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	01/16/2020

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview and record review, the facility failed to provide a dignified dining experience for five of seven dependent residents in the main dining room. Staff failed to provide consistent and timely assistance for three dependent residents (Residents #23, #15 and #24). Additionally, staff were observed to move two of 15 residents in wheelchairs (Residents #60 and #15) from their table without either seeking permission or forewarning while seating other residents. Failure to provide a dignified environment placed the residents at risk of feelings of institutionalization and diminished self-worth. Findings included . DINING OBSERVATIONS Observations of lunch service on 01/05/20 showed drink service began at 11:43 AM and food service at 11:55 AM. Resident #24, who was assessed as totally dependent for eating, per the 11/06/19 Significant Change Minimum Data Set (MDS, an assessment tool), was seated at a table with Residents #30 and #57 were assessed to require extensive assistance with eating per the 11/13/19 Annual MDS and 12/11/19 Admission MDS. Resident #57 was served food at 12:04 PM and given assistance with dining at 12:09 PM. Resident #24 was served a beverage at 12:09 PM and received a food tray was at 12:12 PM, but not given assistance with dining until 12:17 PM, eight minutes after Resident #57 received assistance. Resident #30 did not receive assistance to eat until 12:30 PM, thirteen minutes after Resident #24, and 21 minutes after Resident #57 received assistance. Resident #23, who was assessed to require extensive assistance on her 11/03/19 Significant Change MDS, was seated at a table with Residents #49 and #34. Resident #49 was assessed to require extensive assistance to eat, according to his 12/04/19 Admission MDS. Resident #34 was assessed to require set up assistance only, according to his Annual MS dated 11/17/19. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #23 made repeated requests for assistance to eat immediately upon being seated at 12:00 PM. Resident #23 received her lunch at 12:06 PM but was not offered assistance to eat it, and was not served a drink until 12:10 PM. Her tablemate, Resident #34 was brought a drink at 12:02 PM and given set up assistance at 12:04 PM, but not given his lunch. Resident #34 then had to wait until 12:16 PM for his food. In total, there was a 10 minute period when Resident #23 had food but no assistance, and Resident #34 had no lunch but did not require assistance. At 12:08 PM, Resident #23 attempted to feed herself but dropped her fork and stopped trying. At 12:19 PM, Resident #23 asked for assistance with dining from resident #34, who asked her what she would like him to do, before pushing her plate closer to her. At 12:21 PM Resident #23 received 1:1 assistance to dine, fifteen minutes after her food arrived. On 01/15/2020 at 12:32 PM, Staff A, Administrator, was interviewed and confirmed it is the facility's expectation that dependent residents receive the same dining service as all other residents. When asked if dependent residents should wait to for assistance to dine once their food has been served, or while tablemates are dining, Staff A responded the protocol should be to assist with food as soon as it's served to a resident, not to go and give out more trays. Residents Dining In Wheelchairs: Observations from 01/08/20. At 11:50 AM, Staff M, Registered Nursing Assistant (NAR), was observed to roll Resident #60, who was seated in a tilt-in-space wheelchair, away from her table in order allow another resident in a wheelchair to pass behind her to get to an empty space at the table. Staff M did not seek permission from Resident #60, nor explain why it was necessary for her to move aside, nor warn her in any way that she was about to be moved. At 11:52 AM, Staff N, Certified Nursing Assistant (NAC), was observed to move Resident #15 from one table to another without seeking permission to move from the resident, or explaining why it was necessary for her to move aside, or warning her in any way that she was about to be moved. The dining room was observed to have adequate physical space but the arrangement of tables, and the distribution of residents in wheelchairs around them, failed to accommodate residents' needs. In an interview on 01/09/20 at 01:41 PM, when asked how staff should manage situations where it is necessary [NAME] momentarily move residents dining in wheelchairs in order to seat other diners, Staff A, administrator, stated such situations are best avoided but if absolutely necessary, staff should say excuse me and that staff should ask residents before moving them. I'll be including it in my in-service. REFERENCE: WAC 388-97-0180(1-4).

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32898 Based on interview and record review, the facility failed to fully inform the resident and/or legal representative orally or in writing, of the risks and benefits of psychotropic medications for two (#s 49 & 48) of five residents reviewed for unnecessary medications, and one (#47) supplemental resident. These failures prevented residents and/or legal representatives from making informed decisions regarding care and treatment related to the use of psychotropic medications and safety devices Findings included . 37044 RESIDENT #49 Resident #49 admitted to the facility on [DATE], with orders for Risperidone (an antipsychotic) twice daily for dementia. Record review showed no indication facility staff explained the risks versus benefits of the antipsychotic medication or obtained informed consent for the medication. During an interview on 01/13/2020 at 2:29 PM, Staff C, Assistant Director of Nursing, explained the facility used a Psychopharmacologic Medication Information Sheet (PMIS) to explain the risks versus benefits of psychotropic medications and to obtain informed consent. When asked if Resident #49 had a PMIS for his Risperidone Staff C stated, No and indicated it should have been done. RESIDENT #48 Resident #48 admitted to the facility on [DATE], with orders for Venlafaxine (an antidepressant), Buspirone (an anxiolytic), and Abilify (an antipsychotic). Record review revealed no indication facility staff explained the risks versus benefits of the psychotropic medications, or obtained consent. During an interview on 01/09/2020 at 11:11 AM, when asked if PMISs were completed for Resident #48's Buspirone, Venlafaxine, and Abilify, Staff C stated, No. RESIDENT #47 Resident #47 admitted to the facility on [DATE], and according to the 10/04/19 OBRA assessment, received an antipsychotic medication (Seroquel) for six days during the assessment period. A review of the physician's orders revealed the resident received several antipsychotic medications. In an interview on 01/06/20 at 9:45 AM, Resident #47 complained,I can't get out of here to get fresh air without this alarm ringing .I don't even know who put the alarm on my chair or why it was put on here. Every time I want to go outside it (wander guard) rings so loud plus I can't get the door open. The resident was observed at this time to have a Wanderguard (a system that evokes an alarm when approaching exit doors) secured to the wheelchair. Record review showed no risk versus benefits or informed consent was obtained from the resident or his representative for either the Wanderguard alarm system or for the antipsychotic medication. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/10/20 at 11:50 AM Staff E, Licensed Practical Nurse, said, Our forms are computerized, so we can't obtain the written consent for the use of the wander guard or the antipsychotic medications, so I don't know what we are supposed to do in that case. REFERENCE: WAC 388-97-0260(1)(2).

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32898 Based on observation, interview and record review the facility failed to allow five (#s 65, 30, 51, 55, & 50) of five and one supplemental (#55) resident reviewed for choices, the right to make choices regarding important daily routines and health care, including accommodating preferences for the frequency and/or type of bathing. The facility's failure to accommodate resident choice, placed these residents at risk for a diminished quality of life. Findings included . RESIDENT #51 In an interview on 01/05/20 at 1:09 PM, when asked if he was able to choose his frequency of bathing, Resident #51 stated, Oh geez no . I am supposed to get two a week. According to the ADL (Activities of Daily Living) . care plan (CP), revised 12/10/19, Resident #51 Requires total assistance with bathing/showering 2x/week and as necessary. Review of the bathing flowsheets for October, November and December 2019 showed the following: from 10/04/19 through 10/28/19 (25 days) no shower was given, with only one refusal documented on 10/17/19; from 11/20/19 through 12/05/19 (16 days) no shower was provided, with only one refusal documented on 10/21/19; from 12/11/19 through 12/16/19 (six days) no shower was offered; and from 12/18/19 through 12/23/19 (six days) no shower was offered. During an interview on 01/08/19 at 9:51 AM, Staff G, Resident Care Manager, explained that Residents' shower preferences were listed on their CP. When asked how often Resident #51's CP stated he was to be showered Staff G stated, twice a week. When asked if staff were honoring Resident #51's bathing preferences Staff G stated, No, but they should have. RESIDENT #55 According to anADL [activities of daily living] . CP, revised 10/24/19, Resident #55 Requires full assistance with bathing/showering twice weekly and as necessary. Resident #55 was unable to be interviewed due to impaired cognition. Review of the shower flowsheets from November and December 2019 showed no shower was offered or provided for the following time periods: 11/05/19 through 11/10/19 (six days); 11/15/19 through 11/24/19 (10 days); 11/26/19 through 12/03/19 (eight days); and 12/21/19 through 12/26/19 (six days). During an interview on 01/08/19 at 9:40 AM, when asked if it was the expectation that resident preferences for frequency of bathing be honored Staff G stated, Absolutely. When asked if Resident #55's bathing preference of being showered twice a week was honored Staff G stated, No. RESIDENT #65 (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the Entry tracking MDS (Minimum Data Set- an assessment tool) dated 12/11/19 Resident #65 required physical assistance of two people for bathing, and extensive assistance of two people for personal hygiene. A review of the resident's care plan dated 12/11/19 revealed the resident preferred to shower twice week. On 01/06/20 at 8:26 AM, Resident #65 was observed wearing a hospital type gown, her lower legs was exposed, and her hair was jutted up on her head. Resident #65 indicated at this time she did not receive showers as frequently as she would like and she did not receive assistance with her hair stating, I don't want it like this, (raking her hands through her hair.) In an interview on 01/08/20 at 12:52 PM Staff D (Registered Nurse - Assistant Director Of Nursing) said, I believe the resident prefers having a shower twice a week. Staff D acknowledged the resident did not receive a shower twice a week but instead had only had one shower on 12/27/19 and again on 01/07/20. Staff D said, It looks like we are not meeting the resident's preference related to getting two showers each week. RESIDENT #30 According to the Quarterly MDS dated [DATE], the resident required total physical assistance of one person for bathing/showering. A review of the ADL (Activiites of Daily Living) Self Care Performance Deficit r/t Limited mobility, pain, CP revised on 11/20/18 indicated the resident preferred 2 x/week and as necessary. A review of the documentation on the Look back documentation showed that the facility consistently failed to provide the resident with two showers each week. According to the bathing/shower documents, Resident #30 was showered six times in October, 10/10, 10/14 10/23, 10/24, 10/28,10/31/19. In addition, the resident only received seven shower November, 11/04, 11/11, 11/13 ,11/18 ,11/21 ,11/26 and 11/27/19. Additionally, in December 2019, the resident received six showers on 12/02,12/05, 12/09, 12/12, 12/21 and 12/30/19. In an interview on 01/08/20 at 12:52 PM, Staff D said, It looks like the same is true for this resident, also, we're not meeting the resident's preferred frequency for bathing/showers. 37044 42203 RESIDENT #50 (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/05/20 at 01:20 PM, Resident #50 expressed his preference for shower frequency of twice a week wasn't met. Review of the resident's ADLs CP, revised 10/07/19, confirmed that Resident #50 was assessed to require assistance with bathing, with a frequency of 2x/week and as necessary. Review of Resident #50's shower flowsheets revealed that Resident #50 received only one shower on the weeks of 10/06/19-10/12/19, 11/17/19-11/23/19, 12/15/19-12/21/19 and 12/30/19-01/04/20. During an interview conducted on 01/13/20 at 12:40 PM, when asked if Resident #50 was receiving bathing care per his preference, Staff C, ADON stated he is not. REFERENCE: WAC 388-97-0900 (1)-(4).

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32898 42203 Based on interview and record review, the facility failed to address required documentation for advanced directives, including incorporation into the care planning process, for three (#s 47, 60 & 65) of four residents reviewed for advanced directives. These failures placed the residents at risk of losing their right to have their stated preferences/decisions regarding end-of-life care followed. Findings included . Advance Directives An Advance directive (AD) is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated, per Centers for Medicare/Medicaid Services definition. (see CFR 489.100.) The regulations also stipulate, If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. RESIDENT #60 Resident #60 admitted to the facility on [DATE] with diagnoses of Parkinson's Disease and Progressive Neurological Conditions. On the Admission Minimum Data Set (MDS, an assessment tool) dated 12/14/19, Resident #60's preferred language was stated to be Ukrainian. Resident #60 was assessed as having no speech, as rarely/ never understood, and as rarely/never understanding others. Resident #60's Care Plan (CP) dated 12/07/2019 stated that Resident #60 had an AD, that the AD will be followed, and directed staff to refer to Advance Directive documents for care preferences and/or directives. Record review on 01/07/20 revealed that the facility did not have an AD in Resident #60's electronic health record. In an interview on 01/07/20 at 09:07 AM, Staff I, Social Service Assistant, stated that Resident #60 didn't have an AD. Staff I subsequently provided a document he understood to be Resident #60's AD. However this was not an AD, but an admission packet form that stated Resident #60 had an AD which was in Resident #60's daughter's possession. In an interview at 11:40 AM on 01/15/20, Staff I confirmed staff couldn't follow the CP directions in the absence of an AD. When asked if further efforts had been made to obtain Resident #60's Advance Directive, Staff I said no. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RESIDENT #47 Resident #47 admitted to the 09/27/19.Record review revealed no AD, and no indication staff had requested one or inquired about the desire to formulate one. Care Plan documents dated 10/17/19, directed staff to, refer to advanced directive documentation for care preferences and/or directives. Refer to cardiopulmonary resuscitation consent form for specific instruction. In an interview on 01/15/20 at 10:01 AM, Staff C (Registered Nurse-Assistant Director Of Nursing) said, after speaking with Staff I (Social Service Assistant), I realized that he hadn't requested or obtained a copy of the resident's advanced directives. According to Staff C, Staff I thought the POLST (directions to emergency personnel for life sustaining treatment) was the only document required for an advanced directive. Similar finding were observed in the electronic medical record of Resident #65 for whom there was no documentation to support facility staff had requested an AD or inquired about the desire to formulate one. REFERENCE: WAC 388-97-0240(3).

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 37044 Based on interview and record review, the facility failed to provide Skilled Nursing Facility Advanced Beneficiary Notices (SNF ABN) as required for two (#s 231 & 78) of three residents reviewed, whose Medicare stay ended, but remained in the facility. This failure placed the residents and/or the resident representative at risk for not having adequate information to make financial decisions, related to a continued stay in the facility. Findings included . RESIDENT #231 According to facility documents Resident #231 started on skilled Medicare services on 06/17/19, with a last covered day (LCD) of 07/01/19, and remained in the facility. Record review showed no indication a SNF ABN was provided as required. During an interview on 01/13/2020 at 9:20 AM, when asked if Resident #231 was provided a SNF ABN as required Staff I, Social Work Assistant, stated, No. RESIDENT #78 According to facility documents Resident #78 started on skilled Medicare services on 10/06/19, with a LCD of 11/04/19, and remained in the facility. Record review showed no indication a SNF ABN was provided as required. During an interview on 01/13/2020 at 9:20 AM, when asked if Resident #78 was provided a SNF ABN as required Staff I stated, No. REFERENCE: WAC 388-97-0300(1)(e), (5), (6).

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32898 Based on observation and interview, the facility failed to ensure the facility was maintained in a clean, comfortable, homelike and safe environment, for residents (#s 71 & 18) and seven resident rooms (6, 14, 15, 16, 17, 20 & 22). Failure to ensure the facility was free from urine odors, and kept clean and in good repair placed resident at risk for decreased quality of life, compromised dignity and potential infection control issues. Findings included . On 01/05/20 at 9:00 AM, during the initial tour of the facility room [ROOM NUMBER] was noted with a strong smell of feces. Resident #71's wheelchair had a thick layer of dust and debris on the back and under the seat of the chair. During Environmental rounds on 01/15/20 at 10:14 AM, Staff T, Maintenance Director, stated that staff typically notified him verbally or filled out a maintenance request form when repairs were needed. During Environmental rounds the following were observed: room [ROOM NUMBER] had chipped paint on the wall closest to Resident #3's bed, room [ROOM NUMBER] had loose trim on the foot board on the bed where Resident # 33 resided, and in room [ROOM NUMBER], the wood facing on the door had separated leaving unfinished wood exposed with missing portions of the door trim. The drywall near the bathroom door in room [ROOM NUMBER] was damaged. Staff T said, This will require repair and paint. In room [ROOM NUMBER], the entrance door was damaged. Staff T said, If I can't repaired this door I'll replace it. In room [ROOM NUMBER] there was damage to the dry wall near the bathroom and near the head of the first bed where Resident #40 resided. Additionally, the drywall in room [ROOM NUMBER] near the bathroom door was severely damaged and in need of repair. REFERENCE: WAC 388-97-0880 (1).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 32898 Based on observation, interview and record review the facility failed to accurately assess five (#s 71, 65, 48, 29, & 55) of 18 residents' Minimum Data Sets (MDS- an assessment tool) reviewed. Failure to ensure accurate assessments regarding Vision & Hearing (#71), skin conditions (#s 65 & 55), Medications (# 48), Diagnoses (#29), and Activities of Daily Living (#55) placed residents at risk for unidentified and/or unmet needs. Findings Included . RESIDENT #71 According to the 12/27/19 Quarterly Minimum Data Set (MDS - an assessment tool) Resident #71 had adequate hearing - no difficulty in normal conversation, social interaction, or listening to the TV, did not require the use of hearing aids, and determined the resident did not require visual aides including contacts, glasses, or a magnifying glass. In an interview on 01/05/20 at 1:00 PM, Resident #71 stated, I have two hearing aids and, I have a pair of glasses in one of those drawers. In an interview on 01/09/19 at 2:00 PM, Staff E, Licensed Practical Nurse-MDS Nurse, stated the resident did have hearing aides and used glassed and acknowledged the MDS was incorrect stating, we will have to update this section to reflect the use of corrective lenses and hearing aids. RESIDENT #65 According to the 12/19/19 Admission MDS, the resident admitted with one unstageable pressure ulcer with suspected deep tissue injury (DTI). However, according to a 12/11/19 Care Plan (CP), the resident had a Stage III wound DTI. In an interview on 01/15/20 at 12:36 PM, Staff E said, the resident admitted to the facility with a (R)ight heel wound. According to Staff E, the MDS was incorrect stating, The wound on the resident's heel deteriorated and went from a Stage II to a Stage III. I don't think it was a DTI because it was on her heel. 37044 RESIDENT #48 According to the 12/04/19 Admission MDS, the resident received no antipsychotic medication during the assessment period. Record review showed an 11/27/19 order for Abilify (an antipsychotic). Review of the November 2019 Medication Administration Record (MAR) showed the resident received Abilify on 11/28/19, 11/29/19, and 11/30/19. Review of the December 2019 MAR showed the resident received Abilify on 12/01-04/19. (continued on next page)

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	505195	A. Building B. Wing	01/16/2020

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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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/09/2020 at 2:25 PM, when asked if the MDS was accurate Staff F, MDS Coordinator, stated, No and indicated the MDS should be coded as received antipsychotic medication on seven of seven days during the assessment period. RESIDENT #29 According to the 09/26/19 Admission MDS, Resident #29 had a active diagnosis of anxiety, but received no antianxiety medication. Record review revealed no orders to treat anxiety and no behavior monitoring related to anxiety. During an interview on 01/10/2020 at 10:28 AM, when asked if Resident #29 was treated for anxiety or staff were actively monitoring for anxiety Staff F stated, No. When asked if the MDS was inaccurate Staff F stated, Yes. RESIDENT #55 According to the 12/12/19 Quarterly MDS, the resident was dependant for transfers and hygiene with the assistance of one staff member. Review of the Activiites of Daily Living (ADL) flowsheets during the assessment period (12/06/19 through 12/12/19) showed staff documented on 12/10/19 and 12/12/19 the resident required two extensive assistance with transfers. Additionally, staff documented the resident required limited assistance for hygiene on 12/10/19 and extensive assistance on 12/12/19. During an interview on 1/08/19 at 2:47 PM, when asked if the MDS was accurately coded Staff F stated, No and indicated transfers should have been coded as extensive two person assistance and hygiene as one person extensive assistance. Additionally, according to the 12/12/19 Quarterly MDS, Resident #55 was on a turning/repositioning program. According to the Resident Assessment Instrument (RAI, tool used to assist nurses to accurately code the MDS) manual a turning/repositioning program must be organized, planned, documented, monitored, and evaluated. Record review revealed a Actual Pressure Ulcer . care plan that directed staff to turn the resident side to side, support with pillows and reposition with rounds approximately every two hours. There was no indication that a organized, resident specific program had been developed, was being documented, monitored, or reevaluated as required. In an interview on 01/15/19 at 9:26 AM, Staff F was asked to provide documentation to support Resident #55 was receiving a turning/repositioning program,. Nothing was provided. When asked if the MDS was correctly coded Staff F stated, No. REFERENCE: WAC 388-97-1000(1)(a)(b). .

