STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505195	A. Building B. Wing	12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Auburn Rehab & Health Center	2830 I Street Northeast Auburn, WA 98002

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44296 Based on interview and record review the facility failed to implement effective discharge planning processes to transition residents to post-discharge care for 2 of 3 (Residents 161 & 69) residents and 1 supplemental resident (Resident 51) reviewed for discharge planning. The failure to identify and plan for the individual discharge needs of each resident placed residents at risk for unmet needs after discharge, lack of medical equipment, distress about plans to go home, unsafe discharge location, and rehospitalization . Findings included . Resident 121 According to the 10/28/2022 Admission Minimum Data Set (MDS, an assessment tool) Resident 121 admitted to the facility on [DATE], was cognitively intact, and made their own decisions. Resident 121 had medically complex conditions, including Atrial Fibrillation (A-fib, abnormal heart rhythm), Coronary Artery Disease (damage in the heart's major blood vessels), and Hypertension (high blood pressure). Resident 121 received a blood thinning (anti-coagulant) medication during the assessment period. Review of a 10/28/2022 Social Services Admission/Discharge evaluation showed Resident 121 was projected to stay in the facility three to four weeks and the plan was to discharge home independently with a walker. Review of a Resident 121's 10/21/2022 comprehensive care plan (CP) revealed the facility did not create a discharge care plan with goals and interventions. Review of a 11/17/2022 Nurse Practitioner (NP) telephone encounter note showed the facility staff called the NP about abnormal blood test results regarding Resident 121's blood thinning medications, values elevated indicated blood required extensive time to clot (prolonged bleeding that can be life-threatening). The NP ordered a coagulate medication (assists with blood clotting to stop bleeding) due to Resident 121's ongoing elevated blood test results. The NP directed staff to obtain a blood test on 11/18/2022 and monitor the resident closely for any signs of bleeding or bruising. Review of the 11/17/2022 blood test results showed the results were flagged and the report contained critical results. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the November 2022 Medication Administration Record (MAR) showed Resident 121 did not receive the coagulate medicate on 11/17/2022 when the NP ordered the medication. Resident 121 received the coagulate medication on 11/18/2022 at 7:49 AM. A 11/18/2022 NP note showed that Resident 121 received the coagulate medication and directed staff to re-check the blood test on 11/19/2022 and continue to monitor the resident for bleeding. Review of a 11/18/2022 Social Services discharge summary showed Resident 121 discharged from the facility on 11/18/2022 at 2:15 PM with a collateral contact for transportation. Home health services, for healthcare follow up at home, were set up to start on 11/22/2022, 4 days after the resident discharged from the facility. Review of a 11/18/2022 Interdisciplinary resident discharge note showed the facility provided no supporting education to the resident. The note showed Resident 121 required post-discharge treatments including lab tests for blood clotting monitoring. The summary was minimally completed with only three sections filled out; all other areas of the discharge summary were left blank. The form was not signed by Resident 121 or staff confirming that discharge instructions were provided to the resident or allowed the resident the opportunity to ask questions. An 11/18/2022 Nursing progress note showed discharged home with orders and belongings. Review of a 11/19/2022 NP discharge summary note showed that home health was arranged for Resident 121, and they are discharged in fair/stable condition. The NP documented for Resident 121 to obtain the blood test on 11/19/2022 in an outpatient setting and monitor the resident for bleeding. Resident 121 had already discharged from the facility without discharge instructions or the ability to ask questions about follow up medical needs. In an interview on 11/29/2022 at 10:29 AM with Resident 121's collateral contact (CC) stated they picked up the resident from the facility and was not provided any education or information about a medication that could cause bleeding, or information for an appointment for a blood test. The CC stated Resident 122 was having some shortness of breath and the CC decided to take Resident 121 to the emergency room where the resident was admitted for low blood pressure. The CC stated Resident 121 passed away five days being admitted to the hospital. During an interview on 12/6/2022 at 3:17 PM, Staff L (Social Services Assistant) stated Resident 121's discharge plan was to return home and acknowledged there was not a discharge CP in place for the resident. In an interview on 12/06/2022 at 3:27 PM Staff B (Director of Nursing) confirmed the NP placed orders on 11/18/2022 for Resident 121 to have a blood test completed and to monitor the resident for any signs or symptoms of bleeding. When asked who oversaw monitoring Resident 121 for bleeding, Staff B replied staff should have provided education to the Resident and the CC before discharge including signs and symptoms to monitor for bleeding and what to do if symptoms were observed. Staff B stated Resident 121's blood tests were unstable while the Resident resided in the facility and if the NP ordered blood tests for 11/19/2022 facility staff should have, but did not, set the Resident up with an appointment or information on how or where to get the blood test completed. When asked why home health was set up to start four days after the resident discharged , Staff B stated discharge was before a weekend, but it was a little long for the resident to wait. