STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505509	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spokane Veterans Home	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)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview and record review, the facility failed to ensure narcotic medication was administered to the resident for which it had been prescribed, and not diverted from use, for 1 of 3 sample residents (Resident 1) reviewed for medication administration. This incident constituted a Past-Non-Compliance (the facility was not in compliance at the time the incident occurred; however, there was sufficient evidence that the facility corrected the non-compliance after it was identified). The facility immediately and thoroughly investigated, made appropriate notifications, took appropriate safety actions to ensure resident safety. Education of all nursing staff on the proper administration and documentation for narcotic medications was completed by 07/11/2025. The facility was notified of the past non-compliance on 02/20/2026.Findings included. Review of a facility investigation dated 06/29/2025 documented a clear pouch containing two pills was found on the floor at the second-floor nurse's station by Staff A, Administrator, on the morning of 06/26/2025 at 7:00 AM. The medication was identified as being Norco 10/325 milligram (mg) tablets, a narcotic medication used to treat pain. Review of all of the resident's medication orders showed Resident 1 was the only resident in the facility that had the medication prescribed. A review of the narcotic logbook showed Staff D, Registered Nurse, had signed out the narcotic medication the night of 06/28/2025 at 11:30 PM, and at 5:00 AM on the morning of 06/29/2025. Resident 1's Medication Administration Records (MARS) documented the 11:30 PM dose had been given, but there was no documentation that showed the 5:00 AM dose was administered to the resident. When interviewed, Staff D stated they had given the medication, and had no knowledge or explanation for the pouch that had been found. When Resident 1 was interviewed, they stated they did not recall receiving any pain medication and they had not been woken during the night for cares or medication. An order was obtained on 06/26/2025 to obtain a urine sample from Resident 1 for a drug screen to check for the presence of narcotic medication. On 07/01/2025 the facility was informed the results of the drug screen was negative. The facility consulted with the laboratory for clarification and was informed the Norco would be detectable in the urine within one to two days of administration. Additional consultation with Resident 1's provider was done and it was determined that narcotic diversion had occurred. During the course of the investigation, in addition to Staff D, the facility identified two other nurses, Staff E and Staff F, both Registered Nurses, who had signed out the Norco and documented it had been administered to Resident 1 from 06/24/2025 to 06/26/2025. The facility substantiated drug diversion, and all three identified nurses were terminated from employment. Audits of all resident's records, and interviews found no other discrepancies. In an interview on 02/19/2026 at 11:13 AM, Resident 1 stated they felt the care was good, they had no concerns and anytime they had concerns in the past, the facility took care of it. Resident 1 stated they had chronic back pain and felt the pain management was good. In an interview on 02/20/2026 at 11:41 AM, Staff C, Registered Nurse, stated narcotic medication was signed out and documented at the time of administration to the resident, and the narcotics were counted and reconciled by checking the narcotic (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication card to the narcotic logbook at the end of each shift. Staff C further stated that any discrepancies needed to be reported immediately to the Director of Nursing and the Administrator, and there had been education and training on the process. In an interview on 02/20/2026 from 2:15 PM to 3:00 PM with Staff A, Administrator and Staff B, Director of Nursing, the incident as described in the facility investigation was discussed, and both confirmed the facility had substantiated diversion. Staff B stated ongoing audits and reviews of narcotic medication administration have continued and the results are discussed and shared with the facility's Medical Director, and during their Quality Assurance meetings. This was a Past Non-Compliance, and the facility is not required to submit a plan of correction.