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR) Level II comprehensive evaluations were obtained for two (#s 73 & 33) of two residents reviewed who were assessed to require them. This failure placed residents at risk for not receiving necessary mental health care and services they required. Findings included . RESIDENT #73 Resident #73 admitted to the facility on [DATE]. According to the 12/29/19 Quarterly Minimum Data Set (MDS, an assessment tool), the resident was cognitively intact, had a diagnosis of depression, and received antidepressant medication on seven of seven days during the assessment period. Record review showed on 10/15/19 the facility performed a new level I PASRR, adding a diagnoses of psychotic disorder and depression, and referred Resident #73 for a level II PASRR evaluation. A 11/09/19 PASRR Notice of Determination indicated the resident did have a mental health diagnosis and required specialized behavioral services. According to this document the full PASRR report/treatment plan would be available within 30 days. Hand written on the document was Patient declines Psychiatry, he would like mental health counseling with a community agency. Record review on 01/09/20 showed no indication that the facility had obtained or implemented Resident #73's level two treatment plan, or that the resident had been seen by mental health as recommended on 11/09/19 notice of determination. During an interview on 01/10/20 at 11:31 AM, when asked if the facility had Resident #73's full PASRR level II and treatment plan Staff A, Administrator, stated, No. When asked if there was documentation of their calls/attempts to obtain it, Staff A stated, No. When asked if the facility should have obtained it by now Staff A stated, Yes. Additionally, during an interview on 01/15/19 at 9:26 AM, when asked if the resident had been seen by mental health as recommended on 11/09/19 Staff C stated, No. 42203 RESIDENT #33 Resident #33 admitted to the facility on [DATE]. Record review revealed a 11/13/18 PASRR level I screening which showed a diagnosis of depression. Resident #33's record also showed that on 10/15/19 the facility performed a new level I PASRR which now included a diagnosis of psychosis which caused serious functional limitations. Resident #33 was referred for a level II PASRR evaluation. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 11/09/19 PASRR Notice of Determination indicated the resident met the requirements for specialized behavioral services. According to this document the full PASRR report/treatment plan would be available within 30 days. Hand written on the document was Patient declined assessment. Report will follow pending record review. Record review on 01/09/20 showed no indication that the facility obtained Resident #33's level II treatment plan, which prevented staff from implementing any recommendations. REFERENCE: WAC 388-97-1915(4).

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR) assessments were accurately completed prior to or upon admission to the facility, for one (#48) of five, and two (#29 & 73) supplemental residents reviewed for PASRR compliance. This failure placed residents at risk for inappropriate placement and/or not receiving timely and necessary services to meet their mental health care needs. Findings included . RESIDENT #48 According to the 12/04/19 Admission Minimum Data Set (MDS, an assessment tool), the resident had diagnoses of anxiety and depression, and received antidepressant and antianxiety medication on seven of seven days during the assessment period. Record review showed the resident admitted to the facility on [DATE], with orders for Venlafaxine (an antidepressant) for depression and Buspirone (an anxiolytic) for anxiety. According to the 11/25/19 level I PASRR, Resident #48 had a diagnosis of depression but no diagnosis of anxiety. During an interview on 01/09/2020 at 11:22 AM, when asked what mental illness was listed on Resident #48's level one PASRR Staff C, Assistant Director of Nursing, stated, Depression. When asked why the resident was being treated with Buspirone Staff C stated, anxiety. When asked if the level one PASRR was accurate Staff C stated, No. RESIDENT #29 Resident #29 admitted to the facility on [DATE]. According to the 09/26/19 Admission MDS, the resident had a diagnosis of depression, and received antidepressant medication on seven of seven days during the assessment period. Record review showed the resident admitted with a 09/19/19 order for Celexa (an antidepressant). However, according to the 09/12/19 level I PASRR the resident had no serious mental illness indicators, including depression. During an interview on 01/10/2020 at 10:53 AM, when asked if Resident #29's level I PASRR was accurate Staff B, Director of Nursing, Stated, No. RESIDENT #73 Resident #73 admitted to the facility on [DATE]. According to a 07/19/19 level I PASRR the resident had no mental illness indicators and did not require a level II referral. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review showed that the facility performed a new level one PASRR on 10/15/19, and according to this PASRR the resident had diagnoses of depression and psychotic disorder and was referred for a level two PASRR evaluation. Review of Resident #73's nurses' notes and provider notes revealed no indication the resident was diagnosed with psychotic disorder. During an interview on 01/09/2020 at 1:38 AM, Staff A, Administrator, and [NAME], Social Work Assistant, were asked where the diagnosis of psychotic disorder came from. Staff A indicated they needed to review the chart. In a follow up interview on 01/10/2020 at 11:31 AM, Staff A stated, We could not find that diagnosis. When asked if the 10/15/19 level one PASRR was inaccurate, Staff A stated, Yes. REFERENCE: WAC 388-97-1975(7).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32898 Based on observation, interview and record review, the facility failed to develop, and/or implement comprehensive care plans for seven (#s 18, 71, 48, 55, 73, 49, & 8) of 21 sample residents whose care plans were reviewed. Failure to establish care plans that were individualized and accurately reflected assessed care needs, placed residents at risk of unmet care needs, due to inaccurate or inadequate direction to staff. Findings included . RESIDENT #18 According to the Significant Change MDS (Minimum Data Set- an assessment tool) dated 10/30/19, Resident #18 re-entered the facility on 03/04/07. A review of the resident clinical record revealed the resident received Hospice services From Providence Hospice Care. Record review revealed the facility failed to develop a Care Plan (CP) related to end of life /hospice services with individualized goals and interventions. In an interview on 01/09/20 at 12:21 PM, Staff C, Registered Nurse (RN) -Assistant Director of Nursing, was asked if the facility had developed a care plan related to end of life care needs. According to Staff C, the facility usually obtained a copy of the care plan from the hospice provider to go into the resident's clinical record. Staff C said, However, Staff D, RN-Assistant Director Of Nursing, was responsible for ensuring all of the hospice CP's were complete and in the resident's records. In an interview on 01/09/20 at 12:25 PM. Staff D, said, Normally we use the CP developed by the hospice agency. Staff D said, Unfortunately, there isn't a copy of the Hospice CP in the resident's chart. Failure to develop a plan of care with individualized goals and intervention placed the resident at risk of not having her needs met. Record review showed no CP that the resident refused care. In an interview on 01/09/20 at 11:26 AM Staff G, Licensed Practical Nurse - LPN, stated the resident frequently refused to allow staff to assist with grooming and the CP should reflect this behavior along with interventions and goals. RESIDENT #71 A review of the Quarterly MDS, dated [DATE], revealed the resident admitted to the facility on [DATE]. In an interview on 01/05/20 at 12:55 PM, the resident stated that he had a new denture that he frequently forgot to wear. A review of the resident's CP and Kardex showed no instruction to staff regarding the use of dentures. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/15/20 at 8:43 AM Staff E, LPN acknowledged the CP failed to address the use of dentures, stating, If the CP and Kardex fail to address the use of dentures, the care givers wouldn't know what care the resident required. ORAL CARE RESIDENT #71 In an interview on 01/05/20 at 12:55 PM, Resident #71 said, [I] got new dentures, but I keep forgetting to wear them. Resident #71, was asked if the staff assist or remind him to wear his denture, No, A review of the CP dated 11/19/18, Oral /Dental Health Problems: Edentulous. provide mouth care as per ADL/Mobility Care Plan. Encourage resident to wear denture daily. On 01/13/20 at 10:16 AM, when asked if she offered to assist or encourage Resident #71 with his dentures Staff Z, CNA, replied, No. A review of the resident's Kardex revealed the resident required, set up to be able to independently perform oral care. According to the resident went on an outing after getting up in the AM, and didn't return until the afternoon and she didn't think to offer him oral care upon his return to the facility. In an interview on 01/15/20 at 8:43 AM, According to Staff E (LPN-MDS) indicated direct care staff should implement the plan of care. 37044 RESIDENT #48 During an interview on 01/06/20 at 1:05 PM, Resident #48 indicated that he smoked. Record review showed a 12/12/19 smoking evaluation that assessed the resident as safe to smoke independently. Review of the resident's comprehensive CP revealed no smoking CP was developed. During an interview on 01/09/2020 at 10:20 AM, Staff C indicated a smoking CP should have been, but was not developed. A Has an advanced directive: POLST form activated CP, revised 01/05/20, stated, Advanced directives will be followed. However, record review revealed no advanced directives were in the resident's record. During an interview on 01/09/20 at 10:20 AM, when asked if a POLST form was an advanced directive Staff C stated, No. When asked if the resident had actually formulated an advanced directive Staff C stated, No and acknowledged the CP was inaccurate. Additionally, when asked what components made up a CP Staff C stated, Problem, goal, and interventions. When asked if there were any interventions for Resident #48's advanced directive CP Staff C stated, No. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Similar findings were noted for the Resident preference/quality of life CP, revised 01/05/20, in which no interventions were developed. A Limited physical mobility r/t [related to] LLE [Left Lower Extremity] amputation CP, revised 01/05/20, stated, Is able to propel wheelchair independently. The next intervention stated, Totally dependent on staff to for ambulation/locomotion in wheelchair. During an interview on 01/09/2020 at 10:20 AM, Staff C acknowledged that the two entries were contradictory and stated that the intervention that stated the resident was dependent for wheelchair mobility was inaccurate. Additionally, the CP did not identify what was amputated on Resident #48's LLE (e.g. toes, below knee amputation, or above knee amputation), or identify that the resident was required to wear a shrinker on his stump, prior to obtaining a prosthesis. During an interview on 01/09/20 at 10:20 AM, when asked if the CP should have identified the resident had a below knee amputation and required the use of a shrinker Staff C stated, Yes and acknowledged it did not. A Has amputation of LLE CP, revised 01/05/20, directed staff to Monitor for bleeding. Document amount of bloody drainage on [the] dressing and in the drainage system. During an interview on 01/09/20 at 10:20 AM, when asked what type of drainage system Resident #48 had, Staff C stated, He did not have a drainage system and indicated the CP was inaccurate. Review of Resident #48's January 2020 Physician's Orders (PO) showed Resident #48 was receiving Xarelto (an anticoagulant). Review of the comprehensive CP revealed no anticoagulant CP was developed. During an interview on 01/09/20 at 10:20 AM, Staff C indicated that if a resident received anticoagulant therapy, there should be a CP in place. Staff C acknowledged that Resident #48 did not, but should have a CP which addressed the anticoagulant use. According to the January 2020 PO's Resident #48 received Buspar (an anxiolytic), Abilify (an antipsychotic) and Venlafaxine (an antidepressant). Review of the psychotropic CP's revealed there was no direction to staff to obtain monthly postural blood pressures (BPs). In an interview on 01/09/2020 at 10:47 AM, Staff B stated that residents on psychotropic medications should have monthly postural BPs performed and acknowledged no such CP existed for Resident #48. RESIDENT #55 Record review showed a CP problem of, Alteration in neurological status rt [related to], but did not indicate what the neurological problem was related to. Additionally, there were no interventions developed for the identified problem. During an interview on 01/13/20 at 12:05 PM, Staff C indicated the resident's neurological problem was related to a stroke. When asked if the stroke should have been and interventions developed CP'd Staff C stated, yes and acknowledged that did not occur. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Has colonized MRSA [Methicillin resistant staphylococcus Aureus], revised 08/31/19, failed to identify the location/part of the body that was colonized. During an interview on 01/13/20 at 12:05 PM, Staff C indicated the location of the MRSA should have been identified on the CP, but was not. According to a Nutrition risk . CP, revised 10/09/19, the goal was listed as Weight will maintain/return to baseline range .dry goal wt (weight) 165 lbs [pounds] . Record review showed on 01/11/20, Resident #55's weight was 154 lbs. During an interview on 01/15/19 at 8:17 AM, when asked if Resident #55's dialysis goal wt/dry wt had changed, Staff C called dialysis and stated, Yes, it is 70 kilograms [154 lbs]. When asked if the Nutrition risk . CP was accurate listing the resident's goal wt as 165 lbs Staff C stated, No, it needs to be updated. A Has UTI [urinary tract infection] . CP, revised 12/08/19, indicated the resident had a UTI. Record review showed the resident was not being treated with any antibiotics. During an interview on 01/13/20 at 12:05 PM, when asked if the CP was accurate Staff C stated, No, it needs to be updated. A Resident preferences/quality of life CP, revised 10/24/19, had a listed goal of Resident will verbalize any changes to current preferences and choices during stay at the center. The CP did not have any interventions listed. During an interview on 01/13/20 at 12:05 PM, Staff C stated, Yes, the CP should have interventions and acknowledged it did not. RESIDENT #73 According to a Has behavior problem . CP, revised 12/27/19, a goal was listed as Will have no evidence of behavior problems [such as] .not following directives of medical staff .lack of willingness to transfer to a respite facility by review date. During an interview on 01/15/20 at 11:51 AM, when asked if Resident #73 had the right not to not follow directives of medical staff and to decline to transfer to a respite. Staff B, Director of Nursing, stated, Yes and indicated the goals were Not appropriate. RESIDENT #49 An Impaired cognitive function/dementia . CP, revised 12/17/19, had a listed goal of Needs will be anticipated by staff 100% of the time. During an interview on 01/15/2020 08:27 AM, when asked if anticipating the resident's 100% of the time was a realistic/attainable goal Staff C stated, No. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 09/26/19 Admission Minimum Data Set (MDS, an assessment tool), the resident had obvious or likely cavity or broken teeth. Review of the Oral /Dental health . CP, showed the resident was identified as having missing teeth. There was no mention of the obvious or likely cavities or broken teeth. In an interview on 01/10/19 at 10:28 AM, when asked if the MDS identified the resident had obvious or likely cavities or broken teeth, should that be on the CP Staff F, MDS Coordinator stated, Yes and acknowledged it was not. 40303 RESIDENT #8 According to the Admission (10/11/19) MDS, Resident #8 had multiple medically complex diagnoses and had care needs related to multiple sclerosis and chronic pain. Observations on 01/05/20 at 9:02 AM and 01/08/20 at 11:51 AM, revealed Resident #8 lying in bed, both feet appeared swollen. Resident #8 indicated her legs are swollen, and painful sometimes. Review of Resident #8's Comprehensive CP, revealed no indication the resident had edema and no instructions to the staff on how to care for the edema. During an observation and interview on 01/09/20 at 11:10 AM, Staff U, LPN confirmed the resident had pitting edema and there was no care plan in place for caring Resident #8's edema. Interview on 01/09/20 at 12:55 PM Staff G, LPN acknowledged Resident #8's care plan did not, but should address the resident's edema. REFERENCE: WAC 388-97-1020(1).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32898 Based on interview and record review the facility failed to review and revise care plans for 11 (#s 71, 18, 47, 30, 49, 48, 29, 55, 73, 35, & 281) of 21 residents reviewed for care plan revisions. The failure to review and revise care plans by the interdisciplinary team after each assessment placed the residents at risk for unmet care needs, and a diminished quality of life. Findings included . RESIDENT #71 A review of the resident's CP (Care Plan) dated 08/10/17 showed the resident had Activity Intolerance related to confusion/impaired cognition. In an interview on 01/09/20 at 2:20 PM, Staff B (Registered Nurse-Director Of Nursing) stated that Resident #71 did not have impaired cognition and wasn't confused. Staff B, said, the CP dated 08/10/17 should've been updated to reflect the resident current level of function, as the resident was capable of making his needs known and frequently went out into the community independently to visit family and friends. During the same interview Staff E, (Licensed Practical Nurse - LPN) said, the care plan will have to be updated to reflect the use of hearing aides and glasses, since the resident recently was issued bilateral hearing aides on 11/21/19. Also, the resident currently wears glasses. RESIDENT #18 According to CP dated 09/02/19, Resident #18 was identified as, At risk for elopement related to impaired cognition and diagnosis of dementia. In an interview on 01/09/20 at 11:26 AM, Staff G, LPN, stated that Resident #18 wasn't at risk for elopement. Staff G acknowledged the CP should've been updated to reflect the resident was no longer at risk of eloping. RESIDENT #47 A review of the 11/05/19, At risk for elopement r/t [related to] Desire to return Home CP revealed staff failed to include individualized goals and interventions. The interventions included: provide structured activiites: toileting walking inside and outside with supervision. Wander Alert (Specify: device, number, model.) No other information was provided. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/06/20 at 9:30 AM, Resident #47 said, I have an alarm on my chair to keep me from going outside .The staff are supposed to take me outside to walk around in the parking lot, but that never happens. They either forget or they say they're to busy to take me out. RESIDENT #30 Record review showed a oral dental health problem -irritated gums CP revised on 12/02/19. In a interview on 01/09/19 at 10:20 AM. Staff E (LPN) was asked if the rersident still had gum irritation. Staff E replied it's hard to say, she often refuses oral care or allows us to look in her mouth. Staff E, when asked if refusals of oral care was care planed, stated, I'm assuming not. We'll have to update the CP. 37044 RESIDENT #49 According to the 12/04/19 Admission Minimum Data Set (MDS, an assessment tool), the resident had no natural teeth. According to the 12/06/19 Care Area Assessment (CAA), the resident had no natural teeth and the family was to bring in the resident's dentures. During an interview on 01/05/2020 12:52 PM, Resident #49 was observed without any dentures. Resident #49 stated, My dentures are in the top drawer, they're not in because I need to clean them but I don't have any denture cleaning supplies, so I won't wear them like that, it leaves a rotten taste in my mouth. Review of Resident #49's comprehensive care plan (CP) revealed no indication the resident had upper/lower dentures, and gave no instruction to staff as to when or how to clean them. During an interview on 01/15/2020 08:27 AM, when asked if Resident #49's dentures should be care planned Staff C, Assistant Director of Nursing, stated, Yes. When asked if they were CP'd Staff C stated, No. RESIDENT #48 According to the 12/04/19 Admission MDS, the resident had no infections to the feet. Review of Resident #48's comprehensive care plan (CP) revealed an 11/29/19 Has acute osteomyelitis of left foot CP, revised. Record review showed the resident had osteomyelitis in the left foot on his prior stay, but the foot had since been amputated. During an interview on 01/09/2020 at 10:20 AM, when asked if the resident still had acute osteomyelitis Staff C, Assistant Director of Nursing, stated, No and indicated the CP needed to be revised/updated. RESIDENT #29 (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	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 11/29/19 5 day MDS, the resident had adequate vision and utilized corrective lenses. Prior MDS assessments indicated the resident did not use corrective lenses. Review of the Resident's comprehensive CP revealed, no visual function CP was developed, and there was no indication the resident required the use of glasses. During an interview on 01/15/19 at 9:19 AM, when asked if Resident #29's CP should reflect the resident requires corrective lenses/glasses Staff C stated, Yes and indicated the CP needed to be updated/revised. RESIDENT #55 According to the 12/12/19 Quarterly MDS, the resident did not have a diagnosis of anxiety, and did not receive any antianxiety medication. A Uses anti-anxiety medications hydroxyzine r/t [related to] anxiety disorder CP, revised 10/14/19, directed staff to administer anti-anxiety medication as ordered by the physician. Review of the Medication Administration Record for January 2020 and December 2019 showed the resident did not have an order for any anti-anxiety medications. During an interview on 01/15/19 at 9:19 AM, Staff C indicated the resident used to receive hydroxyzine for anxiety but it had been discontinued. When asked if the CP was inaccurate Staff C stated, Yes, it needs to be updated. According to the 12/12/19 Quarterly MDS, the resident had no ulcer, wounds or skin problems to the foot. A Has abrasion great [to the] great toe CP, initiated 08/02/19, had a goal of abrasion will show signs of healing and remain free of infection. No interventions were listed. During an interview on 01/15/19 at 9:19 AM, when asked if the CP was accurate Staff C stated, No, it needs to be updated. RESIDENT #73 A 20 day order for antibiotics for R[ight] foot infection CP, initiated 07/20/19, indicated the resident was receiving antibiotics. Record review revealed the resident's 20 day antibiotics were completed on 08/08/19. During an interview on 01/09/2020 at 10:20 AM, when asked if the CP was accurate Staff C stated, No and indicated it should have been updated. 40303 RESIDENT #281 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #281 was admitted to the facility on [DATE] with medically complex diagnoses, including gangrene, diabetes, and chronic kidney disease which required dialysis. Review of January 2020 Medication Administration Record revealed Resident #281 received Lasix 40 milligrams (diuretic medication) daily for hypertension. Record review revealed no CP with goals or intervention regarding the resident's diuretic medication. RESIDENT #35 According to the 11/19/19 Quarterly MDS, Resident#35 was cognitively intact, understood by others and able to understand conversation. Review of January 2020 MAR revealed resident was receiving Lasix 20 milligrams (diuretic medication) 1 tablet every morning for edema. Record review revealed no CPs with goals or intervention regarding the resident's diuretic medication In an interview on 01/10/19 at 11:25 AM, Staff G confirmed there was no CP which addressed the Resident's #281 and #35 diuretic medications and the CP should be updated. In an interview on 01/10/20 at 11:25 AM, Staff B, Director of Nursing, confirmed Resident #281 and #35 did not have care plans which reflected care needs related to diuretic management and that nurses are responsible to update residents' care plans to reflect current care status. REFERENCE: WAC 388-97-1020(5)(b).