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 69 The 10/20/2022 Admission MDS showed Resident 69 was admitted to the facility on [DATE] with the diagnoses of Urinary Tract Infection (UTI), new nephrostomy catheter (implanted urinary tube for draining urine) and received intravenous (IV, through a vein) antibiotics. Resident 39 was assessed as cognitively intact and able to make daily care decisions. The MDS showed Resident 69 discharged to an acute hospital, return not anticipated on 10/20/2022. In an interview on 12/08/2022 at 12:07 PM, the designated Resident Representative (RR) stated Resident 69 did not speak English, would not be able to make medical decisions if spoken to in English. The RR stated Resident 69 could understand simple English for easy daily task decisions. The RR stated there was not a translator used to help Resident 69 to make discharge plans or make decisions about their care. The RR stated they were not called about any care planning or discharge planning discussions, and did not talk to any social workers, nurses, or physicians. The RR stated Resident 69 called (the RR) on 10/20/2022 and asked to be picked up from the facility to go home. The RR was told by Resident 69 they were not getting the care they expected and wanted to leave. The RR stated they arrived to pick up the resident and the facility made the RR sign a form that Resident 69 was leaving against medical advice. The RR stated when Resident 69 left the facility, they wanted to go straight to the hospital to see a doctor, then was admitted for medical issues. A review of Resident 69's medical record showed no progress notes, assessments or discussions regarding discharge planning was completed with the resident or the RR. A 10/19/2022 progress note showed the interdisciplinary team discussed Resident 69's skilled care provided and current status. The note showed Resident [69] discharge plan is to return home . resident will not likely be available to safely discharge home . will continue to work with therapy on strengthening, social services director will speak with resident on discharge plan and may need to discuss palliative care needs. There was no further follow-up documentation from facility staff about discussion with the resident or the RR. In an interview on 12/09/2022 at 2:36 PM, Staff B stated Resident 69 should have had a discharge planning discussion with the social worker just a couple days after admission, then ongoing until discharge. Staff B stated the facility can provide translator services but did not provide for Resident 69's discharge planning. Staff B reviewed Resident 69's records and stated there was no discharge planning notes with the resident or the RR, there was no discharge CP, and there was no discharge summary from the physician as required. Staff B stated these items were not done by the facility staff as required. 43642 Resident 51 According to a 10/06/2022 Admission MDS, Resident 51 was cognitively intact, had clear speech, was understood and able to understand others. This MDS indicated Resident 51 did not have an active discharge plan for the resident to return to the community and no referral to a local contact agency was needed. In an interview on 12/02/2022 at 10:48 AM, Resident 51 reported staff had not involved them in discussions regarding their care and stated they wanted to know if they had a discharge plan in place. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a 09/28/2022 discharge CP showed Resident 51 wished to discharge to their apartment where they lived alone with scheduled caregiver assistance, and wished to administer their own medications. This CP directed staff to ask resident their preferences of outside services post-discharge, complete a referral from the county if needed, discuss discharge goals/prognosis with the resident, provide with written instructions regarding their medications/exercise/nutrition, and plan family meetings as needed. Record review showed a 10/14/2022 provider progress note that stated Resident 51's discharge plan was to return home with family support and to continue follow up by facility social worker for discharge planning. On 11/09/2022 a provider progress note stated Resident 51 had participated in physical and occupational therapy, had been discharged from skilled Medicare services due to lack of progress, and was to have continued follow up by facility social worker for discharge planning. Record review revealed no documentation from social services that a discharge plan was in place or any plans had been discussed with Resident 51 since their readmission on 09/28/2022. In an interview on 12/12/2022 at 3:13 PM, Staff L stated their expectation is social services staff would meet with residents to discuss discharge planning and assist them as needed to obtain the referrals and equipment needed for a safe discharge. Staff L stated a resident's CP should be updated and revised if discharge plans change. The discharge expectations were not met for Resident 51. REFERENCE: WAC 388-97-0080.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46472 Based on observation, interview, and record review the facility failed to ensure 1 of 18 residents (Resident 45) received necessary care and services in accordance with professional standards of practice related to hospitalization , significant change in condition, edema management, and medically related appointments. The facility's failure to recognize, accurately assess, and provide ongoing monitoring for worsening heart failure and kidney function; assess and adequately monitor progressively significant weight gain and edema; implement repeated physician orders for daily weights and multiple referral requests to Nephrology (kidney specialist); and ensure reliable transportation was established for appointments resulted in harm to Resident 45 who sustained avoidable acute kidney injury and acute respiratory failure, required two likely avoidable hospitalization s and one emergency room visit, avoidable psychological stress, and significantly diminished quality of life. Findings included . Resident 45 According to the The Fundamentals of Nursing -The Art and Science of Person-Centered Care, 9th edition (pages 1554-1578), alterations in fluid balance and electrolytes (potassium) are commonly caused by a malfunction of the kidneys ability to excrete excess fluids and heart failure that results in fluid accumulating (edema/swelling) in the lungs and dependent parts of the body (lower legs). Accurate assessment of fluid and electrolyte balance when symptoms occur is critical because such imbalances can have serious negative outcomes and could even be life-threatening. The Care Plan (CP) should include monitoring of fluid intake and output, daily weights- at the same time every day preferably in the morning, and routine labs. Daily weighing is the most accurate way to depict changes in fluid volume. A rapid increase or loss of 2.2 pounds is equal to one liter of fluid. Edema is graded from 1+ to 4+ and brawny (swelling that is so significant it will no longer show pitting) edema by pressing on the affected area and evaluating the level or pitting. A more accurate way to measure edema is measuring