

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  03/14/2024
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 0550</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 a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>46115</p> <p>Based on observation, interview and record review, the facility failed to ensure catheter care was provided in a dignified manner for 1 of 1 sampled residents (31), reviewed for use and care of a urinary catheter (a flexible tube that passes through the urethra and into the bladder to drain urine). This failure placed the resident at risk for diminished quality of life.</p> <p>Findings included .</p> <p>Per review of the 01/19/2024 annual assessment, Resident 31 had diagnoses which included neurogenic bladder, (a condition in which one lacked bladder control due to a brain, spinal cord, or nerve problem), and utilized a urinary catheter.</p> <p>On 03/06/2024 at 12:54 PM, Resident 31 was observed with the urine collection bag of their catheter attached to the bed, not covered by a privacy bag. Staff J, Nursing Assistant emptied the urine into a container and the procedure was visualized from the doorway of Resident 31's room.</p> <p>Additional observations of the collection bag without a privacy bag were observed on 03/06/2024 at 12:54 PM, 03/07/2024 at 9:22 AM, 03/08/2024 at 8:50 AM, 03/11/2024 at 9:00 and 03/14/2024 at 1:41 PM.</p> <p>In an interview on 03/14/2024 at 1:12 PM, Staff I, Licensed Practical Nurse, stated when a catheter was emptied, the curtain should have been pulled to ensure privacy.</p> <p>In an interview on 03/14/2024 at 1:32 PM, Staff B, Director of Nursing, stated the urine collection bag should have been placed in a privacy bag and it was a dignity issue if others could have seen staff empty the urine in the collection bag into a container.</p> <p>Reference: WAC 388-97-0180 (1-4)</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 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46115</p> <p>Based on interview and record review, the facility failed to complete a discharge summary that included a recapitulation/synopsis of the resident's stay as required, for 1 of 1 sampled residents (94), reviewed for community discharge. This failure placed the resident at risk for having an incomplete medical record.</p> <p>Findings included .</p> <p>Per the admission assessment dated [DATE], Resident 94 had diagnoses which included urinary retention and aspiration pneumonia (when food or liquid is breathed into the airways or lungs, instead of being swallowed), had moderate cognitive impairments, and needed moderate to substantial assistance to complete activities of daily living.</p> <p>A record review showed Resident 94 was admitted to the facility for physical and occupational therapy, following deconditioning related to the above diagnoses. The resident discharged to home on 01/26/2024.</p> <p>A review of the discharge packet showed the resident was discharged with a referral to a wound care provider and included the list of prescribed medications. A recapitulation, a summary that recounted the care and services the resident received at the facility, was not found documented in Resident 94's record.</p> <p>In an interview on 03/14/2024 at 3:15 PM, after review of Resident 94's record, Staff N, Resident Care Manager, stated a recapitulation discharge summary had not been completed.</p> <p>Reference: WAC 388-97-0080(7)(a)</p>		

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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>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>46033</p> <p>Based on observation, interview and record review, the facility failed to ensure that residents with fluid balance concerns were monitored for 1 of 3 sampled residents (89) reviewed for fluid restrictions. This failure placed residents at risk for adverse health events and decreased quality of life.</p> <p>Findings included</p> <p>The facility provided policy Encouraging and Restricting Fluids revised in 10/2010 documented guidelines which included to record fluid intake in milliliters (mls) as instructed by the physician. When placed on restricted fluids, remove the water pitcher and cup from the resident's room. If the resident refuses to have the pitcher removed, notify the supervisor and provider to discuss the risk and benefits of continuing versus discontinuing the restriction to honor the resident's preference.</p> <p>A review of the record documented Resident 89 had diagnoses including cirrhosis of the liver (scarring caused by many years of damage to the liver from various sources), ascites (fluid in the abdomen caused by cirrhosis) and general edema (too much fluid trapped in the body's tissues.)</p> <p>The 01/08/2024 admission assessment documented Resident 89 was cognitively intact, required set-up assistance for their meals, and weighed 183 pounds (lbs).