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264 Based on observation, interview and record review, the facility failed to ensure services provided met professional standards of practice for 12 (#s 73, 39, 71, 30, 18, 83, 29, 47, 33, 48, 49, & 55) of 21 residents reviewed. Nursing staff failed to obtain, follow or clarify physicians orders (PO) when indicated for (#s 73, 39, 71, 30, 18, 83, 29, 48), document for only those tasks completed for resident (#s 48, 49, 55 & 30) and forward consulting practitioners' recommendations to the Primary Care Physician (PCP) for approval for (#s 73 & 29), and ensure site rotations for injections for one (#71) resident reviewed. These failures placed residents at risk for medication errors, delayed treatment, adverse outcomes, and resulted in harm to Resident #73, for whom nursing staff initiated invasive procedures without physician orders. Findings included . REFER to: CFR 483.45(d)(1)(5), F-757, Drug Regimen is Free From Unnecessary Drugs CFR 483.45(d)(F)(1), F-759, Free of Medication Error Rates of 5% or More CFR 483.45(f)(2), F-760, Free of Significant Medication Errors FAILURE TO OBTAIN/CLARIFY/IMPLEMENT PHYSICIAN ORDERS RESIDENT #73 Record review revealed nurses notes dated 12/17/19 at 11:05 PM which showed, .Midline [a specialized intravenous access line inserted in the antecubital [forearm] area with the tip advanced at or below the axillary vein] placed to left [arm], will start abo [antibiotic] at 11:00 PM. Record review showed no Physician Order or direction in the record for nursing staff to initiate a Midline or to initiate antibiotics to Resident #73 on 12/17/19. Progress notes dated 12/20/19 at 10:41 PM showed, Resident c/o [complained of] pain to left bicep at midline site. Area red, warm to touch and tender. Called on call MD [Medical Doctor], got an order to obtain a Doppler [ultrasound] and call IV [Intravenous] nurse to switch midline to right arm . A provider note dated 12/21/19 at 8:15 PM showed, .yesterday patient's IV site infiltrated to left arm and at that time was presenting with redness, swelling and tenderness to touch .Doppler to be completed to rule out blood [clot]. On 12/24/19 at 8:30 PM the provider documented, [Resident #73] is being seen today for follow-up on Doppler ultrasound to left upper extremity status post midline infiltration .Ultrasound results reviewed by me today with conflicting results. Preliminary result shows positive for thrombus [blood clot] of left cephalic vein, however, final result concludes with no DVT [deep vein thrombosis]. Mobile ultrasound services was contacted. Ultrasound tech[nician] agrees with conflicting results. On 12/22/19 the results of an additional ultrasound concluded there was no DVT, but, There is thrombus in the superficial cephalic vein. (continued on next page)

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	505195	A. Building B. Wing	01/16/2020

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F 0658 Level of Harm - Actual harm Residents Affected - Few	In a 12/27/19 at 12:22 AM progress note, Resident #73's provider documented concerns stating, I contacted patient's wound care clinic requesting them to fax over patient's report from his recent visit that was on the 26th of Dec[[NAME]], since reports from the last visit on [DATE]th as well as his recent visit was not available for me to review and that the staff at facility was unable to provide me with any report from resident's last and recent visit to wound care clinic . Upon reviewing the patient's results which was [sic] faxed to me by the wound care clinic, there was no indication of [the] patient being on IV antibiotics .[in a telephone call] wound care provider stated she did not start the patient on IV antibiotics on 12/17/19 .The order for IV antibiotics was entered by facility staff on the 17th of December without my knowledge . Review of the facility's December 2019 incident log showed a 12/30/19 entry for a medication error involving Resident #73. According to the 12/27/19 investigative document under the heading Description: Medication error [was] noted regarding resident rx [prescription] of Cefazolin [an antibiotic] .Review of the 12/17/19 AVS [after visit summary - a brief summary of what occurred at the visit, frequently given to patients] showed under Instructions the doctor documented no instruction to start IV Cefazolin for an infection. The 12/27/19 Medication Error investigation concluded that Staff C, Licensed Practical Nurse - LPN, Assistant Director of Nursing, Mistakenly saw an order for ABO [antibiotics], which resulted in Resident #73 receiving 28 doses of IV Cefazolin without an order. According to the investigation, There is significant risk for harm as resident was treated with ABO and no apparent infection . During an interview on 01/09/20 at 12:44 PM, Staff B, Director of Nursing, confirmed there were no instructions to nursing staff to initiate a Midline access IV or administer IV Cefazolin for Resident #73. Staff B indicated the nurse who implemented these interventions mistakenly entered orders from an outdated medication list which referenced a course of IV Cefazolin that was discontinued on 08/08/19, greater than four months prior. The nurse's decision to initiate IV antibiotics without an order, resulted in Resident #73 undergoing two unnecessary invasive procedures (Midline placements), which infiltrated causing pain, redness, and swelling to Resident #73's left arm, and ultimately resulted in a cephalic vein blood clot. These multiple failures to follow nursing professional standards of practice, resulted in harm to Resident #73. RESIDENT #39 Observation during medication pass on 01/05/20 10:21 AM showed Staff P, LPN, prepare medications to administer to Resident #39. Upon review of the Physician Orders (POs) Staff P indicated she should administer Vitamin B12 extended release 1000 mcg (micrograms) and retrieved two different bottles of vitamin B12 from the medication cart, neither of which were in the form of extended release. Staff P looked at the bottles stating, it does not say extended release. Review of the December 2019 and January 2020 Medication Administration Records (MAR) showed nursing staff consistently signed that the extended release form of the Vitamin B12 was administered each day. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	In an interview on 01/05/20 at 10:38 AM, Staff U, Central Supply Clerk, stated that Vitamin B12 was a house supply medication which she ordered. When asked to supply any documentation to support Vitamin B12 was ever ordered in the extended release form, Staff U indicated she had never ordered any ER form of Vitamin B12 and stated, I do not believe I can get extended release. In an interview on 01/05/19 at 10:44 AM, Staff E, LPN, indicated nursing staff should have identified the ER version of the Vitamin B12 was not available and clarified the order to reflect the medication which was being administered. 32898 A review of the November 2019 PO's revealed an order dated 11/02/19, Tamiflu (Oseltamivir Phosphate) give 75 mg (milligrams) by mouth in the evening for Flu prophylaxis (prevention) for seven days. A review of November 2019 MARs showed Resident #'s 71, 30, 18, 47 and 83 had orders for Tamiflu. According to the documentation on the resident's MAR, the residents received their first dose on 11/03/19 at 6:00 PM, with the last dose administered on 11/08/19 at 6:00 PM, indicating staff administered the medication for six days rather than seven days for which it was ordered. In an interview on 01/08/19 at 2:06 PM, Staff G (Licensed Practical Nurse) was asked if the resident's received the medication for seven days as ordered . Staff G replied, based on the documentation, it looks like they only received the medication for 6 of the 7 days. Staff G said, we received the PO's on November 2nd, 2019, However, we didn't get the medication from the pharmacy until November 3rd, 2019. Therefore, first dose was administered. until 11//03/19. Staff G said, I guess we should have notified the provider that there had been a delay in starting the medication and extended the stop date to ensure the residents received the medication for the full 7 days. RESIDENT #73 Additionally, review of Resident #73's December 2019 Medication Administration Record (MAR) showed orders for oxycodone 15 mg (milligrams) as needed (PRN) for pain 7-10, and oxycodone 10 mg PRN for pain level 4-6. According to the MAR on 12/07/19 at 1:23 AM, 12/08/19 at 9:05 AM, 12/15/19 at 11:23 PM, 12/20/19 at 12:18 PM, and 12/21/19 at 11:53 AM, the resident reported a pain level of 6, and nursing administered 15 mg of oxycodone, instead of the 10 mg that was ordered. During an interview on 01/15/2020 at 8:03 AM, Staff C acknowledged on the above occasions the resident should have received 10 mg of oxycodone instead of 15mg. When asked if nursing followed the Physicians Order (PO) Staff C stated, No. 37044 RESIDENT #29 Record review showed a 12/26/19 PO for a complete blood count (CBC), comprehensive metabolic panel (CMP), and a wound culture of a boil to the resident's right breast which, has burst open on its own and is draining pus. The resident was also started on Bactrim DS (an antibiotic) for five days. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Review of the December 2019 MAR showed direction to staff to obtain, CBC, CMP and wound culture one time only for right breast abscess.12/26/19 and 12/27/19 had blanks where the nurses were to sign. Record review revealed no results were present for the CBC, CMP, or wound culture. During an interview on 01/13/19 at 9:09 AM, when asked where the results for the CBC, CMP, and wound culture were Staff D, Assistant Director of Nursing, looked in the lab book and indicated there was no lab slip in the book for the ordered labs. Staff D then called the lab and stated that the lab had no record of the labs or culture. When asked whose responsibility it was to ensure the lab requisition was completed, and that the labs were drawn and the culture obtained as ordered Staff D stated, Nursing and acknowledged nursing failed to carry out the physicians order. A 12/23/19 dental hygienist consult stated SDF [Silver Diamine Fluoride] applied today to arrest lesions, applied to all lesions and crown margins. and recommended Patient brushing own teeth 2x/day with ACT fluoride rinse. The consult was noted by Staff C. Review of Resident #29's January 2020 MAR and Treatment Administration Record (TAR) revealed no direction to staff to ensure Resident #29 rinsed her mouth with ACT fluoride rinse twice daily after brushing. There was a order on the MAR for the resident to swish and spit twice daily with Chlorhexadine solution, a germicidal mouth wash that decreases bacteria. During an interview on 01/15/2020 at 8:42 AM, when asked why the recommendation to use ACT fluoride rinse after brushing was not implemented Staff C, who noted the consult, stated, No, she has a different mouthwash Chlorhexadine .she uses that. After discussing that Chlorhexadine was a germicidal mouth wash and ACT was a fluoride rinse, and the dental hygienist treated the residents lesions with SDF and then recommended Act fluoride rinse, Staff C was asked if the two rinses were equivalent and served the same purpose to which Staff C stated, No. Staff C then acknowledged the hygienists recommendation for ACT should have been forwarded to the MD for approval. When asked if there was any indication that occurred Staff C stated, No. RESIDENT #33 Resident #33 admitted to the facility on [DATE]. In an interview on 01/06/20 at 2:38 PM, when asked if he had a Urinary Tract Infection (UTI) while in the facility, Resident #33 stated yes. I'm mad about it because I still have the problem. When asked to clarify the problem, resident #33 replied It stings when I urinate. Record review showed that following a Urinalysis report dated 11/12/19 with a handwritten note of, Kidney stones, urology appoint[ment]. This report was noted by Staff H, RN on 11/13/19. Progress notes written by Staff H dated 11/13/19 showed, Called .Urology r/t [related to] insurance issue faxed referral noted . The progress notes showed no further follow up on the Urology referral and record review showed no indication the resident was seen by a Urologist. Staff H was interviewed on 01/09/20 at 12:36 PM, 49 days after the last progress note regarding the referral. Staff H confirmed that no urology appointment was scheduled. NURSES SIGNING FOR TASKS NOT COMPLETED (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	RESIDENT #48 Review of the December 2019 MAR showed an order to obtain a CBC and CMP. It was signed off as completed on 12/03/19. However, record review showed no indication a CBC or CMP were drawn on 12/03/19. A CBC and CMP were drawn on 12/09/19. In an interview on 01/09/2020 at 11:25 AM, Staff C explained the purpose for putting labs on the MAR was so nurses could verify the labs were drawn as ordered, and then sign off. When asked if the nurse that signed of on the CBC and CMP on 12/03/19 was signing that she verified the lab was drawn Staff C stated, Yes. When asked if Resident #48's labs were drawn on 12/03/19 as the nurse signed for Staff C stated, No and acknowledged they were not drawn until 12/09/19. When asked if the nurse signed for a task she did not complete Staff C stated, Yes. Review of the November and December 2019 MARs showed Resident #48 had orders for: oxycodone 10 mg PRN for pain level of 4-6, and oxycodone 15 mg PRN for pain level of 7-10, on a scale to 10. According to the MARs on 11/28/19 at 6:54 AM the resident reported a pain level of 6, and was medicated with 15 mg of oxycodone instead of 10 mg as ordered. On 12/01/19 the resident reported a pain level of 8 and was medicated with 10 mg of oxycodone instead of 15 mg as ordered. During an interview on 01/09/2020 at 11:25 AM, Staff acknowledged Resident #48 was administered the wrong dose of oxycodone on the above occasions. When asked if nurses followed the Physician's order Staff C stated, No. RESIDENT #49 On 01/05/19 at 1:01 PM, Resident #49 was observed with long untrimmed nails, with dark brown debris noted under the nails. When asked if staff trimmed his nails weekly Resident #49 stated, No, they need cut. When asked about his toenails the resident indicated they get cut every month or so. The toenails were not observed at this time. On 01/13/19 at 11:29 AM Resident #49 was again observed with long untrimmed nails with brown debris noted under the nails, observations of his toenails revealed they were long untrimmed with the great toenails [NAME] medially. On 01/13/19 at 1:08 PM Staff C was present in Resident #49's room. When asked to describe the residents fingernails Staff C stated, They look long. At which time the resident called out They are long, I don't like them long they need cut. When asked if she saw anything under his nails Staff C stated, dark debris. When observing Resident #49's toenails Staff C stated, They need clipped. When asked if it appeared either the toenails or fingernails had been trimmed in the last several weeks Staff C stated, It does not appear they have been cut recently, no. Review of the January 2020 TAR showed direction to staff with the weekly skin check to every Sat[urday] trim finger and toenails. According to the TAR nurses signed that this was completed on 01/04/2020 and 01/011/19. When asked if it appeared that the nail care had been done Staff C stated, no. and acknowledged nurses signed for tasks they did not complete (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Review of the January 2020 TAR showed direction to staff to Monitor tube site to include marking of the tube. The tube will be marked with a black line at insertion upon admission and verified with each medication/tube feeding administration . Observation of Resident #49's gastric tube on 01/09/19 at 8:11 AM and 01/13/19 at 11:29 AM, revealed there was no black line on the tube (which staff used to verify placement/ensure no migration). According to the January 2020 TAR, staff signed off three times daily that they verified the black line at the insertion site. During an observation/interview on 01/13/19 at 1:13 PM, when asked if there was a black line on the gastric tube at the insertion site Staff C stated, No. After reviewing the January TAR where staff were signing off that they verified the black line Staff C acknowledged nurses were signing for a task they did not complete/perform. Review of the January 2020 TAR showed direction to staff to change tube feeding syringe and tubing every 24 hours. This task was signed of on 01/13/19 at 12:06 AM. Observation on 01/13/19 at 1:13 PM showed a opened 60 cc syringe dated 01/12/2020. Another undated, unopened syringe was next to it. This was validated by Staff C who was present in the room. When asked why it was necessary to change the syringe every 24 hours Staff C indicated it was for infection control purposes. Review of the January 2020 MAR showed the resident had already received his morning bolus tube feeding. When asked if it was reasonable to conclude that the nurse used the syringe from the prior day to administer the bolus feed Staff C stated, yes, as the undated syringe was still sealed. Staff C indicated the nurse should have checked the date on the syringe prior to using it. RESIDENT #55 Review of the December 2019 and January 2020 TAR revealed direction to staff to check the bruit/thrill to the right chest every daily. According to the TARs staff are signing off that they verified the bruit/thrill. Observation revealed the resident had a triple lumen Central Venous Catheter (CVC) to the right chest. CVCs do not have a bruit/thrill. According to Resident #55's record she has a fistula to the left arm. During an interview on 01/13/2020 at 11:59 AM, when asked if a CVC had a bruit/thrill Staff C stated, No. Staff C acknowledged that nurses were signing for a task that could not have been completed. When asked if a nurse should have identified that the order was inaccurate Staff C stated, Yes. RESIDENT #30 (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	A review Resident #30's January TAR (treatment administration record) revealed staff signed they provided nail care on 01/07/20. On 01/09/20 at 11:20 AM, Staff E observed the resident's finger nails and acknowledged the residents fingernails on her left hand were long and jagged and untrimmed and indicated it did not appear staff provided the nail care that was documented as completed. 40303 MEDICATION PASS During a medication pass observation on 01/13/20 at 1:56 PM, Staff U Licensed Practical Nurse, administered five of ten medications to Resident #49 that were scheduled to be administered between 8:00 AM-11:00AM. Review of January 2020 Medication Administration Records (MAR) showed staff U administered partial medication and three hours after the allotted time frame. During an interview on 01/08/20 at 11:55 AM, Staff U, LPN, confirmed that she administered partial medication to Resident #49 and did not provide medication as scheduled. During an interview on 01/15/20 at 10:30 AM, Staff B, Director of Nursing Services confirmed that Staff U, LPN did not follow physician orders to administer partial medication. All medication were to be administered the same time not partial. 42203 SITE ROTATION RESIDENT #71 According to the January 2020 PO's, Resident #71 had Physician Orders dated 02/13/19 for Levemir insulin, inject 10 units daily at 6:00 AM. Also, there were additional orders for Levemir 8 units daily at 6:00 PM. A review of the November 2019 Location of Administration Report revealed over the period of three days Resident #71 received three injections in the left arm. On 11/26, 11/27 and 11/28/19 staff documented three injections in the Arm-left. In an interview on 01/09/20 at 2:24 PM, with Staff C said, The expectation was that nurses would rotate injection sites with each injection. Failure to consistently rotate sites of injection placed the resident at risk for pain at the injection site and alteration in the rate of absorption REFERENCE: WAC 388-97-1620 (2)(b)(i)(ii).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 32898 Based on observation, interview and record review the facility failed to provide assistance with Activities of Daily Living (ADLs), related to cleanliness and grooming for four (#s 18, 65, 35 & 50) of nine sample and two (#s 51 & 49) supplemental residents reviewed for ADLs. Facility failure to provide care to residents who were dependent on staff for assistance, placed residents at risk for poor hygiene, embarrassment and diminished quality of life. Findings included . Refer to CFR: 483.21(b)(2)(i)(iii), F - 657, Care Plan Timing and Revision RESIDENT #18 According the Significant Change MDS (Minimum Data Set- an assessment tool) dated 10/30/19, Resident #18 required extensive assistance with hygiene. During initial rounds on 01/05/20 at 9:00 AM, Resident #18 was observed lying in bed wearing a hospital type gown, with short tightly curled that jutted straight up on the top of her head and was flat and back matted. Similar observations were noted on 01/06/20 at 2:24 PM when the resident was observed with hair jutted straight up and flat in the back tightly curled (matted). On 01/08/20 at 10:14 AM the resident's daughter said,They used to braid her hair, but they were braiding it too tight, I asked them not to braid it anymore. I asked them to pick it out into an afro. However, since I told them not to braid her hair anymore, they've stopped combing it altogether. RESIDENT #65 According to the 12/19/19 Admission MDS, Resident #65 required extensive two person assistance with personal hygiene. On 01/05/20 at 9:30 AM. Resident #65 was observe lying in bed with a small pony tail jutted on the side of her head. Resident #65 was asked at this time if she had received assistance with her personal hygiene she replied, No, I want someone to comb my hair and take this ponytail from off the top of my head and is there any way you can get someone to put some lotion on my skin? The resident threw the blanket back to expose her lower legs which appeared dry and scaly, stating, I think I came here the first part of December . I am suppose to get showered twice a week and my skin is dry, I'd like them to put lotion put on my legs and back. A review of the Resident's 12/11/19 ADL-Self care Performance Deficit related to CHF(Congested Heart Failure) Care Plan (CP) showed, Bathing resident requires Maximum level of assistance with bathing and hygiene 2 x and as necessary. Documentation on the Bath report revealed the resident received baths on 12/28/19 and 01/07/20. (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	01/16/2020