the affected body part, in the same area each day or routinely. A physical assessment should include an assessment of the skin, oral membranes, vital signs, oxygen saturation, respiratory and cardiac assessment - including lung sounds, edema grade and location, and weight changes. Moist crackles heard in the lungs is an indication of fluid in the lungs and may indicate fluid volume overload. According to the 09/17/2022 Annual Minimum Data Set (MDS, an assessment tool), Resident 45 had no cognitive deficits and had diagnoses including heart failure, kidney disease, high blood pressure, and diabetes. Resident 45 required supervision with ambulation and bed mobility and required limited assistance with transfers and toileting. Resident 45 did not have breathing difficulty. The MDS showed a weight of 258 pounds, which triggered a significant unplanned weight gain. Review of the 09/23/2022 revised CP showed no identification of problems related to heart failure, kidney disease, edema / weight gain, respiratory problems, or dental problems. There were no interventions to direct staff how to care for Resident 45 related to these medical care areas identified in the MDS assessment. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on 11/30/2022 at 11:10 AM, Resident 45 stated they were very unhappy with the physician services provided by the facility and believed the provider did not know how to manage their care and was incompetent. Resident 45 stated they would have to start dialysis (treatment for filtering blood when the kidneys no longer functioned) much sooner than expected due to the medical mismanagement they experienced. Resident 45 said they were hospitalized several times over the past year because they did not receive the care they needed. Resident 45 stated their quality of life was severely impacted by the medical complications experienced in February 2022 when they were hospitalized for an oral gum infection after requesting to see the dentist and hospitalized again in October 2022 when they had such bad edema they had to go to the hospital, resulting in respiratory failure and diuresis (removal) of 74 pounds of water weight. Resident 45 said their medical circumstances had caused a considerable decline in their mood and made their anxiety almost unmanageable at times. According to record review, Resident 45 admitted to the facility on [DATE] and weighed 218 lbs. An 08/23/2021 Physician note showed Resident 45 was referred to Nephrology due to multiple abnormal kidney function labs and recurrent high potassium (an electrolyte) levels. The note showed Resident 45 weighed 220 lbs. A 12/10/2021 Physician note showed Resident 45's lower leg edema worsened over the past week and the provider adjusted Resident 45's medications to help decrease their edema. The provider failed to identify Resident 45 was not seen by Nephrology as ordered. Resident records showed on 12/10/2021 Resident 45 weighed 237 pounds. A 12/21/2021 Physician note identified the resident had edema but did not address the status of the Nephrology appointment or question why it was not followed up on. A 12/21/2021 document of blood work results showed Resident 45's kidney function had worsened. According to a 02/21/2022 hospital history and physical note, Resident 45 was admitted to the hospital due to an oral gum infection. The hospital admission weight showed Resident 45 weighed 252 lbs, an increase of 15 pounds. Resident 45's kidney function labs were abnormal, and Resident 45 received treatment to stabilize their kidney function. According to Resident 45's census record, they returned to the facility on [DATE]; they weighed 241 lbs. Review of the Physician Progress Notes showed from the date of the first Nephrology referral request on 08/23/2021 to 05/03/2022 (over 8 months), Resident 45 was evaluated by or received consult by facility Physician (or designee) providers 100 times. Facility staff and Physician providers failed to identify or question why Resident 45 had not been referred to a Nephrologist as ordered. On 05/03/2022, Staff II (Physician) placed another order into the electronic record, saying, Refer to Nephrology. A 06/02/2022 nutrition note identified Resident 45 weighed 258 lbs., an increase of 12 lbs. in two days. The note showed the interdisciplinary team (IDT) felt the weight was miscalculated and they would re-weigh Resident 45. The note indicated Resident 45 had a pending Nephrology referral for end stage renal disease (a condition in which the kidneys cease functioning on a permanent basis) and did not address issues with the residents's fluid balance or abnormal lab values. Resident 45's weight record showed the next weight assessed was 11 days later, on 06/13/2022, they weighed 242 lbs. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A 07/06/2022 Physician note showed Resident 45 was seen for fluid volume overload, lower leg edema, and high blood pressure. The note showed there were no new labs drawn and no current weight. The plan for Resident 45's worsening chronic kidney disease was to avoid medications toxic to the kidneys, encourage the resident to increase fluids, and referenced abnormal labs drawn on 05/17/2022, which were not current labs. On 07/07/2022 Resident 45 weighed 266 lbs. (a 24-pound weight gain in 24 days). This weight gain triggered a significant increase alert to the nursing staff in the electronic medical record. There was no nursing assessment of the weight gain. There was no re-weight conducted and no evidence the provider was notified. A 07/17/2022 nursing note showed Resident 45 had significant edema to both legs, hips, low back, and now crackles were heard in the resident's lungs (an indication of increase fluid volume overload, worsening heart failure and/or kidney function). A 07/17/2022 after hours physician provider note showed nursing staff notified the provider of Resident 45's elevated blood pressure, severe edema from their hips to lower legs, and crackles heard in both lungs and that Resident 45 requested to go to the hospital. The provider noted they [Provider] did not think Resident 45 needed to go to the hospital and ordered an additional dose of their diuretic and lab work again. Resident refused the order and insisted to go to the hospital. According to the 07/17/2022 hospital notes, Resident 45 was treated for edema and was scheduled for a follow up with a Nephrologist on 08/23/2022 as the previously ordered Nephrology consults were never implemented by the facility. According to a 07/20/2022 Physician order (PO) staff were directed to obtain daily weights. Review