assistance if needed, and chart minutes of participation 15 minutes/day 6 days/week.Review of flow sheets associated with the grooming RNP showed that between 06/25/2025 and 07/23/2025, the staff documented they implemented the RNP twice a day, on day and afternoon shifts, but Resident 12 refused 22 of the 58 scheduled shifts. Review of the medical record showed no documentation why Resident 12 refused to participate in the RNP and how the staff addressed the refusals.Review of the medical record showed no periodic assessments related to the RNP from 01/2024 to 06/2025.In an interview on 07/25/2025 at 9:44 AM, Staff W, Nursing Assistant (NA), stated Resident 12 was, Not on any RNP and at times rejected cares.The above findings were shared with Staff K, Resident Care Manager, on 07/25/2025 at 12:28 PM. Staff K stated they expected the staff to, Notify [Staff K] of consecutive refusals so that it can be documented by the nurse. I would want the nurse to try and assist them in reapproaching and encouraging them to complete the task, then if the resident is completely disagreeable then I need to be made aware. Staff K acknowledged the medical record showed no documentation the facility evaluated and addressed Resident 12's refusals of their RNP. <Resident 13>Review of a 02/20/2025 Significant Change in Condition assessment showed Resident 13 admitted to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505441	A. Building B. Wing	07/28/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review, the facility failed to maintain oxygen saturations per provider orders and failed to ensure respiratory equipment was cleaned and maintained for 1 of 1 sampled residents (Resident 70), reviewed for respiratory care. This failure placed the resident at risk for illness and decreased quality of life. Findings included .The 05/12/2025 admission assessment documented Resident 70 had diagnoses that included respiratory and heart failure. The resident was cognitively intact and was dependent on supplemental oxygen.In an observation on 07/21/2025 at 11:09 AM, Resident 70 was lying in bed asleep and was wearing oxygen. The resident had a CPAP (continuous positive air pressure, a machine that delivered pressurized air through a mask worn during sleep) on a table near their bed. The CPAP had a few white spots inside of the mask. In an interview on 07/21/2025 at 1:09 PM, Resident 70 was lying in bed wearing oxygen. Resident 70 stated the facility had not cleaned their CPAP.No further observations were made of Resident 70 as they were discharged to the hospital the morning of 07/22/2025.The 05/05/2025 comprehensive care plan documented Resident 70 had chronic obstructive lung disease (COPD, a group of lung diseases that made it difficult to breathe), received oxygen and wore a CPAP at bedtime. The nursing staff were to administer the medications as ordered by the physician. A review of the provider's orders instructed staff to administer 1-2 liters (L) of oxygen per minute and for the CPAP to be worn every night and removed in the morning. There were no orders to clean the CPAP mask in the medication or treatment administration record (MAR/TAR). A review of the July 2025 MARs showed Resident 70 was administered 3. 5L of oxygen on 07/18/2025, 07/19/2025, 07/20/2025 and 07/21/2025. On 07/22/2025 the resident was administered 3L of oxygen. The orders also showed that Resident 70 wore her CPAP nightly. -On 07/19/2025 at 7:17 AM, Resident 70's oxygen saturation was 92%, at 5:24 PM it was 93%.-On 07/20/2024 at 1:27 PM, Resident 70's oxygen saturation was 94%.-On 07/22/2025 at 11:15 AM, Resident 70's oxygen saturation was 94%. A 07/19/2025 progress note stated Resident 70 was on 5L of oxygen.In an interview on 07/24/2025 at 1:30 PM, Staff V, Licensed Practical Nurse, stated they had a binder that contained standing orders from the providers, and they referred to that binder when administering oxygen. Staff V added in an emergent situation the resident's oxygen was increased without a provider's order and if non-emergent, they notified the provider and obtained an order to increase the oxygen. Staff V stated it was important to follow the provider orders for oxygen because the residents needed their oxygen saturations kept within a certain range because of their disease processes. Staff V stated they thought CPAPs were cleaned daily to weekly and that it would be optimal to have this information on the MAR or TAR. Staff V stated it was important to keep the CPAP mask clean to prevent bacteria. In an interview on 07/25/2025 at 8:53 AM, Staff B, Director of Nursing, stated the facility had standing oxygen orders from the providers. The standing order stated the residents were to receive between 0-4L of