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 01/13/20 at 8:26 AM, Staff A, Administrator, acknowledged Resident #'s 18 hair was jutted straight up on the top of her head and was in need of combing. Staff A said that since the resident's hair was so matted, she spoke with the Resident #18's daughter and they've requested to have the resident's hair cut, however, the resident's daughter hadn't responded to the request. Staff A said, I'll follow up with the staff regarding the importance of addressing Resident #65's hair and dry skin. RESIDENT #35 According to the 11/19/19 Quarterly MDS, Resident#35 was cognitively intact, understood by others and able to understand conversation. A CP titled, Self-care Deficit, revised 03/14/17, showed, Assist to choose simple comfortable clothing that maximize ability to dress self. Observations on 01/05/20 at 10:10 AM, 01/06/20 at 10:50 AM, 01/07/20 at 12:10 PM, and 01/08/20 at 11:51 AM, showed Resident #35 lying in bed, wearing a hospital gown. On 01/08/20 at 11:51 AM, a dirty lower denture was noted at the bedside. In an interview at this time, Resident#35 indicated she has clothes but staff don't help her. When asked about her denture, Resident#35 stated I have a denture cup but don't know where it went. Interview on 01/08/20 at 1:50 PM, Staff M, Certified Nursing Assistant - CNA, acknowledged Resident #35 had personal clothes but was not offered assistance to dress in her personal clothing, instead was dressed on hospital gown. When asked about the resident's denture on the table, Staff M indicated, Resident #35 was unable to find Resident #35's denture cup and proceeded to obtain a new one. On 01/13/19 at 9:26 AM, Staff B, Director of Nursing, indicated the nurses and nursing assistants are responsible to provide grooming and dressing. Nurses should follow up with any resident refusals. RESIDENT #50 During an interview on 01/05/20 at 1:20 PM, Resident #50 expressed he wasn't receiving showers as frequently as he should. Review of the resident's care plan confirmed that Resident #50 is assessed to require a 1-person assist with bathing, with a frequency of 2x/week and as necessary. Review of Resident #50's bathing chart revealed that Resident #50 went seven days without a shower from 10/7/19-10/14/19, and seven days from 12/30/19-01/06/20. Resident #50 went six days without a shower from 11/15/19-11/21/19, and also six days from 12/13/19-12/19/19. There was no documentation of any refusal of care over any of these periods. When asked in an interview at 10:11 AM on 01/15/20 how lack of bathing affected his appearance, Resident #50 replied, I mean, I could smell myself. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted on 01/13/20 at 12:40 PM, when asked if Resident #50 received bathing assistance as assessed, Staff C, Assistant Director Of Nursing (ADON) stated, he is not. 37044 RESIDENT #51 According to the 11/19/19 Quarterly MDS, the resident had a diagnosis of paraplegia, was cognitively intact, and was totally dependant on staff for bathing. In an interview on 01/05/20 at 1:09 PM, when asked if he received the assistance he needed with bathing, Resident #51 stated, Oh geez no, I haven't had a bed bath in three weeks, they don't have enough staff here, it is really bad, one time it was closer to five weeks .I am supposed to get two a week. According to the ADL (Activities of Daily Living) . care plan (CP), revised 12/10/19, Resident #51 Requires total assistance with bathing/showering 2x/week and as necessary. Review of the bathing flowsheets for October, November and December 2019 showed the following: from 10/04/19 through 10/28/19 (25 days) no shower was given, with only one refusal documented on 10/17/19; from 11/20/19 through 12/05/19 (16 days) no shower was provided, with only one refusal documented on 10/21/19; from 12/11/19 through 12/16/19 (six days) no shower was offered; and from 12/18/19 through 12/23/19 (six days) no shower was offered. During an interview 01/08/2020 at 8:48 AM, when asked how it made him feel when he went extended periods without a shower Resident #51 stated, Pretty dirty, I could smell my armpits, I warned people not to get too close. During an interview on 01/08/2020 at 9:51 AM, Staff G, Resident Care Manager, reviewed the bathing flowsheets, acknowledged Resident #51 was dependant on staff for bathing, and staff failed to consistently provide bathing to the resident, who on one occasion went 25 days without being bathed. RESIDENT #49 According to the 12/04/19 Admission MDS, the resident required extensive assistance with activities of daily living and hygiene, and had no natural teeth. The 12/06/19 Care Area Assessment (CAA) stated that the resident's family was to bring in the resident's dentures. During an interview on 01/05/20 at 12:52 PM, Resident #49 was observed without his dentures. When asked where his dentures were, Resident #49 stated, My dentures are in the top drawer, they're not in because I need to clean them, they (family) brought them back about three weeks ago, but I don't have any denture cleaning supplies, so I won't wear them like that, it leaves a rotten taste in my mouth . Observation at that time, showed a denture cup in the residents top drawer, containing top and bottom dentures. (continued on next page)

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	505195	A. Building B. Wing	01/16/2020

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation/interview on 01/07/20 at 1:38 PM, Resident #49 was again noted without his dentures in. When asked if staff were cleaning his dentures daily, Resident #49 stated, No, not even once, that is why I don't wear them, they taste bad .there aren't any tabs [denture cleaning tablets] or I'd try to do it myself. The dentures were again observed in the top drawer, in a dry denture cup. On 01/15/19 at 8:26 AM, Resident #49 was observed eating breakfast without his dentures in and stated, No, I haven't worn them in about a month because they need to be soaked and cleaned, they taste bad, I don't have any way to clean them, I would like to start wearing them again. Review of Resident #49's comprehensive CP, revealed no indication the resident had upper/lower dentures, and gave no instruction to staff as to when or how to clean them. During an interview on 01/13/20 at 2:20 PM, when asked how a CNA would know to clean a resident's dentures Staff C stated, It would be on the care plan. Staff C then acknowledged Resident #49 did not have a dental care plan, but indicated the direct care staff were probably aware they needed to clean the resident's dentures. On 01/13/20 between 2:23 PM and 2:27 PM, the four direct care staff members on Resident #49's hall were interviewed related Resident #49's dentition/oral care needs, with the following responses: Staff II, CNA, stated, I think he has his own [natural] teeth.; Staff JJ, CNA, stated, Yes, he has his own natural teeth.; Staff U, LPN, stated, I believe he has his own [natural teeth].; and Staff N, CNA, stated, He has dentures but doesn't wear them .maybe they hurt. When queried whether he had ever asked Resident #49 why he didn't where his dentures Staff N stated, I can't remember. The fact that three of four direct care staff were unaware that the resident had dentures and required assistance cleaning them, supported Resident #49's claim, and surveyor observations, that staff were not assisting with oral/denture care. During an interview on 01/13/20 at 2:29 PM, when asked if there was any indication staff were cleaning Resident #49's dentures and providing oral care Staff C stated, No. Additionally, on 01/05/19 at 1:01 PM, Resident #49 was observed with long untrimmed fingernails, with dark brown debris noted under them. When asked if staff trimmed his nails weekly Resident #49 stated, No .they need cut. Review of the January 2020 Treatment Administration Record (TAR) showed direction to staff to every Sat[urday] trim finger and toenails. According to the TAR nurses signed that this was completed on 01/04/2020 and 01/011/19. On 01/13/19 at 11:29 AM, Resident #49 was again observed with long untrimmed nails, with brown debris noted under the nails. On 01/13/19 at 1:08 PM, Staff C was present in Resident #49's room. When asked to describe the residents fingernails Staff C stated, They look long. At which time the resident called out They are long, I don't like them long they need cut. When asked if she saw anything under his nails Staff C stated, dark debris. When asked if it appeared Resident #51's fingernails had been trimmed in the last several weeks Staff C stated, It does not appear they have been cut recently, no. (continued on next page)

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	505195	A. Building B. Wing	01/16/2020

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North Auburn Rehab & Health Center	2830 I Street Northeast Auburn, WA 98002

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	40303 42203 REFERENCE: WAC 388-97-1060 (2)(c).

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	505195	A. Building B. Wing	01/16/2020

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F 0684 Level of Harm - Minimal harm or potential for 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** 32898 Based on observation, interview, and record review, the facility failed to ensure three (#s 30, 33, & 29) of 21 residents reviewed received the necessary care and services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. The facility failed to ensure one (#30) of one residents reviewed received services related positioning, two (#s 33 & 29) of five residents reviewed received services related to bowel management and one (#8) of three residents reviewed received services related to edema. These failures placed residents at risk for decline in medical status and quality of life related to unmet care needs. Finding included . POSITIONING RESIDENT #30 On 01/06/20 at 11:59 AM, Resident #30 was observed sitting in the dining room in a wheelchair with both feet dangling without benefit of foot rests. On 01/07/20 at 1:49 PM and 01/08/20 at 10:09 AM, Resident #30 was observed up in a wheelchair with dangling feet, without foot rests. On 01/08/20 at 11:27 AM, Resident #30 was observed sitting in her room in a wheelchair, feet noted to be unsupported and dangling. At 11:45 AM, the resident was observed in the dining room seated in a slightly recumbent position with the feet unsupported. Similar observations of the resident's feet dangling unsupported were noted on 01/08/20 at 1:13 PM. During an interview on 01/08/20 at 1:40 PM, Staff N, Certified Nursing Assistant - CNA, was asked if the resident had foot rests for her wheel chair. Staff N said, I don't usually work that section of the facility. However, the only reason I can come up with is, that someone knocked them off couldn't figure out how to put them back on. In an interview on 01/08/20 at 2:06 PM Staff G, Licensed Practical Nurse - LPN, said the expectation was there should've been some form of support for the resident's feet. According to Staff G, she would have Staff X (Rehabilitation Director) assess the resident for the need of foot support. During an interview and observation on 01/08/20 at 2:30 PM, Staff X said that the resident had some ROM (range of motion) in her left foot. According to Staff X, without ROM and some support, there was a risk of continued foot drop and decline in mobility of the joint. Staff X said, I'll try and locate the resident's footrest and teach facility staff how the foot rests attach to the chair and express the importance of using foot support when the resident was up in the chair to prevent further decline in joint mobility. 37044 BOWEL MANAGEMENT RESIDENT #29 (continued on next page)

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	505195	A. Building B. Wing	01/16/2020

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/06/19 at 12:13 PM, when asked if she had any issues with constipation, Resident #29 nodded yes and pointed to her stomach. Record review showed Resident #29 had the following 09/19/19 bowel orders: Milk of Magnesia (MOM) as needed (PRN) for constipation, give at bedtime or at resident preferred time if no bowel movement (BM) on the third day; Dulcolax suppository every 24 hours PRN, if no results from MOM in 12 hours; and Fleets enema every 24 hours PRN, if no results from Dulcolax after 4-6 hours, if no results from enema, notify the doctor. Review of Resident #29's October 2019 bowel flowsheet showed the resident went the following time periods with no BM: 10/04/19 through 10/08/19 (5 days); 10/11/19 through 10/14/19 (4 days); and 10/19/19 through 10/22/19 (4 days). Review of the October 2019 Medication Administration Record (MAR) revealed no PRN bowel medications were administered. During an interview on 01/15/19 at 9:08 AM, Staff C, Assistant Director of Nursing, acknowledged the above occasions in which the resident went beyond three days with no BM. When asked if the resident should have received MOM on he third day of no BM as ordered Staff C stated, Yes. When asked if that occurred Staff C stated, No. RESIDENT #33 Resident #33 admitted to the facility on [DATE]. Resident #33 had the following Physician's Orders pertaining to constipation; Milk Of Magnesia (MOM) at bed time or at resident preferred time if no BM [bowel movement] on 3rd day .; Dulcolax Suppository, 1 application rectally every 24 hours as needed for constipation if no result from MOM; Fleet Enema, insert 1 application rectally for constipation if no results from Dulcolax. Review of resident #30's Bowel Chart showed that from 10/3/19 at 3:01 AM to 10/8/19 at 05:00 AM Resident #33 did not have a bowel movement. Resident #33's Medical Administration Record (MAR) shows that MOM was not given on the third day, 10/6/19, as ordered, nor on the 7th or 8th. Resident #33 was not administered Dulcolax on the fourth day, 10/7/19, as ordered, nor was a Fleet's enema administered. The chart further showed that Resident #33 went from 1:37 AM on 10/20/19 to 10/24/19 at 5:59 AM without a bowel movement. No MOM was administered on 10/24/19 or 10/25/19, the 3rd and 4th days In an interview on 01/15/20 at 8:20 AM with Staff D, Assistant Director Of Nursing (ADON), acknowledged the dates in October when Resident #33 experienced incontinence and didn't received prescribed treatments. When asked if he should have, she replied yes. 40303 EDEMA (continued on next page)

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	505195	A. Building B. Wing	01/16/2020

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Admission (10/11/19) Minimum Data Sets (MDS - an assessment tool), Resident #8 had multiple medically complex diagnoses and had care needs related to multiple sclerosis and chronic pain. The resident was assessed as cognitively intact, having lower extremity impairment on both sides, and requiring extensive one person assistance with personal hygiene. Observations on 01/05/20 at 9:02 AM and 01/08/20 at 11:51 AM, revealed Resident #8 lying in bed, both foot appeared more swollen. Resident #8 indicated her legs are swollen, and painful sometimes. Record review revealed that, there was no assessment of Resident #8's edema. On 01/09/20 at 11:10 AM, Resident #8 was observed sitting in a wheelchair her room, feet on the foot rest, legs dependent. Staff U, Licensed Practical Nurse removed the resident's socks, Resident #8 appeared to have edema to the lower extremities. When asked to assess the edema, Staff U depressed a finger into the resident's right and left foot, which left a depression in the tissue, and stated, Yes, she has edema. Staff U described the edema as pitting On 01/13/19 at 2:02 PM, when asked how staff monitor edema, Staff B, Director of Nursing, stated, We've established we don't have assessment or monitoring Resident#8's edema. There should be a parameter by which we assess and monitor edema. 42203 REFERENCE: WAC 388-97-1060 (1).