</p> <p>A review of the provider orders from 01/02/2024 and 01/03/2024 documented Resident 89 was to receive a regular diet and fluids were to be restricted to 2000mls daily. The resident was to receive 240mls with each meal, 240mls with each medication pass, and extra fluids received were to be documented each shift. Additionally, Resident 89 was to be weighed every day.</p> <p>A Spokane Veteran's Home Care Delivery Guide updated on 01/02/2024 (located in a binder at the nurse's station) documented Resident 89 was on a 2000mls fluid restriction and the resident was not to have a water pitcher.</p> <p>A 01/09/2024 Staff D, Registered Dietician, (RD), documented they spoke to Resident 89, the resident was aware of their fluid restriction, and the two discussed maintaining the fluid restriction to minimize fluid retention.</p> <p>On 02/22/2024, the Staff D progress note documented Resident 89 reported their belly felt larger and they had more edema in their feet. Resident 89 reported that they cheated on the fluid restriction and drank extra water because they got so thirsty.</p> <p>A review of Resident 89's weight showed the following trend:</p> <p>01/03/2024 183.0 lbs. on admission,</p> <p>02/03/2024 172.4 lbs.,</p> <p>03/03/2024 199.0 lbs.,</p> <p>(continued on next page)</p>		

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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>03/11/2024 212.8 lbs.</p> <p>A review of Nursing Assistant (NAC) documentation of the Nutrition-Fluids task from 02/28/2024 to 03/12/2024 had no entries that documented Resident 89's fluid intake.</p> <p>A review of Resident 89's February and March 2024 medication administration records (MARs) included areas for nurses to document the resident's fluid intake each shift. An entry on 03/11/2024 nightshift had 180ml documented. All other shift entries for February and March had an X documented, no fluid amounts.</p> <p>On 03/08/2024 at 8:43 AM, Resident 89 was observed napping in their bed. A water pitcher was on the overbed table and was full of ice chips and had a spoon in it. An empty coffee mug was also on the table. At 2:56 PM, the water pitcher was still on the resident's table and the ice had melted. The pitcher was half full of water. Resident 89 was watching TV and stated they were not supposed to drink more than two 20-ounce bottles of water each day because they had a lot of fluid in their abdomen. While talking, an unidentified NAC brought in a fresh water pitcher full of ice and removed the pitcher that contained water. When asked who kept track of how much fluid the resident drank, Resident 89 stated I don't know .someone does.</p> <p>On 03/11/2024 at 8:54 AM, two plastic liners for the water pitcher were observed full of ice chips on Resident 89's overbed table. The water pitcher and an empty coffee mug were also on the table. At 11:52 AM, Resident 89 was eating their lunch, which included one mug of coffee, almost empty.</p> <p>On 03/12/2024 at 7:51 AM, Resident 89 was observed eating breakfast. There was a water pitcher full of ice chips on the overbed table. An empty coffee mug and a full coffee mug were on the resident's breakfast tray.</p> <p>During an interview on 03/12/2024 at 8:01 AM, Staff E, NAC, was asked where staff kept track of the amount of fluids Resident 89 was getting. Staff E stated they did not keep track of the resident's fluids unless the nurses did. Staff E stated Resident 89 got one drink on their meal trays because they were on a fluid restriction; Resident 89 was not supposed to have other fluids, so they gave Resident 89 ice chips instead.</p> <p>During an interview on 03/12/2024 at 11:01 AM, Staff F, Registered Nurse, stated staff did not document Resident 89's fluid intake. When asked how they would know if the resident maintained their fluid restriction, Staff F stated Resident 89 knew what they were supposed to do and kept track.</p> <p>During an interview on 03/13/2024 at 9:59 AM, Staff G, Resident Care Manager, stated staff were instructed to begin documenting Resident 89's fluid intake and the resident was not to have a water pitcher. Staff G stated initially, Resident 89 wanted to keep track of their own fluids, but the resident did not keep up with it so that had not worked. Staff G stated Resident 89 did not drink a lot of fluids but ate a lot of ice. Resident 89 had been told at the hospital that ice chips did not count as fluid and that is what the resident believed. Staff G stated it was important to monitor Resident 89's fluid intake so that the resident did not get overloaded with fluid related to their ascites.