

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 10/22/2024
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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>38527</p> <p>Based on interview and record review, the facility failed to provide timely follow-up for resident representative reported concerns (grievances) for 1 of 3 sampled residents (Resident 1), reviewed for grievances. This failure placed the resident at risk of having unresolved grievances and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the policy titled, Washington State Veterans Home Grievances, effective 08/01/2024, showed that residents had a right to make formal or informal concerns or grievances orally or in writing, and the facility would make efforts to provide a reasonable timeframe the resident or representative could expect a completed review of the grievance. Once the investigation was completed the facility would respond back to the resident or representative with any findings and steps the facility would take to resolve the concern, and the resident or representative's response to the investigation would be recorded on the grievance form.</p> <p>In an interview on 10/22/2024 at 1:11 PM a representative for Resident 1 stated they had several concerns with the resident's care during their stay at the facility which they had brought up orally to staff including licensed nurses, nurse managers, and social services. The resident's representative stated they did not hear back from the facility on the outcome of any investigations related to their reports and did not think their concerns had been registered as official concerns.</p> <p>Review of the September and October 2024 Grievance Logs showed no entries for Resident 1 during their stay at the facility. One entry for Resident 1 was marked as received after the resident no longer resided in the facility.</p> <p>In an interview on 10/22/2024 at 2:14 PM, Staff C, Resident Care Manager, stated Resident 1 and their representative reported concerns regarding their respiratory equipment and staff management of respiratory equipment during their stay at the facility. Staff C stated the facility investigated and determined additional staff training related to the resident's equipment was required, and the training had been implemented prior to the resident's discharge.</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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview at 4:46 PM the same day, Staff D, Social Services, stated Resident 1's representative had informed them of concerns related to the resident's care, which was referred to Staff C for nursing follow-up. Staff D stated they believed Staff C resolved the resident/representative's concern at the time it was brought up, and the resident/representative did not ask for a formal grievance process, so it was not documented and followed-up as a grievance.</p> <p>In an interview on 10/22/2024 at 5:10 PM, Staff A, Administrator, and Staff B, Director of Nursing, stated grievance forms were available throughout the facility for staff, residents, and visitors to fill out. Staff A and B stated families reported concerns all the time and if something just needed a quick fix then it would not be written up as a grievance and only something that needed a permanent fix would be a grievance. Staff B stated additional training related to Resident 1's respiratory equipment was provided after the resident's representative brought forth their concerns and stated it probably should have been viewed as a grievance.</p> <p>Reference WAC 388-97-0460</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>38527</p> <p>Based on observation, interview, and record review, the facility failed to implement standards of care to prevent elopement (leaving a facility without notice or supervision) for 1 of 3 sampled residents (Resident 2), reviewed for accidents/supervision. This failure placed the resident at risk of injury, becoming lost, and/or exposure to the elements.</p> <p>Findings included .</p> <p>Review of the facility policy titled, WanderGuards, effective 02/06/2019, showed WanderGuards would be placed on residents identified to have a history of wandering and exit seeking. WanderGuards would be tested routinely to ensure they were working and all doors with WanderGuard monitors were to be checked monthly by maintenance to ensure they were working properly. The policy did not list any direction to staff on how to respond when a WanderGuard alarm sounded, and/or additional actions to take when an alarm sounded but no residents were found at the door/area of alarm.</p> <p>Review of the 08/26/2024 quarterly assessment showed Resident 2 had a diagnosis of dementia, was severely cognitively impaired, and required supervision with walking. During the assessment period the resident wandered 4 to 6 days of the week.</p> <p>Per Resident 2's care plan, initiated 08/09/2023, they walked independently with a walker, and used a WanderGuard (a device that alarms when near a sensor placed on exit doors).</p> <p>Review of a 10/20/2024 facility investigation showed Resident 2 left the facility unattended that evening. Per the investigation, local law enforcement called the facility to report finding Resident 2 at a nearby intersection, confused and uninjured. The resident returned to the facility and their WanderGuard was functioning. The facility's investigation showed the resident exited the front door and a nursing assistant responded to the door alarm, but the resident was walking outside and no longer in view, so the staff member did not investigate further. The following day the facility's front door magnetic lock was found to be malfunctioning and was repaired.</p> <p>On 10/22/2024 at 11:46 AM Resident 2 was observed in their room with a WanderGuard attached to their walker. The resident was confused and unable to answer questions related to the incident.</p> <p>In an interview at 12:38 PM the same day, Staff B, Director of Nursing, stated staff responded to the front door alarm one minute after Resident 2 had exited the building, and Resident 2 was already outside walking on the sidewalk. Per Staff B, the staff who responded turned off the alarm because no resident was in the area and the door was supposed to lock closed when the WanderGuard alarm sounded (preventing the resident from leaving).</p> <p>Reference: (WAC) 388-97-1060 (3)(g)</p>		