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	505195	A. Building B. Wing	01/16/2020

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 32898 Based on observation, interview and record review the facility failed to ensure residents received proper treatment and assistance with assistive devices to maintain hearing abilities. Failure to ensure Resident #71 received assistance with the use of hearing devices placed this resident at risk for decline in Activities of Daily Living (ADLs) related to hearing. Failure to assess why the resident wasn't wearing his hearing aids, placed this resident at risk for a decline in communication. Findings included . RESIDENT #71 On 01/05/20 01:05 PM, During the initial interview with the resident when asked if he had any problems with his hearing he replied, Yes. I have hearing aids, I don't know how to put them in. In an interview on 01/13/20 at 3:06 PM, Staff H (Registered Nurse-Resident Care Manager), was asked if the resident had hearing aids. Staff H said, to my knowledge the resident doesn't have or wear hearing aids. In an interview on 01/15/20 at 8:43 AM Staff E, Licensed Practical Nurse, indicated she was aware the resident had hearing aides and provided an Audiogram and invoice for hearing aides dated 11/22/19 which revealed the resident purchased bilateral hearing aides. Staff E said, if the resident had hearing aids the CNA [Certified Nursing Assistant] providing AM care was responsible for obtaining the aids from the nurse and assisting the resident to put the hearing aids in daily. Staff E said, I'll update the resident's care plan to indicate the hearing aids are to be worn daily. REFERENCE: WAC 388-97-1060(3)(a).

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview and record review, the facility failed to provide necessary foot care and treatment in accordance with professional standards, including provision of nail care. Deficient practice was identified for one (#8) of four residents reviewed for nail care and one supplemental (#49) resident. Failure to provide timely foot/nail care, placed the residents at risk for decreased quality of life and negative health outcomes. Findings included . RESIDENT #49 According to the 12/04/19 Admission Minimum Data Set (MDS, an assessment tool), Resident #49 required extensive assistance with activities of daily living (ADLs), including hygiene. On 01/05/19 at 1:01 PM, Resident #49 indicated his toenails needed to be cut and that facility staff provided toenail care every month or so. On 01/13/19 at 11:29 AM, Resident #49's toenails were observed to be long, untrimmed, with the great toenails [NAME] medially. Review of the January 2020 (Treatment Administration Record) TAR showed direction to staff to, every Sat[urday] trim finger and toenails. According to the TAR nurses signed that this was completed on 01/04/20 and 01/11/20. On 01/13/19 at 1:08 PM, Staff C, Assistant Director of Nursing, was present in Resident #49's room. When observing Resident #49's toenails Staff C stated, They need clipped. While discussing Resident #49's nails the resident stated, They are long, I don't like them long, they need cut. When asked if it appeared the toenails had been trimmed in the last several weeks Staff C stated, It does not appear they have been cut recently, no. 40303 RESIDENT #8 According to the 10/25/19 Quarterly MDS, Resident #8 was cognitively intact and required one person extensive assistance with personal hygiene. On 01/05/20 at 9:50 AM Resident #8 was observed laying in bed, the toenails were noted to be long, chipped and thick, requiring trimming. On 01/09/20 at 11:10 AM, Resident #8 was observed sitting in a wheelchair her room. Staff U, Licensed Practical Nurse, removed the resident's shoes, confirmed the resident's toes were long, chipped and thick stating, These need to be trimmed. REFERENCE: WAC 388-97-1060(3)(j)(viii).

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 32898 Based on observation, interview, and record review, the facility failed to ensure four (#s 55, 51, 29, &71) of seven residents reviewed for Range of Motion (ROM) services, were consistently provided their restorative ROM programs at the frequency they were assessed to require or provided clear staff instructions regarding the frequency of these programs. This failure placed residents at risk for further decline in ROM. Findings included . Refer to CFR: 483.35(a)(1)(2), F-725, Sufficient Staff 37044 RESIDENT #55 According to the 12/12/19 Quarterly Minimum Data Set (MDS, an assessment tool), the resident had a diagnosis of stroke with hemiplegia (muscle weakness or partial paralysis on one side of the body), impaired functional range of motion (ROM) to upper and lower extremities on one side, and received no therapy or restorative services. According to a 06/18/19 Therapy Recommendations for Restorative Program Resident #55 was to: wear a right hand splint six to eight hours; receive right upper extremity (RUE) passive range of motion (PROM); and bilateral lower extremity (LE) PROM for contracture management. An ADL (activities of daily living) self performance . care plan (CP), revised 10/24/19, directed staff to provide: R(ight) hand splint 6-8 hours, R shoulder abduction with pillow when resting with pre/post skin check daily .; and PROM to R UE and bilateral LEs for contracture management daily . Observations on: 01/06/20 at 10:28 AM and 12:47 PM; and on 01/07/19 at 9:03 AM, 11:27 AM, and 1:42 PM, showed Resident #55 did not have a right shoulder abduction pillow or right hand splint in place. Review of the restorative flowsheets for November 2019, showed Resident #55's ROM program was offered/provided on only 20 of 30 days and no splint program was in place. According to the December 2019 restorative flowsheets, the resident was offered/provided her ROM program only 17 of 28 days (Resident was out of facility for 3 days), and again no splint program was provided. (continued on next page)

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	505195	A. Building B. Wing	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/08/2020 at 1:23 PM, when asked if Resident #55 was offered/provided her restorative ROM program at the frequency she was assessed to require, Staff D, Assistant Director of Nursing/ Restorative Nurse, stated, No. When asked why Staff D stated, Usually that means the restorative aide was pulled. When asked if there was any indication the resident was receiving her restorative splint program Staff D stated, The nurses on the floor are taking care of the splint. Review of the November 2019 and January 2020 Medication Administration Record (MAR) and Treatment Administration Record (TAR), showed no direction to nursing to apply Resident #55's right hand splint. Staff D then stated, I think she went to the hospital and it didn't get reinstated. RESIDENT # 51 According to the 11/03/19 Quarterly MDS, Resident #51 had a diagnosis of paraplegia, had impaired functional ROM to bilateral upper and lower extremities, and received no therapy or restorative services. According to the Limited physical mobility . CP, revised 09/03/19, staff were directed to provide .Initial tennis ball roll over interscapular and bilateral trapezius musculature followed by shoulder protraction/retraction and shoulder circles 5-6 times a week, 15 minutes a day as tolerated. During an interview on 01/08/2020 at 2:07 PM, when asked who determined if the program was to be done five or six times a week Staff B, Director of Nursing, stated, It's as the resident tolerates. When asked if the only way to determine if the resident could tolerate the program six times a week, was to offer it six times a week, Staff B stated, yes. Review of the November 2019 restorative flowsheets, showed Resident #51 was only offered/provided his restorative program 15 of 24 times, with no refusals documented. RESIDENT # 29 Similar findings were noted for Resident #29, who according to the Limited physical mobility . CP, revised 11/26/19, staff were directed to provide: an ambulation program, walking 35 feet with a front wheeled walker and stand by to contact guard assist daily; and AROM to bilateral UEs and LEs, two to three sets, 10-15 repetitions for 15 minutes, six days a week. Review of the Restorative flowsheets for the past two weeks (12/25/19-01/07/2020) showed Resident #29 was offered/provided her ambulation and ROM restorative programs only five times during the 14 day period. During an interview on 01/08/2020 at 2:09 PM, when asked if the resident was provided her ROM and ambulation programs at the frequency she was assessed to require, Staff B stated, No. RESIDENT #71 A review of Resident #71's Restorative Program directed staff to perform an Ambulation program of Ambulation with FWW (front wheel walker) and close supervision to Limited assistance for 200 feet as resident tolerates. These directions failed to include the frequency with which staff were supposed to offer the ambulation program. (continued on next page)

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	505195	A. Building B. Wing	01/16/2020

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/10/20 at 12:23 PM, Staff E, Licensed Practical Nurse, said, I don't see where the frequency of the program was documented. I have to be honest, the care plan isn't worded correctly, therefore, the frequency wasn't assigned. REFERENCE: WAC 388-97- 1060 (3)(d), (j)(ix).

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40303 Based on observation, interview, and record review, the facility failed to monitor nutritional and hydration intake for two residents observed during dining. This failure placed Resident #39 and #28 at risk of choking, consuming wrong texture/ diet of food and lead diminished quality of life. The facility also failed to accurately monitor weights for Resident #60. Failure to ensure timely weight collection and documentation placed Resident #33 at risk of avoidable weight loss. Findings included . On 01/05/20 at 11:50 AM, Resident #39 was observed receiving food (Chef Salad) from another Resident #29. Resident #39 was observed eating the salad, Staff H intervened and removed the food from the Resident. Resident #39 was observed eating a regular sugar cookie. Review of Resident #39's 01/05/20's menu revealed Regular -Dysphagia mechanical diet, Puree sugar cookie. In an interview on 01/08/20 at 1:50 PM Staff H, Registered Nurse, stated that residents are not supposed to share food because diet orders are different. Staff H, when informed Resident #29 shared her salad with Resident #39 stated, [Resident #39] is on dysphagia mechanical diet and cannot have chef salad. When asked if the resident should have a regular sugar cookie, Staff H, said No, the menu says puree sugar cookie. On 01/06/20 at 11:50 AM, Resident #28 was observed eating lunch. Review of the tray card revealed another resident's name (Resident #1), with a diet order of Carbohydrate Controlled Diet (CCD). Staff removed the food and exchanged Resident #28's for a Regular diet, which was detailed on the tray card. In an interview on 01/13/20 at 11:50 AM Staff B, Director of Nursing revealed, dining staff should monitor residents during meals and ensure residents receives the right meal as per the diet order, and kitchen staff are responsible to serve residents the right texture of food as per the menu/order. In an interview on 01/15/20 at 11:50 AM, Staff A, Executive Director, indicated that staff to pay attention to make sure residents are getting the right diet and residents are not sharing food. 42203 RESIDENT #60 Resident #60 admitted to the facility on [DATE] and according to the 12/14/19 Admission Minimum Data Set (MDS: an assessment tool) had Malnutrition (protein or calorie), or at risk for malnutrition. The MDS also assessed resident #60 as totally dependent for eating and drinking. Resident #60's Nutrition Care Plan dated 12/10/19 included the goal will not have weight loss and instructed staff to monitor weight weekly with no end date stated. (continued on next page)

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	505195	A. Building B. Wing	01/16/2020

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Weight Monitoring Policy stated 1. Weigh each resident within 24 hours of admission . 2. Weigh the resident weekly for four weeks and/or until the weight is determined to be stable by the interdisciplinary team . A review of Resident #60's chart on 01/08/20 showed that no weights were collected from 12/08/19 to 12/22/19, an interval of 14 days during which Resident #60's weight dropped by 5.1%. No further weights were entered in the record in the following 17 days. On 01/10/20 at 11:14 AM, Staff C, Assistant Director Of Nursing (ADON), provided a print out of weights collected in December 2019 that included a weight measurement for Resident #60 on 12/22/19 with a 2.33% weight increase. Review of the resident record at 11:45 AM on 01/10/20 showed that the 12/22/19 weight had not yet been entered into Resident #60's electronic health record. Asked during an interview on 01/10/20 at 12:16 PM if the facility has issues with the timely entry of resident weights, Staff V, Registered Dietician (RD), stated there can be. Asked if she is able to see weights if they aren't entered, Staff V replied I have a hard time seeing them without the inputs and confirmed that a lack of accurate weight data created the risk of less effective nutritional interventions. REFERENCE: WAC 388-97-1060(3)(h), (3)(i).

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview and record review, the facility failed to provide appropriate care and treatment, consistent with professional standards of practice, for one (#55) of one resident reviewed for with a Central Venous Access Device (CVAD, a tube that goes into a vein in your chest and ends at your heart). Nursing staff failed to provide CVAD care to include, measuring external length, changing luer locks (needleless injection cap), providing maintenance flushes, dressing changes, and monitoring insertion site for signs and symptoms of infection. These failures placed the resident at risk for loss of vascular access and infection. Findings included . According to the facility Central Venous Access Device (CVAD) policy, dated 2016, CVAD external length, transparent dressings and needleless connectors, should be obtained and/or changed upon admit and every week. Observation of the insertion site should be performed every shift when not in use and weekly with dressing changes. When not in use, each lumen of a valved CVADs, should be flushed weekly with 10 milliliters of normal saline. RESIDENT #55 Observation on 01/13/20 at 11:46 AM, showed Resident #55 had a triple lumen CVAD to her right chest with no dressing over the insertion site. At that time Staff B, Director of Nursing, confirmed the presence of the CVAD to the right chest and lack of dressing. Review of the December 2019 and January 2020 Medication Administration Records (MARs) and Treatment Administration Records (TARs), showed no orders for the maintenance of the CVAD. There was no indication facility staff were checking external length, providing maintenance flushes or changing luer locks and dressing weekly, per accepted professional standards of practice. According to 07/01/19, Interdisciplinary Transfer Orders Resident #55 had a tunneled, valved, triple lumen CVAD placed on 07/01/19 at 11:09 AM, for administration of IV antibiotics. Record review showed Resident #55 completed her course of IV antibiotics on 08/07/19. Review of the August 2019 MAR and TAR showed CVAD maintenance orders were in place until 08/12/19, at which time Resident #55 discharged to the hospital. Resident #55 was readmitted to the facility on [DATE]. Since the the readmission on 08/19/19, there is no indication the facility identified the resident had a CVAD or provided any care/maintenance of the CVAD. During an interview 01/15/2020 at 8:09 AM, when asked if there was any indication that the facility was providing CVAD care to include measuring external length, providing maintenance flushes, changing dressing/ luer locks weekly, and monitoring the insertion site for signs and symptoms of infection Staff C, Assistant Director of Nursing, stated, No and indicated when the resident discharged on [DATE] and readmitted on [DATE] the CVAD maintenance orders were never re-implemented. When asked for clarification, so there is no indication that CVAD care has been provided in over four months Staff C stated, Correct. REFERENCE: WAC 388-97-1060(3)(j)(ii).

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview and record review, the facility failed to have sufficient staff to provide and supervise care as evidenced by information provided by nine (#s 51, 2, 47, 62, 50, 20, 73, 11, & 8) resident interviews, and six staff interviews. The facility had insufficient staff to ensure residents received assistance with Activities of Daily Living (ADL) including showers, restorative services, and nail care in accordance with established clinical standards, care plans, and identified preferences. Additionally, the facility had insufficient staf to ensure resident trust balnces were conveyed within 30 days as These failures placed residents at risk for unmet care needs and negative outcomes. Findings included . Refer to CFR: 483.10(f)(1)-(3)(8), F-561, Self Determination 483.24(a)(2), F-677, ADL Care Provided for Dependent Residents 483.25(c)(1)-(3), F-688, Increase/Prevent Decrease in ROM/Mobility RESIDENT INTERVIEWS RESIDENT #51 During an interview on 01/05/20 at 1:09 PM, when asked if he could chose the frequency of bathing Resident #51 stated, Oh geez no, I haven't had a bed bath in three weeks, they dont have enough staff here, it is really bad, one time it was closer to five weeks .I am supposed to get two a week . When asked if there was enough staff toprovide the care and services he needed Resident #51 stated, No, no no , it is always waiting, sometimes up to two hours and they dont turn me every two hours like they are suppose to, the aides complain about it too (poor staffing.) RESIDENT #2 On 01/06/20 at 12:58 PM, when asked if the facility had sufficiant staff Resident #2 stated, No, we need more staffing, more nurses, more nurse aides indicating there was poor assistance at meals in the dining room and poor call light response. Resident #2 stated, They had upper level staff serving breakfast in the dining room today, I told the other residents don't get used to it. RESIDENT #47 On 01/06/20 at 09:46 AM when asked about staffing Resident #47 satted, They're under staffed, we have wait for help, but its better than living on the street. RESIDENT #62 (continued on next page)

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	505195	A. Building B. Wing	01/16/2020

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/05/20 at 11:04 AM [NAME] asked about sufficiant staffing Resident #62 stated, It takes a long time to get help from staff, sometimes it takes 20 minutes to one hour, depending on the time of the day. RESIDENT #50 On 01/05/20 at 01:37 PM, Resident #50 stated, When you press your call light, it takes a half an hour to forty minutes (for staff to respond) .once I had to wait three hours to get changed when I was wet. RESIDENT #20 On 01/06/20 at 12:02 PM when asked about staffing Resident #20 indicated after turning on the call lightSometimes I have to go to sleep and wake up two hours later (without a response). The resindet reported this occurr Mostly at night. RESIDENT #73 On 01/06/20 at 10:55 AM, when asked if there was sufficiant staf Resident #73 stated, No, I take care of myself now, but in the beginning it would take two to three hours to answer the call light. RESIDENT #11 On 01/06/20 at 09:59 AM, when asked about staffing Resident #11 stated, Sometimes it's as long as half an hour (for the call light to be answered) .sometimes its quick and indicated the longest waits were on nights. RESIDENT #8 On 01/06/20 at 01:38 PM Resident #8 reported that staff respnde slowly (to requests for assistance) and indicated it was due to not enough staff and, constant [staff] turn over. STAFF INTERVIEWS In an interview on 01/08/20 at 12:03 PM, when asked if there was anything preventing staff from providing showers at residents identified frequency Staff HH, shower aide, stated, Yes, getting pulled to the floor when we are short. In an interview on 01/08/20 at 12:06 PM, when why residents were not being showered at their desired frequency Staff GG, shower aide, stated, mostly just .getting pulled to the floor, if we weren't pulled we could get them done. When asked how often shower aides were pulled to the floor Staff GG stated, Just about everyday one of the three [shower aides] gets pulled. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/08/20 at 1:23 PM, when asked why Residents were not consistently provided their restorative programs at the frequency they were assessed to require Staff D, Assistant Director of Nursing/Restorative Nurse, stated, Usually that means the Restorative Aide was pulled and acknowledged that insufficient staffing has affected the provision of restorative services. In an interview on 01/08/20 at 1:56 PM, when asked if she was aware of anything that might be preventing staff from consistently completing resident showers and restorative programs Staff B stated, Staffing. In an interview on 01/08/20 at 10:07 AM, when asked if she was aware of anything that might be preventing staff from consistently completing resident showers and restorative programs Staff A, Administrator, acknowledged that staffing had been an issue stating, When staff call off or walk off the job with no notice, we had to pull the shower and/or restorative aide. Interview on 01/13/20 at 1:39 AM, Staff AA, Director of Accounting, reviewed Resident #s 134, and #135, and confirmed that the trust funds were not conveyed back within 30 day, when asked why, Staff AA, stated, the facility did not have accounts staff, but they have hired one REFERENCE: WAC 388-97-1080(1), 1090(1).