of Resident 45's weight record showed staff failed to implement the daily weights, only weighing the resident on one day between 07/20/2022 to 08/31/2022. A 08/31/2022 Physician provider note showed Resident 45 had edema to both lower legs and had a newly identified heart murmur (abnormal heart sound). The provider again wrote refer to nephrology, encouraged increased fluid intake, and repeat the blood work. The provider documented, start daily weights if greater than 3-pound weight gain in 1 day or 5 pounds in 1 week, notify provider. The provider said to continue current medications. The provider note did not address the lack of daily weights in the resident's record or delay in obtaining the nephrology appointment. On 08/23/2022 Resident 45 had a Nephrology appointment scheduled. Resident 45 was ill that day and the appointment was rescheduled for 10/04/2022. Resident 45's weight record for September 2022 showed staff failed to obtain daily weights on six of 30 days. A 09/28/2022 Physician provider note repeated the order to, Refer to Nephrology. On 10/04/2022 Resident 45 missed their appointment to Nephrology due to the facility's failure to ensure transportation. The appointment was re-scheduled for 11/01/2022. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 45's October 2022 weight record showed facility staff failed to obtain daily weights on five days between 10/01/2022 and 10/13/2022. Weight record showed on 10/04/2022 (281 lb.), on 10/02/2022 (288 lb.), and on 10/13/2022 (292 lb.- a 37 lb. weight gain in 30 days, a 51 lb. weight gain in 120 days, and 72 lb. weight gain in 245 days - the date of the first Nephrology referral request). Resident 45 was subsequently sent to the hospital related to significant edema from their lower legs to their abdomen, causing the resident breathing complications. According to the 10/13/2022 emergency room Physician note: Resident 45 had chest tightness and shortness of breath, lower leg swelling and abdominal edema. Their labs indicated acute kidney injury. The hospital physician stated Resident 45's declining kidney function was concerning. The physician note identified the resident never received the Nephrology referral recommended from the July 2022 emergency room visit. The physician documented, now today [their] renal function continues to decline, and [their] swelling has worsened significantly. The resident was admitted to the hospital with acute respiratory failure and acute kidney injury. According to a 10/14/2022 hospital Nephrology consultation, Resident 45 had acute kidney injury with chronic disease and Nephrotic Syndrome (a kidney disorder that caused the body to excrete too much protein). According to this Nephrology consult, the diuretic medication prescribed by the facility physician did not help control Resident 45's ongoing and worsening fluid overload. The kidney specialist prescribed a plan to use medication and fluids to remove the excess fluid from the resident's body and manage their recurrent critical electrolyte imbalance. Review of hospital documents showed on 11/05/2022 Resident 45 readmitted to the facility weighting 204 lbs. ; a decrease in weight of 88 pounds in 23 days. According to the 11/12/2022 5 day Quarterly MDS, Resident 45 had diagnoses of acute respiratory failure and kidney disease. Resident 45 required extensive assistance with their bed mobility, transfers, walking, and toileting, which was a decline in function from the previous assessment. Resident 45 required oxygen therapy which was new for the resident. Resident 45 had a newly acquired Foley catheter (flexible tube inserted in the bladder to drain urine). Resident 45 weighed 229 pounds (lb.) and had a significant planned weight loss. The revised 09/23/2022 CP showed no new updates related to respiratory failure, oxygen, kidney disease, heart failure, edema, or daily weights. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on 12/09/2022 at 3:45 PM with Staff B (Director of Nursing) and Staff KK (Corporate Clinical Nurse), Staff B stated they were not aware of the initial Nephrology referral ordered August of 2021. Staff B stated the process for referrals was the provider wrote a referral order and/or notified the nurse. The nurse notified transportation staff who would schedule the appointment and transportation. Staff B and Staff KK were not aware of transportation concerns or residents missing appointments due to transportation problems. Staff B stated, once referred, it was their expectation residents were evaluated by specialists as soon as possible, depending on the specialist availability. Staff B stated 15 months of repeated requests for referral was not an acceptable timeframe for Resident 45 to wait and other avenues should have been explored to obtain the referral but were not. Staff B stated they would call to other provider groups, get on cancellation lists, and do whatever it took to make sure the referring provider was aware of what the facility was doing to meet the residents' needs. Staff B stated if a resident had heart failure or problems with edema, their expectation was the resident would be weighed routinely according to the frequency ordered by the provider. Staff B expected nursing to monitor Resident 45's level of edema, skin condition, respiratory, and urinary status, and to document their findings and notify the provider as soon as possible of any changes or abnormalities identified. Staff B verified Resident 45 should have been seen by a specialist in a timely manner but was not. Staff B verified Resident 45 should have daily weights but did not. Staff B stated nursing staff should have notified and documented their communication to the provider when Resident 45's weight gain was outside the parameters of professional standards for fluid volume management and the provider's order, but they did not. In an interview on 12/13/2022 at 2:40 PM, Staff II (Physician) stated they were not aware of Resident 45's extent of referral requests for Nephrology because they didn't start seeing the patient until recently. Staff II stated they did not necessarily follow up with the nursing department management after daily weights were ordered for Resident 45 because they just expected to order it and it be done. Staff II stated there were some problems with transportation regarding Resident 45's appointments. Staff II stated they put orders for nephrology in the electronic ordering system and that is the process providers should be following. Staff II stated they will even print out the orders and deliver to the nurse on duty and provide a list of the residents seen for that day and orders to implement. REFERENCE: WAC 388-97-1060(1)(2)(a)(3)(i)(4). 44296