</p> <p>Reference: WAC 388-97-1060(1)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37544</b></p> <p>Based on observation, interview and record review, the facility failed to ensure the Registered Dietician (RD) had completed comprehensive nutritional assessments as required for 2 of 4 sampled residents (4, 83) reviewed for nutrition. This failure placed the residents at risk for unplanned weight loss and decreased quality of life.</p> <p>Findings included .</p> <p>&lt;Resident 4&gt;</p> <p>The 01/15/2024 quarterly assessment showed Resident 4 was able to make decisions regarding their care, was independent for eating, and had diagnoses which included depression, diabetes and stroke.</p> <p>On 03/08/2024 at 2:29 PM, Resident 4 was observed lying in bed watching television. When asked about the food, the resident stated lunch was good, and the food was all right.</p> <p>Review of the nutritional care plan last revised 08/24/2022 showed Resident 4 was identified as being at nutritional risk and instructed nursing staff to adhere to the resident's food preferences. In addition, the interventions stated the RD and dietary manager would update preferences when the quarterly and annual reviews were completed.</p> <p>Review of Resident 4's record which included nutritional assessments and nutritional progress notes from 01/01/2022 through 03/11/2024 showed the last annual comprehensive nutritional assessment was completed by Staff R, the former Registered Dietician on 11/16/2022 and the last quarterly comprehensive assessment was done on 04/26/2023. No other documentation was found to show that comprehensive nutritional assessments had been completed as required after 04/26/2023.</p> <p>42802</p> <p>&lt;Resident 83&gt;</p> <p>According to a recent quarterly assessment dated [DATE], Resident 83 had diagnoses which included Parkinson's disease (a progressive nervous system disorder characterized by slowed movement and tremors), and dysphagia (difficulty swallowing) related to the Parkinson's. The assessment further showed that Resident 83 was cognitively intact, made their needs known and ate independently after meal set-up.</p> <p>Resident 83's current diet order was for a soft diet, thin consistency, and no bread products for dysphagia. During their time in the facility, the orders for the thickness of liquids and texture of food had changed due to their dysphagia.</p> <p>An Admission Dietary Assessment, dated 01/04/2024, two months after admission, documented the resident and had a diagnosis of dysphagia and was on a pureed (blended) diet without any supplements. The document was not comprehensive. It did not show an evaluation of the resident's weights, oral intake or estimated caloric and nutritional needs, nor any dietary recommendations.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>There were no comprehensive RD assessments documented in Resident 83's record since their admission on 10/25/2023</p> <p>During an interview on 03/07/2024 at 11:00 AM, Resident 83 expressed concern that they were scheduled to have a feeding tube placed in April, 2024, because they couldn't swallow anything more than nutritional shakes.</p> <p>In an interview on 03/14/2024 at 11:45 AM, Staff D, RD, stated they were employed at the facility 01/02/2024 and were in the process of getting nutritional assessments completed, and had compiled a list to track when residents assessments were due.</p> <p>In an interview on 03/14/2024 at 1:20 PM, Staff B, Director of Nursing, stated Staff R had retired the previous Spring and the facility had contracted/interim dieticians to cover after that, and acknowledged that nutritional assessments were not completed as required.</p> <p>In an interview on 03/14/2024 at 1:35 PM, Staff V, Staff Recruitment, confirmed Staff R had retired on 05/16/2023.</p> <p>Reference: WAC 388-97-1060(3)(h)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46033</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident received their scheduled medications on the mornings they had dialysis for 1 of 7 sampled residents (15) reviewed for medication administration. This failure put residents at risk for worsening of their chronic health conditions or unintended adverse events.</p> <p>Findings included .</p> <p>A quarterly assessment dated [DATE] documented Resident 15 had diagnoses including end-stage renal disease (ESRD) dependent on dialysis (a means of removing waste from the body when the kidneys no longer function) and atrial fibrillation (AFIB, irregular heartbeat) and Parkinson's disease (nerve cell damage in the brain that affects movement). The resident was cognitively intact and able to participate in their care.