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 37044 Based on observation, interview and record review, the facility failed to ensure sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment. Additionally, the facility failed to ensure proficiency of nurse aides. Failure of nursing and nurse aide staff, to demonstrate a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that nurses need to perform work roles or occupational functions successfully, resulted in deficiencies related to the competency of nursing staff. Findings included . F 550 - 483.10(a), Resident Rights Nursing staff failed to ensure care was provided in a dignified manner. F 552 - 483.10(c)(1)(4)(5), Right to be Informed Nursing staff failed to ensure informed consent was obtained for medications psychotropic medications and assistive devices. F 561- 483.10(f)(1)-(3)(8), Self Determination Nursing staff failed to implement individual plans of care to ensure resident's choices were honored regarding bathing frequency. F-578-483.10(c)(6) Right to request/refuse/discontinue treatment and formulate an advanced directive. Nursing failed to obtain advanced directives and inform residents of their right to formulate an advanced directive. F-609-483.12(c)(1) Reporting of alleged violations Nursing failed to report allegations to the state agency as required. F 641 - 483.20(g), Accuracy of Assessments Nursing failed to ensure assessments were accurate. F 656 - 483.21(b)(1), Develop/Implement Comprehensive Care Plan (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing staff failed to ensure care plans were developed and revised as necessary to meet the needs of residents. F-657-483.21(b)(2) Care Plan timing and revision. Nursing failed to update/revise resident care plans with each assessment. F 658 - 483.21(b)(3)(ii)(iii), Services Provided Meet Professional Standards Nursing staff failed to ensure facility staff provided care and services according to professional standards of practice related to obtaining, clarifying and following physicians orders, and signing for tasks that were not completed Administering medication without an order resulted in a significant medication error and harm to a resident. F 677 - 483.24(a)(2), ADL Care Provided for Dependent Residents Nursing staff failed to provide ADL care, including showers, oral care, and nail care to dependent residents. F 684 - 483.25, Quality of Care Nursing staff failed to provided care and services related to bowel management and edema monitoring F 685- 483.25(a) Treatment/devices to maintain treatment and hearing Nursing failed to assist with placement and or appointments for hearing/vision. F-687-483.25(b)(2)(i) Foot Care Nursing failed to provide toenail care for residents who required it. F 688 - 483.25(c)(1)-(3), Increase/Prevent Decrease in ROM/Mobility Nursing staff failed to ensure residents received appropriate treatment and services to increase and/or prevent further decrease in range of motion. F 692- 483.25(g)(1-3) Nutrition/hydration status Nursing failed to provide ordered therapeutic diets and monitor weight as assessed to require. F 694 - 483.25(h), Parenteral/IV Fluids Nursing staff failed to identify a resident had a triple lumen central venous catheter to her right chest without treatment/monitoring or maintenance orders for greater than four months. F-725- 483.35(a) Sufficient nursing staff (continued on next page)

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	505195	A. Building B. Wing	01/16/2020

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to provide sufficient nursing staff to meet the care needs of the resident, in accordance with their plan of care F 757 - 483.45(d)(1)-(6), Drug Regimen is Free From Unnecessary Drugs Nursing failure to adequately monitor and ensure adequate indications for medication use, resulted in residents receiving unnecessary medications. F-758-483.45(e)(1)(2)(4) Free from Unnecessary Psychotropic Drugs. Nursing failed to ensure adequate indication for use, monitor for ASE, and identify and monitor target behaviors, this led to residents receiving unnecessary Psychotropic medication. F-759 483.45(f)(1) Free from medication error rate of less than 5%. Nursing failed to ensure a med error rate of less than 5 %. F-760-483.45(f)(2) Residents are free of any significant medication errors. Nursing failed to ensure residents were free from significant medication errors. F 761 - 483.45(g)(h)(1)(2), Label/Store Drugs & Biologicals Nursing staff did not ensure drugs were stored in accordance with currently accepted principles. F 775 -483.50(a)(2)(iv) Lab reports in record Nursing failed to ensure lab reports were filed in residents records. F -880-483.80(a)(1) Infection Control Nursing failed to develop and implement an effective infection surveillance program. F-883-483.80(d) Influenza and pneumococcal immunizations Nursing failed to obtain immunization records or administer immunizations as indicated. In an interview on 01/15/19 at 11:34 AM, Staff B, Director of Nursing, was asked if. based on the multitude of identified failures including: failure to implement/clarify Physician Orders; Administering medications without Physicians orders, resulting in a significant med error and harm to the resident; failure to identify a central venous catheter on a resident, had no treatment/monitoring or maintenance orders for greater than four months; A medication error rate of 17.2%; and Nurse aides documenting residents had delusions, when through interview it was determined they did not know what a delusion was; the facility nurses demonstrated appropriate competency to provide care to meet residents' needs. Staff B replied, no. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/15/19 at 11:35 AM, after reviewing the above findings, Staff A, Administrator, was asked if facility nurses demonstrated appropriate competency to provide care to meet residents' needs. Staff A responded, No. REFERENCE: WAC 388-97-1080(1), 1090(1).

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	01/16/2020

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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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32898 Based on interview and record review the facility failed to provide medically related social services for two (#s 47 & 30) of five residents reviewed. This failure placed residents at risk of not having their needs met related to refusals of care and services. Findings Included . RESIDENT #47 According to the Quarterly MDS (Minimum Data Set- an assessment tool) dated 01/03/20, revealed the resident had no rejections of care. A review of November and December 2019 Physician Orders (PO's) revealed the resident was taking several medications including Antihypertensives, Diuretics, Antipsychotics, Antiparkinsons and anticonvulsant medication. A review of the November 2019 MAR's (medication administration record), revealed the resident refused eight of his medications 13 times and in December, the resident refused 12 of his medications 48 times. In an interview on 01/10/20 at 11:50 AM, Staff E (Licensed Practical Nurse-MDS Nurse) said, I was not aware the resident was refusing medications. Staff E said, I'm not sure if we referred him to Social Service [SS] related to refusals. He has had several meeting with SS, related to his desire to be discharged . Staff E was unable to provide any documentation to support SS interventions related to refusal of medications. RESIDENT #30 A review of Resident #30's immunization documentation revealed Resident #30 was [AGE] years old and received an PCV13 (pneumococcal vaccine) on 11/23/18. According to Staff E, the resident was not given a PPSV23 (a secondary Pneumococcal vaccination) as the resident's family declined the PPSV23 vaccine. Staff E was unable to provide any documentation to support the resident or family was offered or declined the PPSV23 stating, there isn't any documentation that the family received the risk and benefits related to receiving or declining the vaccine. REFERENCE: WAC 388-97-0960(1).

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 37044 Based on interview and record review, the facility failed to ensure one (#73) of six residents reviewed for unnecessary non-psychotropic medications, were free from unnecessary drugs related to administering medication without a physician's order and/or indication for use. This failure resulted in the resident receiving antibiotics that were not ordered and placed the residents at risk for adverse consequences. Findings included . Refer to CFR: 483.21(b)(3)(i), F- 658, Services Provided Meet Professional Standards 483.45(f)(2), F- 760, Residents Are Free of Significant Medication Errors RESIDENT #73 According to a 12/27/19 Medication Error investigation, Resident #73 returned from a 12/17/19 wound care appointment and provided Staff C, Assistant Director of Nursing, with a 12/17/19 AVS [after visit summary, a brief summary of what occurred at the visit, frequently given to patients] and stated, I have an infection again and need antibiotics. Per the investigation Staff C saw Cefazolin-inject 2g [grams] into vein every 8 hours, among many other medications, on a Your Medication List attached to the AVS. Staff C then called the IV [intravenous] nurse to place a midline and ordered/initiated the medication. Review of the AVS showed under Instructions there was no physician order to start the IV Cefazolin. According to a 12/27/19 provider note, the facility provider called the wound care clinic and was informed that they [wound care doctor] did not order the IV Cefazolin. The medication error investigation concluded that Resident #73 received IV Cefazolin without an order, concluding the Cefazolin was unncessary. During an interview on 01/09/2020 at 12:44 PM, Staff B, Director of Nursing, confirmed Resident #73 was administered IV Cefazolin without an order or indication for use. Administering a medication without a physician's order and lack of indication for use, constitutes an unnecessary medication. REFERENCE: WAC 388-97-1060(3)(k)(i).

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	505195	A. Building B. Wing	01/16/2020

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 42203 Based on interview and record review, the facility failed to ensure one (#48) of five and three (#s 49, 73, & 83) supplemental residents reviewed for unnecessary medications were free from unnecessary psychotropic drugs related to the failure to implement non drug interventions prior to the use of as needed antianxiety medication. These failures placed residents at risk to receive unnecessary medications and/or adverse side effects. Findings included . According to the facility's undated Mood and Behavior Program: Psychoactive Medication policy, The center requires a review of the residents prescribed psychoactive medication upon admission, annually, quarterly and with a significant change in condition . Staff are directed to Document information for residents admitted with prescribed medications for behavior on the Psychopharmacological Med Use Symptom Care Plan. Include the following: Diagnosis the medication is designed to treat. Behavioral symptoms the medication is designed to decrease .Use behavioral interventions in conjunction with medication. Include psychoactive medications as part of, but not the only intervention for behavioral symptoms. Monitor regularly for side effects as indicated on the [Care Plan, CP]. Document the following using the appropriate Mood and Behavior Care Plan(s) and Point of Care. Non-drug approaches .Resident responses to interventions. Complete AIMS [Abnormal Involuntary Movement Scale, a test used to detect TD [Tardive Dyskinesia, neurological disorder characterized by involuntary movement that sometimes develops as a side effect of antipsychotic medications] . RESIDENT #48 According to the 12/04/19 Admission Minimum Data Set (MDS, an assessment tool), the resident had diagnoses of anxiety and depression, and received antipsychotic, antianxiety, and antidepressant medication on seven of seven days during the assessment period. The resident was assessed to demonstrate no hallucinations, delusions or behaviors, but did have indicators of moderate depression. Record review showed the resident had 11/27/19 orders for Buspar (an anxiolytic) for anxiety, Effexor (an antidepressant) for depression, and Abilify (an antipsychotic) for depression. An 11/27/19 provider note indicated the resident had a diagnoses of major depression and anxiety. The note recommended continuing the Abilify and Effexor for depression, Buspar for anxiety and stated, Consider psychiatry specialty consult, if appropriate, consider GDR [Gradual Dose Reduction] of Aripiprozole [Abilify]. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 12/26/19 psychiatric consult stated, Patient expresses some increased depression secondary to loss of part of his limb .Given the patient's reported increase in depression secondary to the above, a GDR of his antidepressant would not be tenable at this time. We will consider to taper off the Abilify once the patient['s] mood is stable .a second-generation antipsychotic is not the best treatment for participation depression. Continue to monitor patient's mood and behavior .encourage the patient's participation in social and interactive activities in the facility .Patient anxiety exacerbated by recent loss of limb .Reassure the patient as much as possible. A Uses antipsychotic medications .r/t [related to] Major Depressive Disorder CP, revised 01/05/20, identified Resident #48's target behavior (TB) for the use of Abilify for treatment of depression as Delusions. Staff were directed to attempt the following interventions when the TB was demonstrated: 1) Administer medications as ordered .2) Attempt GDR per pharmacist, MD, or interdisciplinary team recommendations. 3) Complete AIMS assessment as indicated. Enter the numerical value for each attempted and each successful intervention. The CP did not include any behavioral/ psychosocial interventions as directed in the policy or as identified in the 12/26/19 psychiatric consult. Additionally, there were no interventions identified that could be implemented by non-licensed staff. Review of Resident #48's medical record and history and physical (H&P) revealed: no documentation that the resident had a history of, or ever had a delusion. All notes indicated the resident's Abilify was used as an adjunct in the treatment of Resident #48's depression; No AIMS assessment had been performed/completed; there was no direction to staff to perform monthly postural bloods pressures (BPs) to rule out postural hypotension r/t psychotropic medication use; no indication staff were monitoring for adverse side effects of the medication; and no indication nurses were monitoring for the presence of TBs. During a joint interview on 01/09/20 at 11:01 AM, Staff C, Assistant Director of Nursing, explained staff monitored for the effectiveness of psychotropic medications by reviewing the presence/frequency of demonstrated TBs. When asked what the identified TB for Resident #48's Abilify was Staff C stated, Delusions. When asked if there was any indication the resident had ever experienced delusions Staff C and Staff B stated, No. When asked why and how delusions were determined to be Resident #48's TB, Staff C stated, I don't know .we don't have a qualified social worker .that may be contributing [to inaccurate TBs]. When asked if monitoring for a TB that was not relevant to the resident or associated with the indication for use would detract from staff's ability to evaluate the effectiveness of the medication, Staff B stated, Yes. During an interview on 01/09/20 at 10:47 AM, when asked if residents receiving psychotropic medications should have monthly postural BPs performed Staff B, Director of Nursing, stated, Yes. When asked if there was any indication Resident #48's postural BP's had been assessed since admit Staff B stated, No. During an interview on 01/09/20 at 11:09 AM, when asked if an AIMS assessment had been performed on Resident #48, as directed in the CP, Staff C stated, No current AIMS and indicated it should have been completed. (continued on next page)

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	505195	A. Building B. Wing	01/16/2020

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/09/20 at 11:11 AM, Staff C explained that staff monitored and documented to the presence/absence of adverse side effects (ASEs) for psychotropic medications, On the Medication Administration Record (MAR). Review of the January 2020 and December 2019 MARs, showed no direction to staff to monitor/document the presence or absence of ASEs for Resident #48's antidepressant, antianxiety or antipsychotic medications. Staff C stated at this time that ASE's should be, but were not monitored for Resident #48. During an interview on 01/09/20 at 11:25 AM, Staff B indicated the behavior monitors/TBs for residents on psychoactive medications were documented in Point of Care, a program where Certified Nursing Assistants (CNAs) document care provided. When asked if nurses documented on the behavior monitors Staff B stated, No and indicated the CNAs report the presence of behaviors to the nurse. When asked how CNAs could document to the interventions utilized when the TB was observed, as directed on the CP - 1) Administer medications as ordered .2) Attempt GDR per pharmacist, MD, or interdisciplinary team recommendations. 3) Complete AIMS assessment as indicated, since none of the interventions were within the CNA's scope of practice, Staff B stated, they shouldn't and indicated nurses should be, but were not, documenting to those interventions. When asked if behavioral interventions should have been developed such as, reassure resident, as recommended by the mental health professional, so that staff, other than licensed personnel could utilize non-drug interventions Staff B stated, Yes and acknowledged that did not occur. On 01/13/19 Resident #48's behavior flowsheets were provided for the last 30 days. According to the document, Resident #48 had delusions documented on 12/14/19, 12/15/19 times two, and on 12/29/19. During a joint interview on 01/13/20 at 9:51 AM, Staff C indicated the delusions documented on the above dates, were recorded by Staff N, CNA. When asked if CNAs were trained to recognize/identify delusions Staff B indicated she believed it was included in their CNA course. On 01/15/20 three CNAs working on the floor were asked to verbalize what a delusion was, with the following responses: At 8:50 AM, Staff N (the CNA who documented Resident #48's alleged delusions) responded, It is when a person has no leg, but wants to get up and walk, or had a stroke and thinks they will get better. When asked what delusion Resident #48 was having Staff N stated, I don't remember.; At 11:19 AM Staff FF, CNA, stated, It's someone talking, like yelling and shouting.; and at 11:23 AM Staff KK stated, That's when they are not thinking right, other things pop up in their mind. In an interview on 01/15/20 at 11:34 AM, after discussing the results of the CNA interviews, Staff B acknowledged facility CNAs demonstrated a lack of competence and knowledge related identifying delusions. Staff B stated, The nurse should be documenting assessments of delusions. RESIDENT #49 Similar findings were noted for Resident #49, who according to the 12/04/19 Admission MDS, had a diagnosis of dementia, no psychiatric diagnoses, but received antipsychotic medication on seven of seven days during the assessment period. Record review showed Resident #49 had an 11/27/19 order for Risperidone (an antipsychotic), for a diagnosis of Dementia with behaviors disturbance. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Uses antipsychotic medications risperidone r/t dementia CP, initiated 11/28/19, identified the TB as Might experience delusions that increase distress. Staff were directed to attempt the following interventions when the TB was demonstrated: 1) Administer medications as ordered .2) Attempt GDR per pharmacist, MD, or interdisciplinary team recommendations. 3) Complete AIMS assessment as indicated. Enter the numerical value for each attempted and each successful intervention. No resident specific behavioral/psychosocial interventions were identified as directed in the policy. Additionally, the interventions listed could only be performed by licensed staff. Review of Resident #49's medical record and hospital H&P (History & Physical) revealed: no documentation or indication the resident had a history of, or ever exhibited delusions. According to the H&P the resident received risperidone for dementia with behaviors and had a history of receiving psychotropic medications for alcohol withdrawal symptoms; No AIMS assessment was performed/completed; there was no direction to staff to perform monthly postural BPs to rule out postural hypotension related to psychotropic medication use; there was no indication staff monitored for adverse side effects of the medication; and no indication nurses were monitoring the Resident for the presence of TBs. During an interview on 01/13/19 at 2:29 PM, Staff C acknowledged that the facility failed to: perform monthly postural BPs; perform an AIMS assessment; monitor for ASE's; and failed to identify what specific behaviors the resident demonstrated with his dementia that required the use of the antipsychotic medication. At this time the behavior monitors for November and December 2019 were requested as none were found in the resident's record. On 01/15/20 at 8:37 AM, Staff C provided behavior flowsheet for 01/09/20 through 01/15/20 and stated, That is all we have so far. According to the behavior monitor Resident #49's TB was still identified as .delusions . When asked if, Might experience delusions that increase distress was an appropriate target behavior Staff C stated, No. When asked if there was any indication the resident had a history of or had been experiencing delusions, Staff C acknowledged that the TB was inaccurate stating, No .we don't know where the [TB] of delusions came from, and again indicated the lack of a qualified social worker may have contributed to the inaccurate TBs. RESIDENT #73 According to the 12/29/19 Quarterly MDS, Resident #73 was cognitively intact, had a diagnosis of depression, and received antidepressant medication on seven of seven days during the assessment period. Review of the December 2019 MAR showed Resident #73 had orders for Cymbalta (an antidepressant) 30 mg (milligrams) daily, and Prozac (an antidepressant) 80 mg daily. Record review showed on 12/09/19, Resident #73's as needed (PRN) oxycodone orders were changed from every four hours PRN, to every eight hours PRN. Additionally, on 12/09/19 the resident's Cymbalta was increased from 30 mg daily, to 30 mg twice daily. According to a 12/09/19 provider note this was to help control his nerve pain .if this is ineffective, then I will consider gabapentin (an anticonvulsant, frequently used to treat nerve pain). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 12/16/19 pharmacy Consultation Report stated, [Resident #73] receives multiple antidepressants concomitantly [simultaneously]: Fluoxetine [Prozac] 80mg once daily & Duloxetine 30 mg BID [two times a day], this is too much serotonin. Please attempt a gradual dose reduction of fluoxetine to 30 mg once daily, with the end goal of discontinuation, while monitoring for the reemergence of depressive and/or withdrawal symptoms .If dual therapy is to continue, it is recommended that: a)the prescriber document an assessment of risk versus benefits, indicating that they continue to be valid therapeutic interventions for this individual; and b) the facility ensures ongoing monitoring for effectiveness and potential adverse consequences (e.g. nausea, changes in appetite, falls.) The consult was noted by a practitioner on 10/29/18 (sic), and the recommendation was declined. Under rationale the practitioner wrote, Patient states that current dose has stabilized his mood, vehemently opposed to GDR . A second copy of the same consult was noted by a different practitioner on 12/28/19. The recommendation was declined and under rationale the practitioner wrote Patient is stable on current medication, will continue with it. A 12/29/19 at 8:54 PM, provider note states, .Patient's [sic] talks about past 'OD [overdose] of Prozac', [the medication that the pharmacist recommended be decreased] among a myriad of other complaints .discussed the patient about his mood and he says that [he's] 'very happy and contented with current regimen' involving fluoxetine 80 mg daily and Duloxetine 30 mg twice daily. I reminded the patient that the combo is likely leaving him with too much Serotonin and the risks and symptoms of Serotonin syndrome. The patient however does not want current regimen adjusted. According to CMS guidance, the purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved, and/or non-pharmacological approaches have been effective in reducing the symptoms. Declination of a GDR based on a resident being stable would preclude any attempt at any GDR, could justify indefinite use of a medication, and is not a clinical contraindication for reduction. Facility staff failed to document that the resident demonstrated clinically significant enough (e.g., causing functional decline) signs and symptoms to warrant continuation of the medication therapy. There was no documentation substantiate the rationale for, and benefits of, duplicate therapy of multiple antidepressant use despite pharmacy recommendations indicating, Evidence for the effectiveness and safety of combined antidepressant and medication is limited. The risk for drug interactions, adverse events, non-compliance and medication errors are increased. Facility staff failed to consider Resident #73's history of adverse consequences related to a reported, Overdose of Prozac in the risks and benefits of declining the pharmacy recommendation. RESIDENT #83 According to the 10/21/19 Admission MDS, the resident admitted to the facility with care needs associated with anxiety and major depression. A review of the November 2019 MAR, showed an order for Xanax (an anxiolytic) 0.5mg every 24 hours as needed for anxiety at bedtime. According to the documentation on the MAR, staff administered the medication on 11/05/19 at 9:22 PM, 11/15/19 at 12:25 PM, 11/17/19 at 6:03 PM, 11/24/19 at 5:48 AM, 11/25/19 at 6:42 PM and 11/26/19 at 7:03 PM. (continued on next page)