oxygen and for a resident with COPD the oxygen saturations were not to exceed 88-91%. Staff B stated nursing staff were trying to manage Resident 70's oxygen saturations by adjusting the resident's oxygen up and was unsure if staff had adjusted the oxygen back down after the resident exceeded the recommended saturations. Staff B stated nursing staff should have re-checked Resident 70's oxygen saturations and documented them in the progress notes. In an interview on 07/28/2025 at 9:06 AM, Staff B stated CPAP masks were washed and rinsed daily, and the orders were in the MAR. Staff B acknowledged there were no orders to clean Resident 70's CPAP and there should have been. Staff B stated it was important to perform routine cleaning on respiratory equipment to prevent the risk of infection. Reference: WAC 388-97-1060 (3)(j)(vi)

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	505441	A. Building B. Wing	07/28/2025

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Director of Nursing (DNS) did not serve as a charge nurse when the facility had an average daily occupancy over 60. This failure placed all residents at risk of lack of oversight for care provided, unmet care needs, and a diminished quality of life.Findings included . Review of the facility assessment dated [DATE] showed the facility's average daily census was 75-80. The assessment identified Staff B as the DNS. The staffing plan showed the facility required one DNS to meet the care requirements of the facility resident population during day-to-day operations and during emergencies. The contingency staffing plan showed the facility would utilize interdepartmental staff support from various departments to meet staffing needs in another department, as long as such support does not violate licensure/certification requirements. In an interview on 07/21/2025 at 8:30 AM, Staff A, Administrator, stated Staff B, DNS, was not working that morning because there was a scheduling issue and they worked night shift last night. Review of the facility census for 07/21/2025 showed the facility had 80 current residents. In an interview on 07/25/2025 at 10:35 AM, Staff D, Resident Care Manager, stated nurse managers, including the DNS, rotated being on-call during weekends. Staff D explained the on-call manager received staff call-ins on the weekends, attempted to fill staffing needs, and were required to work on the weekends if unable to find needed staffing coverage. Staff D acknowledged Staff B worked the floor often and the facility average census was about 80. In an interview on 07/25/2025 at 11:27 AM, Staff M, Staffing Coordinator, stated nurse managers, including the DNS, rotated being on-call during weekends. Staff M explained the on-call manager attempted to staff open shifts and were required to come in and work the floor if unable to find needed coverage. Staff M stated the facility's daily average census was between 79-85. Staff M acknowledged Staff B should not work the floor as a charge nurse when the facility census was at a certain level. In an interview on 07/28/2025 at 8:46 AM, Staff B, DNS, stated the facility had a daily average census of 82-83. Staff B explained they and other nurse managers rotated being on-call during weekends; they received staff call-ins, attempted to staff open shifts, and were required to work if unable to find needed staffing coverage. Staff B acknowledged they should not work the floor as a charge nurse but did when needed, if unable to find needed staffing coverage, because they would not ask or require their staff to do something they were not also willing to do. Reference WAC 388-97-1080 (2)(a)

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	505441	A. Building B. Wing	07/28/2025

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete annual staff performance reviews yearly as required and provide education based on the outcome of these reviews for 3 of 8 sampled staff (Staff AA, BB, and CC), reviewed for performance reviews. This failure placed residents at risk of receiving care from inadequately trained and/or under-qualified care staff, and a diminished quality of life.Findings included. <Staff AA>Review of Staff AA's, Nursing Assistant (NA), personnel file showed they were hired on 02/05/2016. No documentation of a performance evaluation was found on file. In an interview on 07/26/2025 at 1:58 PM, the yearly performance evaluation for Staff AA was requested from Staff A, Administrator. No documentation was provided. <Staff BB>Review of Staff BB's, NA, personnel file showed they were re-hired on 07/17/2020. No documentation of a performance evaluation was found on file. In an interview on 07/28/2025 at 8:32 AM, the yearly performance evaluation for Staff BB and Staff CC