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review the facility failed to assess falls timely, identify cause of falls, and implement fall interventions to prevent recurrent falls for 4 (Residents 35,42, 51 & 20) of 8 residents reviewed for accidents, failed to provide required supervision while eating for 1 of 8 (Resident 66) and 4 supplemental (Residents 24, 46, 42, & 40) residents reviewed for nutrition and swallowing difficulty, failed to provide supervision of unsecured emergency exits, failed to maintain handrails in safe condition, and failed to secure construction materials and tools in the resident environment. These failures left residents at risk for falling, choking, aspiration, elopement, injury, and/or death. Findings included . Falls Resident 35 According to the 10/31/2022 Quarterly Minimum Data Set (MDS, an assessment tool) Resident 35 had intact cognition. The MDS showed Resident 35 had diagnoses including debility (physical weakness) and malnutrition. Review of the facility's September 2022 incident log showed Resident 35 had a fall on 09/16/2022. According to the facility's investigation of the 09/16/2022 fall, Resident 35 was found on the floor of their room at 10:00 AM on 09/16/2022 after crying out for help. The incident description showed Resident 35 sustained a 3 x 3-inch hematoma on their forehead, and that neurological checks (neuros - periodic evaluations to establish the presence of a neurological injury after a fall) were started. The 09/16/2022 investigation did not include any evidence neuros were completed. The 09/16/2022 investigation included a 09/15/2022 fall risk evaluation completed after Resident 35 returned to the facility after a stay at the hospital and did not reflect the fall Resident 35 had on 09/16/2022. No fall risk evaluation was found in the resident's record or included in the investigation to demonstrate Resident 35's risk for falling was reassessed after an actual fall. In an interview on 12/09/22 at 2:33 PM, Staff B (Director of Nursing) stated for an unwitnessed fall resulting in a forehead hematoma, neuros should be completed. Staff B stated evidence of the neuros should be included in the investigation. Resident 42 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 09/12/2022 modified Admission MDS showed Resident 42 had no cognitive deficits and diagnoses including multiple falls, fracture related to falls, and had experienced 2 or more falls after admission to the facility. Review of the revised 09/26/2022 Care Plan (CP) showed the basic standard of care interventions used for all residents; directed the staff to make sure the call light was within reach, encourage the resident to use the call light, proper non-skid footwear, provide safe environment, increase supervision, and refer to therapy as needed. The CP failed to include person-centered interventions to address the resident's fall history with fractures, interventions for cardiac / medication related factors that commonly cause falls, care needs, or updated with new interventions after the first two falls sustained after admission. According to the facility Reporting log showed as of 12/09/2022, Resident 42 fallen 10 times since admission. Review of the 10 facility fall Incident Reports (IRs) showed the facility consistently failed to either identify new interventions to help manage falls, update the CP with planned fall interventions, and/or implement the interventions according to the IRs. After Resident 42's fall on 09/09/2022, the 09/11/2022 facility IR showed the new intervention was to encourage the door to be open to the room. The CP showed the new intervention had not been added to the CP until 09/15/2022. In a 12/12/2022 1:30 PM interview, Staff B stated the update was not timely and should have been added on 09/11/22. On 09/11/2022 at 12:45 AM, Resident 42 fell again. The facility IR showed a plan to have the pharmacist review the resident's medications. In a 12/12/2022 1:30 PM interview, Staff B stated they had not gotten the pharmacy review done and the CP was not updated, but should have been. Resident 42 fell on [DATE] at 8:28 AM and the facility IR showed the root cause of the fall was orthostasis (significant drop in blood pressure upon standing, often causing the resident to fall or faint). The plan was for orthostatic blood pressure review. The facility failed to complete neurological assessments, include orthosatic blood pressures, implement the plan, or update the CP. Similar findings for the falls on 10/05/2022, 10/12/2022, and 10/22/2022. Resident's sixth fall was on 10/24/2022. The facility IR showed the plan was for therapy to assess for the placement of anti-roll back brakes (a device placed on the back of the w/c to prevent it from rolling back if the resident stood up from the chair) on the wheelchair (WC). The CP was not updated and the interventions were not implemented. A 12/12/2022 12:38 PM observation showed the resident's wheelchair did not have anti-roll back brakes attached to the back of the wheelchair. On 10/30/2022, Resident 42 fell during a self-transfer without locking the WC brakes. The resident sustained a long abrasion on the middle of their back. The facility IR said the root cause of the fall was orthostasis. The IR showed no consideration or review of the effectiveness of previous planned interventions, identify they were not implemented, and/or care planned. On 12/12/2022 at 1:30 PM, Staff B agreed if the facility had implemented the anti-roll back brakes on the resident's WC, the resident may not have fallen on 10/30/2022 or 11/02/2022. Resident 42's ninth fall was on 11/10/2022. The facility IR showed the root cause was increase confusion, but no investigation into the reason Resident 42 was having increased confusion, or consider if the resident was having a change of condition. The plan was to place a sign on the bedside table to remind the resident to call for help before trying to self-transfer. During observations on 11/30/2022 at 1:30 PM and 12/12/2022 at 2:28 PM showed no sign on the bedside table. The CP was not updated and the interventions were not implemented. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 42's tenth fall was on 11/20/2022. The facility IR showed the resident had rolled from the bed and the plan was to place the resident on a mattress that had raised perimeter. An observation on 11/30/2022 at 1:30 PM showed the resident was lying on a perimeter mattress. An observation on 12/12/2022 at 11:30 AM showed resident 42 had moved to another room, but the perimeter mattress was not on the residents bed, it was left on the bed in the previous room. In the 12/12/2022 1:30 PM interview, Staff B stated the perimeter mattress should have been moved with the resident and should have been updated on the CP, but was not. Staff B said the investigations lacked witness statements and were not all thorough, the CP was not consistently updated as it should have been placing the resident at continued risk for falling and significant injury. Staff B said the post fall alert monitoring by the nurses was not consistently documented but should have been. Resident 51 According to the 10/06/2022 Admission MDS, Resident 51 had multiple medically complex diagnoses including fractures. This MDS assessed Resident 51 with falls prior to admission that resulted in fractures. Review of the facility incident log showed Resident 51 had a fall on 08/10/2022. The incident report completed by staff showed the resident stated, help me, I fell and was found on the floor with a bump on her forehead. This incident report showed, at the time of the incident, Resident 51 had a bruise to their face and left shoulder. On the incident report staff left the following sections blank: Level of pain; level of consciousness; mobility; mental status; injuries post incident, predisposing environmental factors; and predisposing physiological factors. Review of progress notes showed a late entry note for 08/10/2022 for nursing communication to therapy. This note indicated Resident 51 showed a possible change in condition regarding falls and safety/judgement and requested the resident be evaluated and treated by therapy. No further progress notes by nursing staff regarding the fall were found in the Resident 51's records until 08/20/2022 at 4:11 PM, at which time staff documented a left shoulder x-ray completed on 08/11/2022 was placed in the provider file. Review of Resident 51's records revealed no alert monitoring or neuro assessments were completed by nursing staff after the residents fall on 08/10/2022 with injury to their head. In an interview on 12/09/2022 at 2:33 PM Staff B (Director of Nursing) stated nurses are expected to start the investigation by collecting information for the fall report at the time of the fall. The physician and family must be notified and all documentation of the fall is required to be in the progress notes. Resident 20 The 09/17/2022 Quarterly MDS showed Resident 20 was cognitively impaired, had diagnosis of dementia and at risk for falls. The MDS showed Resident 20 had no falls since the prior assessment. Resident 20 was assessed to require supervision with walking, transfers, and bed mobility and extensive physical assistance with toileting. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's November 2022 incident log showed Resident 20 had a fall on 11/17/2022. Review of the 11/17/2022 investigation report showed Resident 20 had an emergency room (ER) visit and broken scapula (collar bone). Record review showed a 12/05/2022 7:55 PM progress note Informed resident family of fall that took place today with the information at hand. Family is going to meet resident at [NAME] ER. State report complete, DNS ADON AND ED notified of fall with Major injury - suspected fracture. The next progress note dated 12/05/2022 9:31 PM showed Nursing communication to Therapy. Resident is showing a possible change in condition in the following areas: Personal hygiene, Toileting/Continence, Falls. A 12/06/2022 5:23 AM progress note showed Resident came back from the hospital alert and verbally responsive. Resident arrived at the facility around 11:45 pm . went to hospital for non-witnessed fall. Resident sustained some injury on the nose . had displaced bilateral nasal bone fractures . periorbital hematoma. Resident continues neuros and on alert for three days [resident representative] informed about the discharge from the hospital. The progress note did not show cause of fall, notification of the physician, interventions put into place immediately. Review of progress notes 12/06/2022 day, evening, and night shift, 12/07/2022 day, evening shift showed no ongoing monitoring of Resident 20 after the fall with a nose fracture. In an interview on 12/06/2022 at 9:35 AM Staff B stated the nurses are expected to start the investigation at the time of the fall, make a progress note describing what happened and who was notified. Staff B stated the physician should have been notified immediately and it should be documented in the record. Staff B was told the information was missing from the progress notes and replied, It should be in there by now. In an interview on 12/09/2022 at 2:30 PM, Staff B was asked to provide a copy of the investigation that had been completed so far on the 12/05/2022 fall, 5 days prior. No documents were provided. In an interview on 12/12/2022 at 11:33 AM, Staff F (Infection Control Preventionist) stated they were the person on duty at the time of the fall and helped the nurse with the investigation and transferring Resident 20 to the ER. Staff F reviewed the progress notes and stated they were incomplete, missed the assessment of the resident after the fall, missed the initial findings of the cause of fall, missed the notification of the physician, and did not place the resident on alert monitoring upon return from the ER. Staff F stated the investigation had not been completed but had been given to the DNS. In an interview on 12/12/2022 at 2:32 PM, Staff B was asked to provide a copy of the investigation for the 12/09/2022 fall, 8 days prior. The document was not provided until the end of survey. Review of the 12/05/2022 fall investigation showed an intervention of a physical therapy evaluation which the resident refused. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/12/2022 at 2:32 PM, Staff B stated a complete fall investigation included interviews with the resident, staff, and other residents to rule out abuse and neglect, have a root cause analysis with interventions on the care plan to prevent future incidents. Alert charting is required after any incident and continues for three days or until stable. Neuro monitoring is required for any head injuries and should be documented in the investigation. Eating Supervision Resident 66 According to the 11/04/2022 Admission MDS, Resident 66 had diagnoses including stroke and difficulty swallowing. The MDS showed Resident 66 required an altered texture diet and required supervision during. According to an 11/04/2022 Physician's Order (PO) Resident 66 should eat all their meals in the facility's dining room for supervision. The PO showed Resident 66 required aspiration precautions be in place. According to the 11/04/2022 Activities of Daily Living (ADL) CP Resident 66 had a self-care deficit related to weakness and deconditioning. The CP indicated Resident 66 required extensive assistance with eating. Observation on 12/06/2022 at 12:23 PM showed Resident 66 eating alone in their room. On 12/07/2022 at 12:17 PM Resident 66 was observed receiving their lunch tray from Staff S (Certified Nursing Assistant - CNA) who then left the room to a pass more trays. Resident 66 was left unattended to eat their lunch. On 12/08/2022 at 7:49 AM Resident 66 was observed eating their breakfast in their room without supervision. In an interview on 12/07/2022 at 12:22 PM Staff S stated they were unsure what level of supervision Resident 66 required. Staff S stated they usually worked the other side of the building. Staff S stated they could use the CP, the resident's tray ticket, or ask a colleague when working with residents they were less familiar with. Resident 24 According to the 09/14/2022 Quarterly MDS, Resident 24 had difficult chewing / swallowing, significant weight loss, received a mechanically altered texture diet, and required supervision for eating. The 07/13/2022 Nutrition CP directed staff to provide 1:1 (one-to-one) feeding assistance / supervision with meals and report to the nurse any signs of chewing or swallowing problems. The CP failed to include information for staff related to the residents' risk for aspiration and physician ordered diet textures for food/fluids. A constant observation on 12/08/2022 from 7:31 AM to 7:54 AM showed Staff PP (CNA) delivered the breakfast tray to Resident 24 who was lying in bed, with their head of bed at a 30 degree angle. Staff PP set the tray on the bedside table, did not elevate the residents head to ensure the resident was sitting upright for swallowing safety, then left the room. During the observation, Resident 24 was observed slowly feeding themselves and no staff ever came to the room to provide the 1:1 eating assistance and supervision the resident was required to receive. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an ongoing observation on 12/08/2022 from 12:23 PM to 1:16 PM showed Resident 42 was set up at the edge of the bed with their meal by the CNA without checking the meal tray for accuracy, then left the room without identifying the meal they delivered to the resident had three incorrect food textures and the wrong liquid consistency. (Refer to F803) After the correct meal was provided to the resident, staff left the room, and did not return to supervise the resident for their meal. During a 12/08/2022 1:23 PM interview, Staff T (Licensed Speech Therapist) said the resident should be supervised for meals due to their risk of choking and aspiration. Resident 40 The 10/13/2022 quarterly MDS showed Resident 40 was assessed with dysphagia (a swallowing problem) and was on a mechanically altered diet, requiring supervision and one person assistance for cueing for eating. A 07/11/2022 PO showed Resident 40 should be up in a wheelchair and in the assisted dining room for lunch. The 08/12/2022 diet order showed Resident 40 required a dysphasia mechanical soft diet with nectar thick liquids and supervision during meals for standard aspiration (inhaled food/fluids into lungs) precautions. Observation on 12/08/2022 at 12:21 PM showed Resident 40 was in bed, the head of the bed was at 30 degrees, too low for eating position, lunch tray was on the overbed table, holding a fork and eating holding head up from the mattress. There was no staff present providing supervision to prevent aspiration. In an interview on 12/09/2022 at 2:33 PM Staff B stated Resident 40 should eat in the assisted dining room, or if eating in their room, should have the required supervision for swallowing safety. Unsecured Building Materials On 12/06/2022 at 10:21 AM the door to room [ROOM NUMBER] was observed to have a sign hung indicating the room was under construction. The door was observed to be unlocked. Inside room [ROOM NUMBER] the following was observed: an open container of a putty-like compound, a half-full, 5-gallon paint can, a drill, a hammer, assorted hardware, painting supplies, a box of ceiling tiles on a cart, a second cart with box of all-purpose joint compound, a can of wall texture spray, and a step ladder. There was a large hole observed to be cut into the ceiling to provide access to water pipes. The bathroom inside room [ROOM NUMBER] was shared with room [ROOM NUMBER] which allowed the occupants of room [ROOM NUMBER] to access room [ROOM NUMBER] through the bathroom as well as from the hallway unsecure both from hallway and through bathroom to room [ROOM NUMBER]. In an interview at 12/06/2022 at 10:48 AM, Staff A (Administrator) stated it was their expectation that construction materials and tools were stored securely. Staff A stated room [ROOM NUMBER] should have been, but was not secured for resident safety. Handrails (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/30/2022 at 8:03 AM showed the handrail fixture next to storage room and opposite room [ROOM NUMBER] had a broken plastic bracket that was potentially sharp enough to tear the skin of residents using it. On 11/30/2022 at 8:39 AM the handrail outside room [ROOM NUMBER] was fractured and had exposed, sharp edges. On 12/09/2022 at 12:54 PM the handrailing on the corner of the office between the shower room and activity room near rooms [ROOM NUMBERS] was detaching from the brackets and wobbly. A 3x3 inch corner piece was not securely fastened and could be detached manually. The second bracket from the corner was missing. In an observation and interview on 12/12/2022 at 10:37 AM, Staff H (Maintenance Director) stated the rails needed to be repaired. Staff H stated they were unsure if they had the parts available but could order them. 44296 Emergency Exit Doors During a life safety inspection on 12/01/2022 from 8:45 AM to 9:50 AM, a [NAME] State Fire Marshal identified the two EE doors (door 2 and 3) on the east side of the building did not function as required. The Fire Marshal determined the EE doors were locked and could not be opened, which prevented residents and staff from exiting emergently. In an interview and observation on 12/01/2022 at 11:51 AM, Staff I (Maintenance Assistant) stated they took the door pins to their private home and needed to collect the pins before they could get the EE doors open. Staff I stated they removed pin from each of the push-bars