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	505195	A. Building B. Wing	01/16/2020

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the documentation in the resident's record revealed staff failed to document the resident's TB and all non-drug interventions attempted prior to administering the antianxiety medication. In an interview on 01/15/20 at 12:07 PM, Staff B stated, The behavior charting should have included potential triggers .such as pain or fear. Staff B acknowledged the facility failed to complete behavior monitoring documentation, record which non-drug interventions were attempted and document whether the intervention was effective, prior to administration of the antianxiety medication. RESIDENT #33 Resident #33 most recently admitted to the facility on [DATE]; his initial admitted was 12/24/15. According to the 05/15/19 Significant Change MDS, Resident #33 was assessed to exhibit behaviors of harm to self and per the 08/15/19 Quarterly MDS was assessed with no behaviors. The 11/15/19 Quarterly MDS showed the resident demonstrated other behaviors. Further review of Resident #33's record revealed only one MDS, an 11/04/18 Discharge MDS, where he was assessed with psychosis. Resident #33 first received a Physician's Order (PO) for Abilify, an antipsychotic, for 10mg on 04/13/19. The rationale for the order was Unspecified dementia without behavioral disturbance. The following POs were noted in the resident record: 09/24/19, Abilify 10mg for dementia; 10/16/19, Abilify 5mg for depression; 10/19/19, Abilify 5mg for psychosis; 01/02/20, Abilify 2.5mg for unspecified dementia with behavioral disturbance; 01/07/2020, Abilify 5mg for behaviors. Record review showed a GDR of the Abilify, and according to the October MAR, the Abilify was discontinued on 10/01/19. A Health Status prog note from 10/15/19 described Resident #33 as suicidal and had plan and included an order from the resident's ARNP [Advanced Registered nurse Practitioner] for Abilify 5mg daily for Major Depression. Resident #33's October MAR showed he received Abilify 5mg on 10/16/19-10/18/19 for depression. A PO dated 10/19/19 started Abilify 5mg for psychosis. Resident #33's 10/18/19 pharmacy consult stated that Resident #33 had, delirium and psychosis right now. According to the October 2019 MAR, the resident was treated with antibiotics for an active infection starting on 10/18/19. Accoridng to the 07/04/17 Dementia CP, staff were instructed to, rule out delirium first, if there is a change in condition. Record review revealed no indication facility staff considered the identified change in behavior as related to the infection with delirium, or that the delirium was a short term condition and failed to consider a return to the previous dose once the infection and delirium resolved. Review of the resident's November and December MARs showed that he received a 5mg dose of Abilify throughout both months. Resident #33's 12/16/19 Pharmacist Review recommended a Gradual Dose Reduction (GDR) to 2.5mg with an end goal of discontinuation, due to Abilify potentially contributing to an increase in falls. This recommendation was signed and accepted by the resident's ARNP and a second physician on 12/26/19. This GDR was not implemented until 01/02/20, two weeks after the pharmacy recommendation. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/07/20, a PO increased the Abilify to 5mg for, behaviors. Review of Resident #33's Target Behavior monitoring, which specified suicidal thoughts as the target behavior, showed no instances of such behavior. A Mood & Behavior prog note from 01/06/20 stated that Resident #33 was noted to finish breakfast and come back to his room and immediately start yelling . wants staff to immediately put him to bed . This is becoming a regular occurrence. The only other mentions of behavior in Resident #33's prog notes refer to an instance where he called 911 on 01/04/20 with concerns about denture discomfort and ADL (Activities of Daily Living) care. In a phone interview on 01/28/20 at 12:08 PM, when asked if she considered yelling sufficient rationale for the dose increase, Staff B, DNS, replied no. Record review revealed no monitoring of TBs which were identified that required the use of antipsychotic medicaiton. In a phone interview on 01/28/20 at 12:08 PM, Staff B stated that TB monitoring began for verbal aggression in August 2019, and for suicidal statements on 10/16/19. When asked if Resident #33 having no identified TBs from April to August was appropriate, Staff B replied no. REFERENCE: WAC 388-97-1060(3)(k)(i).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 40303 Based on observation, interview and record review the facility failed to ensure a medication error rate was less than 5 percent (%). During observation of 29 opportunities for error, one of three Licensed Nurses (Staff U) made five errors, an error rate of 17.2%. This failure placed residents at risk for not receiving medication timely according to the physician orders. Findings included . Review of undated facility policy titled Administering Medications, Licensed nurse and /medication assistant will check the following to administer medication: Right medication, Right Dose, Right route, Right resident, and Right Time. During a medication pass observation on 01/13/20 at 1:56 PM, Staff U, Licensed Practical Nurse (LPN), administered five medications to Resident #49 for blood pressure, anemia, and stroke prevention. Review of January 2020 Medication Administration Records (MAR) showed Carvedilol 3.125 mg, Thiamine HCL 100 mg, Asprin 81mg, Ferrous Sulfate 325 mg and Plavix 75 mg were to be provided between 8:00 AM-11:00AM. However, they were not provided until 1:56 PM, which was three hours after the allotted time frame. During an interview on 01/08/20 at 11:55 AM, Staff U confirmed that Resident #49's medications were provided late. In addition, she had given the resident some medication in the morning but not all the medication as per the orders. During an interview on 01/15/20 at 10:30 AM, Staff B, Director of Nursing Services, indicated that Resident #49's medications needed to be provided according to the Physician's Orders and confirmed that Resident #49 had received his medications three hours after the allotted time frame. REFERENCE: WAC 388-97-1060(3)(k)(ii).

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	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to ensure one (#73) of 21 residents reviewed for medication management, was free from significant medication errors. Failure to call a consulting physician to validate Resident #73's verbal report that he was to begin antibiotic therapy, and implementing intravenous (IV) antibiotics without a physician's order, resulted in a significant medication error, and place the resident at risk for adverse side effects and health complications. Findings included . Refer to CFR: 483.21(b)(3)(i), F-658, Services Provided Meet Professional Standards 483.45(d)(1)(5), F-757, Drug Regiment is Free From Unnecessary Drugs RESIDENT #73 Review of the facility's December 2019 incident log, showed a 12/30/19 entry for a medication error involving Resident #73. According to the 12/27/19 investigative document, a Medication error [was] noted regarding resident rx [prescription] of Cefazolin [an antibiotic]. Resident returned from appointment with wound [clinic] and presented nurse with AVS [after visit summary, a brief summary of what occurred at the visit, frequently given to patients] . Nurse reviewed paperwork and noted 'Cefazolin-inject 2g [grams]into vein every 8 hours.' Nurse called for IV [intravenous venous] placement and ordered medication. Review of the attached 12/17/19 AVS showed under Instructions the doctor documented no instruction to start IV Cefazolin for an infection. Attached to the to the 12/17/19 AVS was an outdated medication list, that listed all the resident's medications which included, among many, Cefazolin-inject 2g [grams]into vein every 8 hours. Record review showed Resident #73's Cefazolin was discontinued on 08/08/19, greater than four months prior. A 12/27/19 provider note stated, I contacted patient's wound care clinic requesting them to fax over patient's report from his recent visit that was on the 26 th of Dec[[NAME]], since reports from the last visit on [DATE] th as well as his recent visit was not available for me to review and that the staff at facility was unable to provide me with any report from resident's last and recent visit to wound care clinic. Upon reviewing the patient's results which was faxed to me by the wound care clinic, there was no indication of patient being on IV antibiotics [During a phone call] wound care provider stated she did not start the patient on IV antibiotics on 12/17/19 .The order for IV antibiotic was entered by facility staff on the 17 th of December without my knowledge . According to the 12/27/19 Medication Error investigation Staff C, Assistant Director of Nursing, .mistakenly saw an order for ABO [antibiotics]. The investigation concluded the IV Cefazolin was administered without an order, resulting in a medication error. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/09/2020 at 12:44 PM, when asked why the nurse took one medication off of a medication list and determined it was a new order Staff B, Director of Nursing, stated, [Resident #73] was very dramatic in stating he was supposed to get antibiotics and she got nervous and wanted him happy. Review of the December 2019 Medication Administration Record (MAR) showed Resident #73 received 28 doses of IV Cefazolin without an order, which constituted a significant medication error. REFERENCE: WAC 388-97-1060(3)(k)(iii).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264 Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were labeled and dated in accordance with current accepted professional standards in two of three medication carts and one medication room refrigerator reviewed. These failures placed residents at risk to receive expired and/or improperly administered medications and biologicals. Findings included . MEDICATION CART A Observation of the A Medication Cart on [DATE] at 8:38 AM revealed the following: Ketotifen eye drops for Resident #2 open and not dated. In an interview at this time, Staff O, Licensed Practical Nurse, stated eye drops should be dated when opened. A Humulin insulin injection pen for Resident # 36 was open but not dated. According to Staff O, the insulin pen should be dated when opened. A Spiriva inhaler was noted for Resident #78 which was open but not dated. The date open sticker on the box was blank. Staff O indicated that date open stickers should be filled in with the date the medications are opened. Eight loose pills were noted on the bottom of the left second drawer of the medication cart. The third right drawer contained moderate amounts of sticky residue. Two bottles of liquid lithium were stored on bags in the drawer, but the bags were ripped open and did not contain the spilled liquid. According to Staff O, No, it doesn't look like it's (medication cart) been cleaned .night shift nurses on the weekend should be cleaning it. Additionally, two cans of Zep Meter Mist air freshener were stored in the bottom right drawer along with external medications. MEDICATION CART D Observation of the D Medication Cart on [DATE] at 9:01 AM revealed the following: Liquid Ciprofloxacin (an antibiotic) for Resident #32 which was open but not dated. According to Staff P, Licensed Practical Nurse, They should always be dated when open. Calcitonin Nasal Spray for Resident #50 which was open and dated, ,d+[DATE]. According to the facility pharmacy policy on Inhaled Medications dated [DATE], staff should, discard after 30 doses or 30 days after opening, whichever comes first. When asked in an interview at this time when the Calcitonin should be discarded, Staff P stated, I have to Google it. An Advair Discus inhaler was noted with no label of name or prescriber or date open. A second Advair Discus inhaler was dated [DATE]. According to the facility pharmacy policy on Inhaled Medications dated [DATE], staff should, Date the Diskus when removed from the foil pouch and discard 1 month after removal from foil pouch or after all blisters have been used, whichever comes first. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Breo Eliptica ,d+[DATE] inhaler was noted for Resident #133 which was dated [DATE]. According to the facility pharmacy policy on Inhaled Medications dated [DATE], staff should, date the inhaler when removed from the foil pouch and discard 6 weeks after removal from foil pouch or when the dose counter reads 0, whichever comes first. A Sportive handihaler in a cup with multiple blister packs of the inhaled medication which was not labeled with a name, prescribing information or open date. In an interview at this time, Staff P stated I think there is only one person who gets Spiriva . Staff P confirmed each medication should be, but was not, labeled with the intended resident's name. Similar findings were identified for an albuterol inhaler which had no label. An external topical medication, Nystatin, for Resident #58 was noted stored with inhaled medications. At least six loose pills were noted on the bottom of one drawer of the medication cart. A pink sticky substance and multiple loose label stickers were noted on the bottom of the bulk liquids drawer. In an interview on [DATE] at 9:02 AM, when asked who was responsible for cleaning medication carts, Staff P stated, all nurses are responsible whenever we have time. Staff P stated that it did not appear the drawers had been cleaned recently. MEDICATION ROOM Observation of the medication room with Staff K, Registered Nurse, on [DATE] at 9:10 AM revealed a vial of Tuberculin testing solution which was open but not dated. According to Staff K, the vial should have been dated when it was opened and should be discarded. REFERENCE: WAC [DATE](2).

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264 Based on interview and record review, the facility failed to ensure laboratory (lab) reports were filed in residents' records for three (#s 33, 10, & 132) of ten residents whose labs were reviewed for infection control purposes and two (#47 & 71) supplemental residents reviewed. This failure placed the residents at risk for unmet care needs, and incomplete information being considered when making medical decisions. Findings included . RESIDENT #33 According to October 2019 Infection Control (IC) documents, Resident #33 was identified with a Urinary Tract Infecting (UTI). According to progress notes dated 10/17/19, [AGE] year old male with UA [Urinalysis] + color red, Turbid, Protein 200 Occult blood 3+, Leukocytes 3+ . Record review revealed no UA results circa 10/17/19. In an interview on 01/05/19 at 1:30 PM, Staff C, Infection Preventionist, reviewed the clinical record and confirmed there was no UA for Resident #33's identified UTI stating, Let me see if I can find one (UA result) .it's not in the chart. While Staff C was subsequently able to obtain the result from the facility's contracted Laboratory, Staff C stated the lab results should be scanned into the computer as part of the resident's record. RESIDENT #10 A Review of the October 2019 IC documents revealed that Resident #10 was identified with a facility acquired UTI and treated with an antibiotic on 10/23/19. The results of the C & S (Culture and Sensitivity- a test to determine effectiveness of antibiotic treatment) were listed as pending. Record review revealed no UA or culture results. After obtaining lab results that were not available in the record, Staff C reported the pending culture was positive for E-coli. In an interview on 01/05/19 at 1:10 PM, how staff could assess accuracy of the antibiotic stewardship program in the absence of necessary information (C & S results), Staff C stated the lab results should be, but were not, available in the residents record. RESIDENT #132 A Review of the November 2019 IC documents revealed Resident #132 was identified with a facility acquired UTI and treated with an antibiotic on 11/07/19. Progress notes dated 11/04/19 showed, placed call to on call ARNP .received order for UA, C & S, urine collected. While progress notes indicated these orders were implemented and the tests were completed, record review showed no lab results were available in the resident's record. In an interview on 01/05/20 at 12:24 PM, Staff C confirmed the lab results were not in the record and subsequently obtained copies from the facility's contracted laboratory. (continued on next page)

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	505195	A. Building B. Wing	01/16/2020

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/22/20 at 9:35 AM, Staff W, Medical Records, stated the process for scanning in lab reports was, scattered and we're working on that. Staff W explained a lot of the time I get the lab results back without a physician signature or a nurses signature, so I send them back to nursing to get signatures. In an interview on 01/22/20 at 9:38 AM, Staff C confirmed there was a systems issue with ensuring lab results were scanned into resident records. RESIDENT #47 Similar findings were identified for Resident #47, who, according to a 12/16/19 pharmacy recommendation, had Keppra lab levels from 11/20/19 which were not, available in the resident record. In an interview on 01/10/20 at 10:00 AM, Staff W confirmed this test result was not in the resident records. RESIDENT #71 A review of the clinical record revealed an order dated 11/14/19 to obtain a TSH (Thyroid stimulating hormone). In an interview on 01/10/20 at 12:52 PM Staff E (Licensed Practical Nurse-MDS Nurse) said, I don't see the result in the record. Staff E said, I have the results, however they weren't in the resident clinical record and they haven't been reviewed by the physician. In an interview on 01/10/20 at 12:54 PM, Staff B (Registered Nurse-Director of Nursing) said, When the lab results get faxed to the facility and the nurses are supposed to review them and place them into the physician's box for review and signature. REFERENCE: WAC 388-97-1720(1)(2).