was requested from Staff B, Director of Nursing (DNS). None was received. <Staff CC>Review of Staff CC's, NA, personnel file showed they were re-hired on 08/21/2023. No documentation of a performance evaluation was found on file. In an interview on 07/25/2025 at 10:35 AM, Staff D, Resident Care Manager, stated staff performance evaluations were supposed to be completed yearly. In an interview on 07/28/2025 at 10:41 AM, Staff B stated they expected staff to complete performance evaluations yearly, as required. On 07/30/2025, an email was received from the DNS that included an evaluation for Staff BB. The evaluation documented it was completed on 07/29/2025, after the recertification survey was exited. Reference WAC 388-97-1680 (1)(2)(a-c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505441	A. Building B. Wing	07/28/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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	505441	A. Building B. Wing	07/28/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview and record review, the facility failed to ensure gloves were changed and hand hygiene was completed when indicated during the lunch meal service, foods were served at the appropriate temperatures and food was labeled and dated as required. The facility further failed to maintain the required dish washing machine temperatures. These failures placed residents at risk for food-borne illnesses. Findings included .<Expired/undated food>During an observation on 07/21/2025 at 9:58 AM, the refrigerator on the Tucson Hall dining room revealed three frozen drinks. There was a name on one of the drinks, the other two drinks were not labeled and none of the drinks had dates of when they had been placed in the freezer. In an interview on 07/21/2025 at 12:24 PM, Staff N, Registered Nurse, stated the refrigerator in the dining room was for the residents. Staff N stated everything in the refrigerator should have had a name and date and it was important to put names and dates on items, so one knew who they belonged to and when to discard them, so they did not spoil. Staff N added it was the kitchen staff's responsibility to clean the refrigerator and to ensure food items were dated, however, whoever put items in the refrigerator needed to label and date them. <Food Temperatures>During observation of the lunch meal service on 07/28/2025 at 11:19 AM, Staff Q, Cook, had checked the temperatures of the cold food items. The pudding was 42.1 degrees Fahrenheit (F), cottage cheese was 43.5 degrees F, the fruit cup was 44.3 degrees F, and the salad was 41.2 degrees F, all above the recommended food temperature of 41 degrees. On 07/28/2025 at 11:40 AM, Staff Q was plating food and the aide placed watermelon on a meal tray. The watermelon came out of the refrigerator and the temperature was 42 degrees F. Once the meal trays were placed in the carts and ready to be served, the staff was asked what the temperature of the cold items needed to be and Staff O, Dietary Manager, stated 40 degrees or below. Staff O stated the cold items were cold in the refrigerator but were not staying cold and were not going to hold their temperature. Staff Q instructed staff to remove the cold items from the meal carts. Staff O stated the watermelon was fine to be served because it came out of the refrigerator and the temperature was subject to change. <Hygienic practice>During an observation of the meal service on 07/28/2025 at 12:10 PM, Staff O microwaved some food that was in mugs. Staff O had touched the microwave handles which had been touched by other staff members. Staff O gave the mugs of food to Staff Q who was wearing gloves and plating food. Staff Q did not remove their gloves and perform hand hygiene after they received the mugs. Staff Q then plated food and with their same gloved hands picked up fish and touched green beans that fell off the plate. On 07/28/2025 at 12:16 PM, Staff Q used their arm to push up their glasses while plating food. Similar observations of Staff Q using their arm to push up their glasses were made on 07/28/2025 at 12:19 PM, 12:20 PM, 12:23 PM, 12:24 PM, 12:25 PM, 12:30 PM, and 12:32 PM. Staff Q stated they needed new glasses because they had to keep pushing their glasses back onto their face. On 07/28/2025 at 12:33 PM, Staff Q wiped the side of their mouth on their shirt while plating food. <Dishwasher temperatures>During an observation of the kitchen on 07/28/2025 at 12:59 PM, Staff O stated the dishwasher was a high temperature dishwasher. This meant the dishes had to be rinsed at 180 degrees F or above to kill bacteria. An observation of the dishwasher showed the final rinse temperature was 170 degrees F. In an observation on 07/28/2025 at 1:11 PM, Staff P, Dishwasher, was