</p> <p>Resident 15 had the following provider orders:</p> <ul style="list-style-type: none"> <li>-06/24/2023 Multivitamin, one tablet daily for supplement</li> <li>-09/14/2023 Apixaban 5 milligrams (mg) twice daily for anticoagulant (prevents blood clots from forming)</li> <li>-09/14/2023 Carbidopa/Levodopa 25-250mg three times daily before meals for Parkinson's disease</li> <li>-09/14/2023 Entacapone 200mg three times daily before meals for Parkinson's disease</li> <li>-09/14/2023 Renvela 800mg three times a day for high phosphate levels in the blood</li> <li>-09/14/2023 Lispro Insulin 100 units/milliliter injection per sliding scale (dose determined by a fingerstick blood sugar, FSBS, value) before meals and at bedtime for diabetes.</li> <li>-09/15/2023 Cholecalciferol 50 micrograms (mcg) daily for supplement</li> <li>-09/15/2023 Pantoprazole delayed release 40 mg daily for stomach acid</li> <li>-09/15/2023 Tamsulosin 0.4mg daily for enlarged prostate</li> <li>-11/27/2023 Dialysis 5:30 AM-10:00 AM every Monday and Friday; ensure resident is ready for transport, send sack meal and binder with the resident.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of medication administration records (MARs) from 01/01/2024 to 03/11/2024 revealed a code 9 had been entered for Resident 15's multivitamin, pantoprazole, apixaban, Tamsulosin, carbidopa/levodopa, entacapone, Renvela, cholecalciferol and FSBS checks with Lispro insulin coverage each Monday and Friday on dialysis days, during the period reviewed. A staff member later identified as Staff P, Registered Nurse, had documented the code on xx of the dialysis days. The chart code on the last page of the MAR indicated a code 9 meant other/see progress note. The corresponding progress notes documented Resident 15 was out of the facility at the time the medications were to be given.</p> <p>During an interview on 03/14/2024 at 10:37 AM, Staff P, Registered Nurse, stated the code 9 they entered on the MAR meant Resident 15 was out of the facility and unavailable to receive their medications. The medications were not sent with the resident to their dialysis appointments. Staff P also stated the carbidopa/levodopa and entacapone could not be given when the resident returned from dialysis as it was too close to the next dose that was due. Staff P stated they had not discussed omitting the medications with the provider but could do that and see what the provider said. When asked if there might be a health consequence to Resident 15 if their medications were omitted, Staff P stated they were unsure.</p> <p>During an interview on 03/14/2024 at 11:00 AM, Staff G, Resident Care Manager, observed the February and March MARs for Resident 15 and stated they needed to discuss the omitted medications with the provider to determine how those medications were to be managed.</p> <p>Reference: 388-97-1060(3)(k)(iii)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>42802</p> <p>Based on observation and interview, the facility failed to ensure controlled medications (medications that have a high risk for abuse such as narcotics, anti-anxiety, hypnotic and hallucinogenics) stored in the medication refrigerators were secured in a permanently affixed container for 2 of 2 medication rooms reviewed for medication storage. This failure placed the facility at risk for potential diversion or misappropriation of narcotic medications.</p> <p>Findings included .</p> <p>On 03/13/2024 at 3:32 PM, in the second floor medication room, the medication refrigerator was inspected with Staff O, Registered Nurse (RN). The door of the refrigerator had a padlock and contained numerous medications that required refrigeration. The controlled medications (Ativan, an anti-anxiety medication and Marinol, an anti-nausea medication) were in an open plastic basket on a shelf in the refrigerator.</p> <p>On 03/14/2024 at 10:24 AM, the medication refrigerator in the first floor medication room was inspected with Staff P, RN. The door of the fridge had a padlock and contained numerous medications that required refrigeration. The controlled medications (Ativan and Marinol) were on the narrow shelf on the inside of the door, not separated from the other medications. During a concurrent interview, Staff P stated there was no need to keep the narcotics in a separate, locked box as the medication room door and the refrigerator door both were locked and only the nurse had a key.</p> <p>During an interview on 03/14/2024 at 10:43 AM, Staff I, Licensed Practical Nurse (LPN) stated they were not aware that narcotic medication should be separated from the non-narcotic medications in the refrigerator, nor that they should be in a permanently affixed, secured box in the refrigerator.</p> <p>During an interview on 03/14/2024 at 10:50 AM, Staff N, Resident Care Manager (RCM), stated they were aware it was a requirement to have a permanently affixed lockbox in the refrigerator and that Staff B, Director of Nursing (DON) was checking into it last week.</p> <p>During an interview on 03/14/2024 at 11:13 AM, Staff B, DON, stated they were aware that they needed a permanently affixed, locked box for narcotics and they were trying to obtain them.