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. 32898 Based on interview and record review, the facility failed to obtain an ultrasound as ordered by the practitioner for one (#73) of one residents reviewed who required ultrasound services. This failure placed the resident at risk for a delay in treatment and a potential negative outcome. Findings included . RESIDENT #73 Record review revealed a 12/24/19 late entry provider note that stated, .(Resident #73) is being seen today for follow-up on Doppler ultrasound of his left upper extremity status post midline infiltration .Ultrasound results reviewed by me today with conflicting results. Preliminary result shows positive for thrombus (blood clot) of left cephalic vein, however, the final result concludes no DVT (deep vein thrombosis). Mobile ultrasound services was contacted. Ultrasound tech(nician) agrees with conflicting results. Stated they will come and repeat left upper extremity venous Doppler today. The ultrasound report in Resident #73's record was dated 12/23/19 at 5:42 PM, and concluded No DVT. On the bottom of the report the practitioner wrote Repeat US [Ultrasound] conflicting result, lab notified. However, no further US was found in the resident's record. The repeat US results were requested but no information was provided. On 01/21/20 the results were requested again from Staff C, via telephone. On 01/22/20 the results were provided. The ultrasound concluded there was no DVT, but There is thrombus [blood clot] in the superficial cephalic vein. The date and time on this US report was 12/23/19 at 5:42 PM, exactly the same as the previous US report, which the practitioner ordered to be repeated. During a phone interview on 01/23/20 at 1:19 PM, when asked why the US was not repeated as ordered Staff C, Assistant Director of Nursing, stated, they just re-evaluated it. When asked if the practitioner wrote an order to discontinue the order to repeat the ultrasound Staff C indicated she was unsure. Staff C then acknowledged the facility did not obtain the results of the re-evaluation until 01/21/20, when the surveyor requested a copy and stated, We had no notification in our record that SVT [superficial vein thrombosis] was present .we are revamping our process, we are trying to find out if they called the result directly to the [practitioner]. No further information was provided. Failure of the facility to obtain a repeat US as ordered and failure to notify the practitioner promptly (just received results 29 days after it was ordered) of a US that identified .a thrombus to the superficial cephalic vein, placed the resident at risk for a delay in treatment and potential negative outcome. REFERENCE: WAC 388-97-0320(1)(b).

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 37044 Based on observation, interview and record review, the facility failed to ensure prompt dental services were provided for one (#s 29) of eight state pay residents reviewed for dental services. This failure placed the residents at risk for unmet dental needs, and a diminished quality of life. Findings included . RESIDENT #29 According to the 09/26/19 Admission Minimum Data Set (MDS, an assessment tool), the resident had obvious or likely cavities or broken teeth. During an interview on 01/06/19 at 12:04 PM, Resident #29 stated, It hurts here, and pointed to her left upper and lower molars and right upper molar. A dark black area was noted to the front of the right upper molar. When asked how long her teeth had been hurting Resident #29 stated, long time (resident has aphasia and speaks in simple one to two responses). Record review showed Resident #29 was seen by the dentist on 11/19/19. According to the consult the resident was to be referred for X-rays, Evaluation and Extractions as well as a Hygiene cleaning. Record review revealed no indication that the resident was referred to a dentist for X-rays, Evaluation or Extractions as recommended. During an interview on 01/10/2020 at 11:14 AM, when asked if there was any documentation to show that the facility followed up on the 11/19/19 dental consult that recommended the resident get X-rays, an evaluation and extractions, Staff C, Assistant Director of Nursing, stated, No. When asked if she would have expected the recommendations to have been acted upon by now (approximately two months later) Staff C stated, Yes. REFERENCE: WAC 388-97-1060 (3)(j)(vii).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40303 Based on observation, interview, and record review, the facility failed to maintain clean and sanitary surfaces, ensure sanitizer solution is replaced routinely, ensure staff used proper food handling techniques when preparing and serving meals, which placed residents at risk for cross-contamination, food borne illnesses, and diminished quality of life. Findings included . Facility Hand Washing Policy revised 01/11/19 indicated, Staff washes hands and exposed portions of arms as necessary to remove contamination after the following-handling utensils or equipment, before donning gloves for working with food. Observation on 01/05/20 at 9:00 AM and 01/10/20 at 9:15 AM revealed Staff Q, Dietary Aide, checked sanitary solution and confirmed the reading was below 150 parts per million (ppm). When asked what time was it changed, Staff Q replied 5:00 AM. Staff S, Dietary Manager, indicated that the solution should be changed every two hours. When asked if the solution was changed every two hours, Staff S said No On 01/10/20 at 10:07 AM Staff R, (Cook/Aide) walked in the kitchen with his jacket, placed the jacket on the food cart and proceeded to provide coffee to a resident in the absence of any hand hygiene. Staff R, applied gloves dispensed sour cream from a large container into small containers then removed the gloves. Staff R then went to the dry storage and brought in three cans of pears slices, which were opened without wiping the top of the can, then applied gloves without hand hygiene in between tasks. At 11:20 AM, Staff R, went outside the hallway door, returned back to the kitchen applied gloves and opened a bag of cheese ravioli, spread them on a tray, with the same gloves, proceeded to serve clean plates for serving food wit no hand hygiene in between tasks. Observation on 01/10/20 at 11:25 AM showed Staff S donned gloves, removed dinner rolls from the oven and transferred them to another tray, which was then placed on top of uncovered cooked fish and mashed potatoes on the steam table. At 12:05 PM, Staff S was observed to don gloves, pick up a dirty towel from the floor, remove the gloves, and proceed to close the lids of multiple juice containers without the benefit of hand hygiene. In an interview on 01/15/20 at 11:50 AM, Staff A, Executive Director, indicated it was the expectation that staff to wash hands before starting work, between tasks, after leaving food station and after removing gloves to prevent food contaminations. REFERENCE: WAC 388-97-1100(3), -2980.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 40303 Based on observation and interview, the facility failed to ensure one of one garbage dumpsters was covered with a lid when actively in use. Failure to cover the dumpster placed the facility at risk of attracting rodents. Findings included . A 01/11/19 facility policy titled Disposal of Garbage and Refuse Policy stated, Garbage and refuse will be disposed of properly and per federal, state, and local requirements, guideline include: All waste is properly contained in the dumpster and are covered appropriately. All areas where garbage/refuge is located is kept clean, free of debris and free of odors and waste fat. On 01/05/20 at 10:21 AM and 2:30 PM, 01/08/20 at 08:40 AM, and 10:45 AM, the dumpster lid was observed to be propped open. Observation of the area around the dumpster showed multiple used/soiled gloves and other debris, lying on the ground surrounding the dumpster. On 01/10/20 at 1:30 PM, joint observation with Staff T, Maintenance Manager, confirmed the dumpster lid was propped open. Staff T, indicated the all staff are responsible to close the dumpster lid after use. Staff T, further revealed he was responsible to make sure the dumpster is closed at all times and debris around it is cleaned. In an interview on 01/15/20 at 11:50 AM, Staff A, Executive Director, indicated it was the expectation that staff closed the dumpster after depositing refuse. REFERENCE: WAC 388-97-1320(4).

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	505195	A. Building B. Wing	01/16/2020

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. 20264 Based on interviews, the facility failed to employ a qualified social worker on a full-time basis. This failure placed residents at risk of having unmet psychosocial needs. Findings included . Refer to CFR: 483.45(c)3(e)(1)-(5), F-758, Free from Unnecessary Psychotropic Medications Findings included . According to federal regulations, any facility with more than 120 beds must employ a qualified social worker (SW) on a full-time basis. A qualified social worker is defined as an individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field and one year of supervised social work experience in a health care setting working directly with individuals. 32898 In an interview on 01/09/20 at 9:12 AM Staff I, Social Service Assistant, stated that he did not meet the listed criteria for a qualified Social Worker (SW) and stated, We have a consultant SW who comes out . Staff I confirmed the consultant did not work at the facility full time as a social worker and stated, We had a full time SW until the end of October 2019. Since that time it's been me and [the consultant]. In an interview on 01/09/20 at 9:30 AM Staff A, Administrator, confirmed the facility was licensed for 125 beds and the building was without a full time social services director since October 2019. Staff A indicated the consultant SW worked approximately 24 hours each week and a full time SW was scheduled to start working at the facility in February 2020. REFERENCE: WAC 388-97-0960(2)(a).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264 Based on observation, interview and record review, the facility failed to implement an effective infection control (Infection Control) program with monitoring to demonstrate ongoing analysis and trending of infectious organisms for one of three months reviewed. This failure detracted from staff's ability to identify trends and implement interventions, placing residents at risk for nosocomial (facility acquired) infections. Additionally, the facility failed to ensure appropriate use of handwashing, consistent implementation of infection control precautions and a sanitary environment which placed residents at risk for the development and transmission of disease and infection. Findings included . INFECTION CONTROL PROGRAM Determining the origin of infections assists the facility to identify the number of residents who developed infections. The comparison of current infection control data to past data enables detection of unusual or unexpected outcomes, trends, effective practices, and performance issues. The evaluation of facility practices then can help determine if the facility should change processes or practices to minimize the potential of infection transmission. According to the facility policy on Surveillance for Infections dated September 2017, The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and Healthcare-Associated Infections, to guide appropriate interventions and to prevent future infections. This policy directs that to gather surveillance data including, Laboratory records, infection documentation records and Positive urine cultures (bacteriuria) with corresponding signs and symptoms that suggest infection. SEPTEMBER 2019 IC REVIEW In an interview on 01/05/20 at 12:50 PM, Staff C, Infection Preventionist, stated that she was responsible for reviewing IC documents each month for any possible trends and to implement associated interventions. Staff C, Infection Preventionist, stated individual resident infections were identified and logged on the Line Listing [LL] form which included resident name and room number, site and type of infection, culture results, type of antibiotic and if the infection was facility acquired. According to the September 2019 IC LL, staff identified four Urinary Tract Infections (UTIs), two of which were facility acquired one each on the 3 and 4 units. The Monthly Healthcare Associated Infection Report [MHAIR], which summarized the month's infections, reflected the two facility acquired UTIs accounted for 2.56% of new infections and 0.85 infections per 1000 patient days. OCTOBER 2019 IC REVIEW (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	01/16/2020

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the October 2019 LL, the facility identified eight facility acquired UTIs. Three of the UTIs had no microorganism listed, but upon further review, two of these three had culture results of E-coli (a fecally related microorganism). With this information, five of the eight UTIs were E-coli, two were Pseudomonas and one UTI had no culture result. The line listing also showed that there were now three UTIs on Unit 1, two UTIs on Unit 3 and one on Unit 4 According to the MHAIR, staff identified only six UTIs, which accounted for 7.41% of new facility infections and 2.39 infections per 1000 patient days. In the Trends identified and Actions Taken section of the summary, staff documented, Overall UTI rate is increased this month without location trend. Possible correlation between reduced hydration [due to] broken sink. Work around initiated and residents now provided with water on all shifts. In an interview at 1:25 PM on 01/05/20, Staff C confirmed the line listing (which included eight facility acquired UTIs) did not match the MHAIR which reflected six UTIs. Staff C confirmed that staff should have, but did not identify the increase of UTIs on Unit 1 from zero to three, as a trend. Staff C also stated that that five (71%) of seven positive cultures triggering for the fecal microorganism E-coli, should have identified as a trend and indicated the E-coli was significant as it could reflect poor peri-care. In an interview on 01/05/10 at 1:40 PM, Staff C indicated the surveillance system was not intact could be improved. FAILURE TO IMPLEMENT PRECAUTIONS Observations on 01/05/20 at 9:31 AM revealed a sign outside room [ROOM NUMBER] indicating contact precautions were required prior to entering the room. Observation at that time revealed Staff J, Certified Nursing Assistant, at the resident's bedside talking to the resident and touching the bed linens and the foot of bed. In an interview at this time, Staff K, Registered Nurse, stated Resident #8, residing in room [ROOM NUMBER], had tested positive for Influenza and that staff were to wear a mask upon entering the resident's room. Staff K observed Staff J, exiting Resident #8's room without a mask. Staff K confirmed Staff J did not, but should have, donned a mask. HANDWASHING On 01/06/20 at 11:11 AM, Staff Y, Licensed Practical Nurse, was observed to check Gastric Tube placement for Resident #80. Staff Y removed the gloves she was wearing, then enter and exit the bathroom without performing hand hygiene. Staff Y then donned another pair of gloves and performed resident care. Staff Y again removed her gloves and exited the room to retrieve additional supplies and again went into the bathroom. Staff Y was observed exiting the bathroom without performing hand hygiene and donned a pair of gloves. Staff Y was observed to assist Resident #80 with repositioning, changed her gloves and then began to administering fluids and medications through the resident's gastric tube without hand hygiene between changing gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/06/20 11:15 AM, Staff Y was asked what was the expectation regarding hand hygiene between task. She replied, Oh, I should have washed my hands. REFERENCE: WAC 388-97-1320 (1)(a)(2)(a)(c). 32898

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264 Based on interview and record review, the facility failed to establish an infection prevention and control program that included developing an antibiotic stewardship program to promote appropriate use of antibiotics and reduce the risk of unnecessary antibiotic use, including the development of antibiotic resistance, three (September, October and November 2019) of three months of Infection Control (IC) documents reviewed. This failure placed residents at risk for potential adverse outcomes, associated with the inappropriate/unnecessary use of antibiotics. Findings included . Refer to CFR: 483.80(g)(1)(i)-(iv), F-880, Infection Prevention and Control FACILITY POLICY According to the December 2016 Antibiotic Stewardship Policy, The purpose of our Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents. This policy showed, When a nurse calls a physician/prescriber to communicate a suspected infection, he or she will have the following information available: Signs and Symptoms, when symptoms were first observed, resident's hydration status .when a culture and sensitivity (C & S - a test which determines effectiveness of antibiotics) is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified or discontinued. This policy detailed appropriate indications for use of antibiotics include: Criteria met for clinical definition of active infection or suspected sepsis; and pathogen susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun culture is pending) and that Empirical use of an antibiotic based on clinical criteria of suspected sepsis may be appropriate. The staff and practitioner will document the specific criteria that support the suspicion in the resident's clinical record. REVIEW OF ANTIBIOTIC STEWARDSHIP In an interview on 01/05/20 10:44 AM Staff C, Infection Preventionist explained the process for antibiotic stewardship as residents should meet criteria for infections in order to be treated with antibiotics stating, We track infections on the Line Listing (LL), and we do our surveillance on the floor. When asked what criterion staff used to establish infections, Staff C stated, We use the CDC [guidelines] .we assess the resident's temperature, x-ray or respiratory status. Staff C explained there was an evaluation form in the computer that staff used to compile information about resident infections on a Infection Surveillance Evaluation (ISE) form, which showed if the resident demonstrated symptoms to meet infection criteria. Staff C stated that usually the floor nurse fills out the ISE and if an antibiotic (ABO) was prescribed, We note the start date and the name of the abo, and then usually a couple of days in, if the symptoms are abating, we readdress [antibiotic use] and we talk to the physician. Staff C also stated that staff would reassess antibiotic used, based on the culture and sensitivity. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	REVIEW OF IC DOCUMENTS FOR SEPTEMBER 2019 RESIDENT #3 According to September LLs, Resident #3 was identified with a facility acquired Urinary Tract Infection (UTI). According to this document, a culture was obtained on 09/25/19 with the results listed as, at hospital. The resident was placed on Keflex (an antibiotic) on 09/26/19. Record review revealed no ISE which showed Resident #3 met the criteria for infection that would require antibiotic treatment. In an interview on 01/05/20 at 11:13 AM, Staff C reviewed the record for an ISE stating, I don't see one. Staff C was unable to explain why facility staff did not review Resident #3 for antibiotic treatment criteria for a UTI. In an interview on 01/05/20 at 11:30 AM, Staff C indicated Resident # demonstrated a change in condition and was sent to the hospital for evaluation and was determined to have a UTI. When asked about C & S results, Staff C stated, We are trying to work on that [obtaining culture results from the hospital]. Upon review of the electronic record C stated, It looks like she went out [to the hospital] on 09/23/19 and returned on 09/26/19. When asked if staff should we have gotten the results of the urinalysis and C & S, Staff C stated, Absolutely, we call for that and request it. When asked if staff attempted to obtain these lab results, Staff C reviewed the record and being unable to find said results stated, apparently not RESIDENT #79 According to September 2019 LL documents, Resident #79 was identified and treated for a Urinary Tract Infection (UTI). In an interview on 01/05/20 at 11:13 AM, Staff C stated she could find no testing for or indication the resident had a UTI stating, it looks like the [antibiotic] was for a skin infection that she was admitted with . At this time, Staff C confirmed the line listing was inaccurate and there was no ISE which showed Resident #79 met the criteria for infection requiring antibiotic treatment. RESIDENT #131 Resident #131 was admitted to the facility on [DATE] and according to the line listing was identified with a facility acquired UTI, was treated with an antibiotic and had the microorganism E-coli. In an interview on 01/05/20 at 11:26 AM, Staff C confirmed that while there was a surveillance report in the resident's record, it was blank. Staff C confirmed staff did not, but should have filled out the ISE to ensure the resident demonstrated the symptoms which would require an antibiotic. Staff C also confirmed the staff's failure to complete the Surveillance record should have been identified with the review of the September 2019 antibiotic stewardship review. REVIEW OF IC DOCUMENTS FOR OCTOBER 2019 RESIDENT #132 (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the October 2019 LLs revealed that Resident #132 was identified with a facility acquired UTI and treated with an antibiotic but did not meet criteria. Record review showed there was no ISE completed for this resident to ensure the resident met criteria for antibiotic treatment. In an interview on 01/05/20 at 1:08 PM, Staff C confirmed staff should have, but did not complete an ISE for Resident #132. Upon further record review, Staff C was able to locate an associated urine test that showed Resident #132 had E-coli and positive Leukocytes (white blood cells) in the urine, both symptoms which met criteria for antibiotic treatment. In an interview on 01/05/19 at 1:10 PM, Staff C confirmed the LL was incorrect and Resident #132 did meet criteria for infection. Staff C confirmed at this time if the LL was incorrect, it was not possible to render an accurate assessment for the use of antibiotics. RESIDENT #33 Review of the October 2019 LLs revealed that Resident #33 was identified with a facility acquired UTI and treated with an antibiotic on 10/19/19. Record review showed the resident was also treated for a UTI on 10/25/19, which was not included on the LL. In an interview on 01/05/20 at 1:30 PM Staff C confirmed staff should have, but did not complete a Surveillance form for the second antibiotic treatment and the resident should have, but was not, included twice on the LL. Additionally, urinalysis results dated 10/15/19 indicated the resident had 3+ leukocytes, but no C & S was completed. When asked, in an interview on 01/05/20 at 1:30 PM, why no C & S was obtained, Staff C stated, I don't know. When asked if staff should have inquired or determined why no culture and sensitivity was done, Staff C replied, yes. Review of progress notes showed no indication why a urinalysis was ordered and there were no notes that addressed the resident's symptoms until after the urinalysis results were obtained. In an interview on 01/05/20 at 1:17 PM Staff C stated, There should have been some type of progress note or assessment which triggered the order for a urinalysis .we don't have documentation of symptoms prior to the results of the UA. Record review showed the Nurse Practitioner wrote an order for an antibiotic on 10/17/19 at 5:00 PM, but according to the Medication Administration Record, it not started until the evening of the 10/18/19. When asked why it took over 24 hours to start an antibiotic, Staff C stated, I do not have an answer for that. Staff C stated antibiotic orders should be implemented, within 4 hours, or as soon as possible .it should be in our Omnicell (a computerized medication dispenser) but it should come before 24 hours RESIDENT #10 A Review of the October 2019 LLs revealed that Resident #10 was identified with a facility acquired UTI and treated with an antibiotic on 10/23/19. The results of the C & S were listed as pending. Review of the ISE did not include required information about culture results. (continued on next page)

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