putting away the dishes that came out of the dishwasher that did not reach the required final rinse temperature. In an observation on 07/28/2025 at 1:12 PM, another dishwasher cycle was observed, and the final rinse temperature was 170 degrees F. A third cycle was observed at 1:14 PM and the final rinse temperature was 172 degrees F. The temperature logs from May 2025 through July 2025 showed the final rinse temperatures were below 180 degrees on 34 different occasions in July, 41 occasions in June and 47 occasions in May. In an interview on 07/28/2025 at 1:23 PM, Staff O stated all items placed in the refrigerators should have names and dates and this was important to know who they belonged to and when the items needed to be discarded. Staff O stated cold food items needed to be served at the appropriate temperatures to prevent food borne illnesses. Staff O stated it was important to maintain hygiene during the meal service to protect the food and the residents. Staff O stated Staff Q should have performed hand hygiene and put on gloves after they touched the mugs of food that were reheated and prior to touching the food. Staff O stated Staff Q should have waited until after the meal service to adjust their glasses and wipe their mouth for infection control. Staff O stated they looked at the dishwasher temperature logs daily and should have notified maintenance. Staff O stated there was an issue with the hot water tank, and they thought things were fixed. Reference: WAC 388-97-1100 (3), 2980

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505441	A. Building B. Wing	07/28/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to ensure interventions developed to prevent the growth of waterborne bacteria or Legionella (a contagious bacteria that caused respiratory illness when water droplets or mist containing the bacteria were inhaled) as part of the Water Management Plan were monitored for completion as required. This failure placed residents and staff at risk of developing severe respiratory illness and unintended health consequences. Findings included.The undated facility Water Management Plan documented areas in the facility were identified that could encourage growth and spread of water borne bacteria or Legionella and included shower heads, sink aerators, dirty utility room hoppers (large basins where soiled linens or clothing were rinsed), tubs, and floor drains. Specific measures currently used to control the spread included:-flushing unused toilets weekly,-running water in unused sinks weekly, -Housekeeping was to clean shower heads with appropriate sanitizing agents,-Maintenance department was to flush basement floor drains weekly, and-the facility was to conduct Legionella testing of the water quarterly. On 07/28/2025 at 10:05 AM, a binder that contained completed logs that documented water temperatures were checked, and flushes of high-risk areas of the facility not in use were completed was observed with Staff G, Maintenance Director. The logs were dated from 12/22/2023 and ended 05/02/2025. Staff G looked for the logs from 05/02/2025 to the present and was unable to locate them. They stated they had assigned the water flushes to one of the staff in the Central Supply department to help them out, but they were unable to confirm that the logs and the water flushes had been completed. Reference: WAC 388-97-1320(1)(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505441	A. Building B. Wing	07/28/2025

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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 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 ensure the kitchen floor was maintained and torn linoleum was repaired when indicated. This failure placed staff at risk of potentially avoidable accidents, and infection control issues because the floor was not a cleanable surface.Findings included .In an observation of the kitchen on 07/21/2025 at 8:52 AM, the floor in the dishwashing area had a large area of the floor where the linoleum was torn off and missing, which created a possible tripping hazard for staff. The area was approximately 4 feet by 4 feet and had exposed wood which was not a cleanable surface. On 07/28/2025 at 1:23 PM, the floor in the dishwashing area was observed with Staff O, Dietary Manager. Staff O agreed the area was an infection control issue and a safety hazard and stated it was on their wish list to have it replaced. In an interview on 07/28/2025 at 1:51 PM, Staff B, Director of Nursing, stated they did not go past the yellow line in the kitchen (an area at the entrance of the kitchen where the staff entered to request items) so they were not aware of the floor in the dishwashing area. Reference: WAC 388-97-3220 (1)