for EE doors 2 and 3 after a resident wandered through the doors outside to the patio area, unsupervised. Staff I was unable to recall the name of the resident or the date they removed the pins from the door but stated that it was a while ago. Staff I was observed using multiple tools to install the pin into the push-bar and 11 minutes later EE Door 2 was unlocked and opened. At 12:08 PM, Staff I installed the pin into the push bar for EE Door 3 and it was unlocked. Both doors 2 and 3 were locked and non-functional for a total of two hours and 12 minutes after the Fire Marshal determined both doors were locked and not functioning as required by federal regulations. Observations on 12/01/2022 1:07 PM showed the EE doors were unlocked but no alarm sounded when opened, which allowed residents to exit the facility without staff knowledge. There was no staff present at the EE doors to watch for residents exiting through the unlocked EE doors. Observation on 12/01/2022 at 2:31 PM showed the facility tested the audible fire alarm system. The fire alarm response by staff cleared the hallways and all staff responded to the nurse's station preventing staff from monitoring the EE doors for residents exiting. The fire alarm sounded for 34 minutes while surveyors monitored the EE Doors for staff supervising for residents exiting. In an interview on 12/01/2022 at 2:48 PM Staff A, while the alarm was sounding, stated staff would be assigned to watch the unlocked/unsecured EE Doors 2 and 3 during the fire alarm testing. Observations of the EE doors 2 and 3 at 2:54 PM, 3:11 PM and 3:23 PM showed no staff present to prevent resident exit/elopement. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46472 Based on observations, interview, and record review the attending physician failed to ensure and/or adequately supervise the complete medical care for 1 of 20 (Resident 45) residents reviewed. The failure to follow up on the status of repeated orders given to nursing staff for a referral to a kidney specialist, address the omission of daily weight monitoring, and facility failure to follow Physician orders (POs) resulted in Resident 45 not being evaluated for worsening fluid balance status by a kidney specialist for over 12 months, required a possibly avoidable hospitalization with the removal of a significant amount of water weight, experienced acute kidney injury and acute respiratory failure. Findings included . Resident 45 According to the 08/23/2021 provider visit note, the resident was referred to Nephrologist (kidney specialist) due to recurrent abnormal and worsening kidney function lab values and critical potassium levels. A 05/03/2022 nurse note showed the Physician ordered repeat labs due to worsening kidney function labs and repeated Refer to Nephrology as the resident had not been set up for a Nephrology appointment yet. A 08/01/2022, 08/31/2022, 09/14/2022, 09/20/2022, 09/28/2022 provider note showed refer to nephrology. The first Nephrology specialty appointment was finally scheduled for 08/23/2022, one year after the first request for referral. Resident 45 was ill that day and unable to attend and the appointment was rescheduled for 10/04/2022. A 10/05/2022 provider note showed Resident 45 missed the 10/04/2022 appointment due to facility's failure to establish reliable transportation. The provider said the resident's potassium level was at a critical level and ordered a medication to help bring the potassium level back to normal. The provider reviewed the resident's medication to manage edema because the resident was complaining of increased edema to the lower legs and abdomen. The provider said the resident's current weight was 287.5 pounds (a 29-pound weight gain in 30 days) and they questioned the current weight trend but did not elaborate as to why. The provider assessed the resident as having pitting edema to both lower legs and up to the trunk (abdomen) and addressed labs values from 10/03/2022 that had significantly worsened. The provider adjusted the residents' medications and said, Refer to Nephrology ASAP (As soon as possible). On 10/13/2022 the Resident was sent to the hospital due to breathing complications related to fluid volume overload. The 10/13/2022 hospital records showed the resident was admitted to the hospital weighting 292 pounds and diagnoses acute respiratory failure, acute kidney injury, high potassium level, and protein in the urine (nephrotic syndrome). The resident was transferred back to the facility on [DATE] and weighed 204 pounds (a loss of 88 pounds in 18 days). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505195	A. Building B. Wing	12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Auburn Rehab & Health Center	2830 I Street Northeast Auburn, WA 98002

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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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a 12/13/2022 2:30 PM interview, Staff II, facility Physician, said they did not recall reviewing the weight list and had not had any conversations with facility administration regarding the facility's failure to obtain daily weights as ordered. Staff II said they write the order and expect the nurses follow the order. Staff II said they were not aware the request for Nephrology referral was first initiated in August of 2021 because they started seeing the patient around May of 2022. They were unsure of the reason it was taking the facility so long to obtain the appointment and was only made aware of a transportation issue. Staff II said a resident waiting 12 to 15 months for a nephrology referral was not acceptable. Staff II said they did not have any conversations with the facility administration regarding the resident not getting into the specialist as ordered or that orders were not followed thru to monitor Resident 45's fluid balance status. Staff II was asked if there was anything else that could have been done to get the resident into the specialist sooner for specialized kidney treatment and possibly slow the progression of kidney failure, need for hospitalization , and now the need for life altering hemodialysis (for instance a provider to provider call to expedite the waiting period, calling other specialists, getting on cancellation lists) and Staff II said they have in the past, but was unsure if it would have been helpful for this situation, and they were not from this area or familiar with the specialists in this area. Refer to F684 Quality of Care Refer to F658 Services Provided to meet Professional Standards REFERENCE: WAC 388-97-1260(3)(a).