</p> <p>Reference: WAC 388-97-1300 (2), -2340</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47728</b></p> <p>Based on observation, interview and record review, the facility failed to ensure dietary staff had the required qualifications (current Food Worker Cards) for two of nine sampled dietary staff (L, M). This failure had the potential risk for unsafe food handling practices and placed all residents at risk for developing foodborne illness.</p> <p>Findings included .</p> <p>A review of the dietary cards on [DATE] at 2:00pm showed no Washington State Food Workers card for Staff L, Food Service Worker, and a Washington State Food Workers card for Staff M, Food Service Worker that had expired on [DATE].</p> <p>On [DATE] at 3:00pm Staff K, Dietary Manager, provided a copy of a Washington State Food Workers card for Staff L with an effective date of [DATE]. When asked, Staff K stated Staff L had been working with an expired food handler's card and had just renewed it.</p> <p>In an interview on [DATE] at 12:52 PM, Staff K stated they did not have a process for ensuring food handler cards were renewed prior to the expiration date but were working on getting a process into place. They stated a process for this was important because improper handling of food could be dangerous especially for the population they served.</p> <p>Reference: WAC [DATE]</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47728</p> <p>Based on observation and interview, the facility failed to ensure food was prepared and served in a sanitary manner during 2 of 2 meal preparations observed. One staff member with a beard was not wearing a beard covering. This failure caused potential risk of contamination of food and exposure of all residents to food borne illness.</p> <p>Findings included .</p> <p>During an observation on 03/06/2024 at 10:49 AM, Staff Q, Cook, was preparing food for lunch service. They were noted to have a beard and were not wearing a beard covering.</p> <p>During an observation on 03/13/2024 at 10:59 AM, Staff Q was serving food for the lunch meal. They were noted to have a beard and were not wearing a beard covering.</p> <p>In an interview on 03/13/2024 at 11:32 AM, Staff Q was asked why they were not wearing a beard covering and they stated in the 5 years they had worked at the facility it had never been an issue and they usually kept their beard shorter. They also stated they didn't know if there were beard covers available.</p> <p>During an observation on 03/13/2024 at 11:35 AM Staff Q put a beard cover on over their beard and continued serving the lunch meal.</p> <p>During an interview on 03/13/2024 at 11:50 AM, Staff K, Dietary Manager, stated it was important for beards to be covered because contamination of food could be dangerous, especially for the population the facility served.</p> <p>Reference: WAC 388-97-1100(3), -2980</p>

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  03/14/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>46115</p> <p>Based on observation and interview, the facility failed to ensure appropriate hand hygiene was performed during the meal service for 1 of 2 dining rooms, during wound care for 1 of 2 sampled residents (31) reviewed for wounds and during personal care for 1 of 1 sampled residents (36). These failures placed the residents at risk for infections and decreased quality of life.</p> <p>Findings included .</p> <p>&lt;Dining Room&gt;</p> <p>During a lunch observation of the second-floor dining room on 03/06/2024 at 11:59 AM, Staff T, Nursing Assistant, donned gloves, then pushed a resident up to the table and no hand hygiene was performed. Staff T then removed lids from their food items, left the dining room wearing the same pair of gloves, grabbed a straw and placed it into their drink, then removed gloves and performed hand hygiene.</p> <p>During the same lunch observation at 12:03 PM, Staff T donned gloves and assisted a resident with cutting up their meat. The resident's table mate attempted to grab their milk and put their hands on top of the container where fluids are consumed. Staff T did not remove the milk and the resident consumed milk from the container that was touched with unclean hands.</p> <p>During an observation on 03/06/2024 at 12:07 PM, Staff I, Licensed Practical Nurse, touched a resident's coat and patted them on the back, then proceeded to pass a tray without performing hand hygiene.</p> <p>During an interview on 03/06/2024, Staff T stated hand hygiene should be done before and after each tray is passed and when touching items such as wheelchairs.</p> <p>During an interview on 03/06/2024 at 12:47 PM, Staff I stated they should have performed hand hygiene after touching the resident's coat and prior to the next tray that was passed.