

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 07/24/2024
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38527</p> <p>Based on interview and record review, the facility failed to notify the resident's representative of a significant change in condition for 1 of 3 sampled residents (Resident 4), reviewed for quality of care. This failure placed the resident at risk of receipt of inadequate care and diminished quality of life.</p> <p>Findings included .</p> <p>Review of the June 2024 progress notes showed on the evening of 06/20/2024, Resident 4 was transferred to the hospital due to a fracture to their foot. There was no documentation showing Resident 4's representative was notified of the transfer. Additional review showed the resident returned to their former residence (instead of the facility) after their hospitalization on [DATE], where the resident was found by their representative with injuries from falls that occurred while the resident was alone.</p> <p>In an interview on 06/27/2024 at 4:48 PM a representative for Resident 4 stated they were not notified of the resident's transfer to the hospital and were surprised to find the resident at their former residence on 06/21/2024. The representative stated they had medical power of attorney (POA; legal document giving a person legal authority to act on another's behalf) and expected to be notified of changes in the resident's status.</p> <p>In an interview on 07/24/2024 at 12:59 PM, Staff C, Licensed Practical Nurse, stated Resident 4 was somewhat confused prior to going to the hospital on 06/20/2024 and gave examples of the resident running over their own foot and blaming someone else, as well as hallucinating stuffed animals were real and playing with other animals. Staff C stated Resident 4 had a representative that facility staff were to report any concerns with the resident to.</p> <p>In an interview at 1:09 PM the same day, Staff B, Staff Development Coordinator, stated they worked with Resident 4 on the evening of 06/20/2024 and received the physician order to transfer the resident to the hospital late in the evening. Staff B stated they left a message for staff to notify the resident's representative the next morning. Per Staff B, whether staff called resident representatives at night for changes depended on the situation.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/24/2024 at 1:46 PM Staff A, Director of Nursing, stated information was posted at the nurse's stations to guide staff on what to do when sending residents to the hospital, which included notifying their representatives. Staff A reviewed Resident 4's electronic medical record and verified the facility had documentation of Resident 4's POA at the time of their hospital transfer. Staff A stated Staff B should have notified the resident's representative of the transfer.</p> <p>Reference: (WAC) 388-97-0320 (1)(b)(d)</p>		