

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505509	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2024
NAME OF PROVIDER OR SUPPLIER Spokane Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 222 East Fifth 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>46115</p> <p>Based on interview and record review, the facility failed to follow up with a physician's order to advance a catheter, and obtain an order to increase the oxygen rate, for 1 of 3 sampled residents (1) reviewed for neglect. This failure placed the resident at risk for potential deterioration in their medical condition and unmet care needs.</p> <p>Findings included .</p> <p>According to the 03/16/2022 admission assessment, Resident 1 had diagnoses which included benign prostatic hyperplasia (prostate gland enlargement that can cause difficulty with urination), chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe) and was able to make their needs known. The assessment also documented the resident required supplemental oxygen.</p> <p>A progress note dated 08/01/2022, by the urology clinic, documented Resident 1's urinary catheter was positioned in their prostate and was not placed fully into the bladder. The clinic called the facility and instructed Staff B, Registered Nurse, to advance the catheter into the bladder.</p> <p>A progress note dated 08/01/2022 at 5:25 PM, documented Staff B received a call from the urology clinic to inform the urinary catheter needed to be advanced an inch. Staff D, Resident Care Manager, instructed the nurse to notify the facility provider. Staff B left the provider a message to obtain the order.</p> <p>Review of Resident 1's record documented there was no further documentation found the facility had received a call back from the provider or that additional follow up communication occurred with the provider.</p> <p>Review of the 03/10/2022 provider orders, documented supplemental oxygen (oxygen delivered into the nostrils through soft tubing, typically at a rate between 1 and 10 liters per minute), was to be administered at 2 liters per minute (LPM) at rest, and 3 LPM with exercise.</p> <p>Review of the Medication Administration Records (MAR) for July and August 2022 documented the following times when oxygen was given above the ordered amount:</p> <p>Day Shift: 4 LPM on 07/13/2022, 07/14/2022, 07/24/2022, 07/30/2022, and 07/31/2022.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Evening Shift: 4 LPM on 07/10/2022, 07/15/2022, 07/18/2022, 07/19/2022, and 08/05/2022. On 08/06/2022 the oxygen was administered at 5 LPM.</p> <p>In an interview on 4/30/2024, at 1:13 PM, Staff C, Registered Nurse, stated the resident care managers processed orders when they were available, if not, the nurses were responsible to do so. Staff C added, they would notify the oncoming nurse if no response was obtained back from a provider. In addition, Staff C stated the provider needed to be notified for an increase in oxygen rate.</p> <p>In an interview on 04/30/2024 at 1:25 PM, Staff D stated the facility provider was notified for all orders by outside providers and needed to approve the order prior to it being processed. Staff D stated the nurses were educated to call the provider more than once, and if no response was obtained, to notify the Director of Nursing. Staff D added the expectation was the nurses would notify the provider of the need for changing the oxygen rate.</p> <p>In an interview on 04/30/2024 at 1:33 PM, Staff A, Director of Nursing, stated the expectation was for nursing staff to continue to call the provider and if unable to make contact, they needed to be notified. With regards to the advancement of the catheter and obtaining an order, Staff A confirmed the provider had not returned the call, no further follow up was done, and the catheter had not been advanced. Staff A added the provider needed to be notified for changes to a resident's oxygen rate.</p> <p>Reference: WAC 388-97-1060 (1)</p>		