</p> <p>&lt;Wound Care&gt;</p> <p>According to the 01/19/2024 annual assessment, Resident 31 had diagnoses which included quadriplegia, traumatic spinal cord dysfunction, chronic pain. Resident 31 was cognitively intact, able to direct their care and required extensive assistance of daily living such as dressing, toileting, and mobility. The assessment showed Resident 31 had no pressure ulcers, and had dressings and ointments applied to feet and other areas.</p> <p>On 03/08/2024 at 11:08 AM, an observation was made of the wound care with Staff U, Registered Nurse, and Staff J, Nursing Assistant. Resident 31 was noted to have a stage II pressure ulcer (a shallow open ulcer with a red wound bed) to their right buttock.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Spokane Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE  222 East Fifth Spokane, WA 99202	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Staff U donned gloves, searched through the dressings in the container and grabbed cream, then touched Resident 31's buttock. Staff U then obtained their pen light out of their pocket, and without performing hand hygiene or changing gloves, wiped the resident's skin and stated they were not aware Resident 31 had an open area.</p> <p>During an interview on 03/14/2024 at 1:18 PM, Staff C, Infection Control Nurse, stated hand hygiene should have been completed after going through the supplies, handling the pen light and before and after the treatment was performed.</p> <p>47728</p> <p>&lt;Personal Care&gt;</p> <p>According to the 2/5/2024 quarterly assessment, Resident 36 had diagnoses including non-pressure chronic wound of the left calf, wound infection, and lymphedema (tissue swelling caused by an accumulation of fluid that does not drain adequately). Resident 36 was cognitively intact and able to direct their care, and required maximum assistance for activities of daily living such as dressing, toileting, and transfers.</p> <p>During an observation on 03/08/2024 at 02:23 PM Staff S, Nursing Assistant, (NAC), put on gloves, rolled Resident 36 onto their left side, removed a urine soaked brief and performed peri-care for the resident (cleaning of the genital area) using wet wipes. After completion of peri-care, Staff S did not change gloves or perform hand hygiene. Wearing the same dirty gloves, Staff S applied a protective cream to scabbed areas on the resident's buttocks, put a clean brief on resident, repositioned resident in bed, used the bed control, rearranged bedding for resident, reached into their pocket and retrieved a garbage bag, then gathered up the garbage. Staff S then removed their gloves but did not perform hand hygiene, opened door, stepped out of the room, set bagged garbage on the floor and then used hand sanitizer to perform hand hygiene.</p> <p>In an interview on 3/8/2024 at 02:43 PM Staff S stated they should change their gloves and perform hand hygiene during brief change/peri-care only if they were moving from the peri-area to the resident's face. When asked, they stated they did not know they should change gloves and sanitize their hands when moving from dirty to clean tasks, and between glove changes to prevent spread of infection.</p> <p>In an interview on 03/14/24 01:18 PM, Staff C, Infection Control Nurse, stated the nursing staff were expected to perform glove changes and hand hygiene when moving from a dirty to clean area when doing tasks.</p> <p>Reference: WAC 388-97-1320 (1)(c)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46115</p> <p>Based on observation and interview, the facility failed to ensure equipment to allow residents to call for staff assistance was provided for 1 of 19 sampled residents (44) reviewed for resident call systems. This failure placed residents at risk of having unmet care needs, accidents, and a diminished quality of life.</p> <p>Findings included .</p> <p>Per the quarterly assessment dated [DATE], Resident 44 had diagnoses which included chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breath), dementia, and falls. Resident 44 had moderate cognitive impairments, and needed partial to substantial assistance to complete activities of daily living.</p> <p>Review of Resident 44's care plan dated 06/08/2022, documented resident was at risk for falling. Staff were to ensure call light was within reach and to encourage the resident to use it as needed.</p> <p>During an observation on 03/06/2024 at 2:59 PM, Resident 31's call light was under their bed, not within their reach.</p> <p>Subsequent observations of the call light not within reach of Resident 31 were made on 03/07/2024 at 9:40 AM, 10:04 AM, and 2:23 PM, 03/08/2024 at 8:43 AM, 10:38 AM, 11:29 AM and 2:10 PM.</p> <p>In an interview on 03/14/2024 at 1:32 PM, Staff B, Director of Nursing, acknowledged call lights needed to be placed within the reach of the residents for their safety.</p> <p>Reference: WAC 388-97-2280(1)(a)</p>