

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>44922</p> <p>Based on interview and record review, the facility failed to ensure the resident, Resident Representative (RR), or payee were notified when their personal funds account reached a balance that was below \$200 of the Social Security Income (SSI, a monthly Social Security benefit for people with low incomes, limited resources and who are blind, disabled or 65 or older) resource limit of \$2000, for 1 of 5 residents (Resident 64) reviewed for personal funds. This failed practice placed the resident at risk of losing their Medicaid (a federal system of health insurance for those requiring financial assistance) or SSI eligibility.</p> <p>Findings included .</p> <p>Review of a policy titled Heritage Grove Trust Procedures dated 10/29/2024, showed the facility must inform the resident or the Resident's Representative (RR) when their trust balance was within \$200.00 of the social security limit of \$2000.00 and a copy of notification would be put in the resident's financial file. The policy also showed the Social Services Director (SSD) would be notified.</p> <p><Resident 64></p> <p>Review of the resident's medical records showed the resident admitted to the facility with diagnoses to include dementia (the loss of cognitive functioning, thinking, remembering, and reasoning that it interferes with a person's daily life and activities).</p> <p>Review of Resident 64's trust fund account dated 09/01/2024 through 09/30/2024 showed a balance of \$6419.37.</p> <p>During an interview on 10/23/2024 at 5:30 PM, Staff S, Business Office Manager, stated there were a few residents with high balances due to a back payment received from Social Security when they first applied for services. Staff S stated the residents had 180 days (six months) to spend down those funds that were given to them.</p> <p>Review of a an email received on 10/28/2024 at 8:50 AM, Staff S wrote they were told the residents had a nine-month time frame to spend down the extra funds received as a lump sum payment from Social Security, so would not count towards the resource limit until after the nine months (not the six months they said they had on 10/23/2024). Staff S could not provide the SSI letter showing when the funds were deposited into Resident 64's account.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 64's deposit transaction receipt dated 09/14/2023, showed a deposit was made from Social Security in the amount of \$5634.20 (13 months and 10 days).</p> <p>During a follow-up interview on 10/28/2024 at 2:49 PM, Staff S stated they had not reached out to Resident 64's RR to inform them of the resident's balance exceeding the \$2000 limit for resources and they needed to take care of that.</p> <p>During an interview on 10/29/2024 at 9:52 AM, Staff F, SSD, stated they had not been notified of Resident 64's high balance and stated they did not get notified of everyone that had a balance within resource limits, they only got involved if need be.</p> <p>During an interview on 10/29/2024 at 10:34 AM, Staff C, Administrator Designee, stated they would have expected the family and or RR notified and a spend down started.</p> <p>WAC Reference: 388-97-0340 (4)(a)(b)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30528</p> <p>Based on interview and record review, the facility failed to ensure a Resident's Representative (RR) was fully informed of a change of condition for 2 of 4 residents (Resident 68 and 79) reviewed for nutrition. The facility failed to inform the RR of severe weight loss. This failure denied the RR the right to be involved and make decisions regarding the care and treatment of the resident.</p> <p>Findings included .</p> <p><Resident 68></p> <p>Record review showed the resident was admitted to the facility with diagnoses to include dementia (a loss of mental ability severe enough to interfere with normal activities of daily living), anxiety disorder (the mind and body's reaction to stressful, dangerous, or unfamiliar situations) and failure to thrive (a progressive functional deterioration of a physical and cognitive nature).</p> <p>Review of the 08/23/2024 quarterly Minimum Data Set (MDS, a required assessment and care planning tool) showed that the resident had a weight of 149 pounds (lbs, a unit of weight measurement), had no weight loss, and required maximum to substantial staff assistance for meals.</p> <p>Record review of a 10/11/2024 nutrition at risk (NAR) meeting note showed Resident 68 had severe weight loss in the past month. On 10/08/2024 Resident 68 weighed 135 lbs compared to a weight of 143 lbs on 09/13/2024; a 5.1% loss. There was an overall six month 13.5% loss from 04/12/2024 at 156.9 lbs. The meeting was attended by Staff B, Director of Nursing Services (DNS), Staff U, Registered Dietitian, Staff R, Dietary Manager, and Staff E, Licensed Practical Nurse (LPN)/MDS Coordinator.</p> <p>During a telephone interview, on 10/16/2024 at 1:36 PM, Resident 68's RR stated they had not been able to visit for the past month and was concerned about Resident 68 losing more weight. The RR stated they last saw the resident in September 2024, and they weighed 144 lbs. The RR stated they had not been had notified of Resident 68's continued weight loss.</p> <p>During an interview on 10/18/2024 at 1:15 PM, Staff MM, LPN, stated the unit nurse and or Unit Manager (UM) should have called and notified the RR of severe weight loss.</p> <p>During an interview on 10/24/2024 at 11:43 AM Staff J, LPN/UM, stated the RD or UM should have called the RR of about the severe weight loss and then documented it in the resident's record.</p> <p>During an interview on 10/25/2024 at 11:29 AM, Staff B stated Resident 68's representative should have been notified of their weight loss.</p> <p>44922</p> <p><Resident 79></p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's medical records showed the resident admitted to the facility with diagnoses to include malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets). The 07/15/2024 comprehensive assessment showed Resident 79's cognition was severely impaired and had not experienced a five percent weight loss in the last month or a ten percent weight loss in the last six months.</p> <p>During an interview on 10/16/2024 at 2:44 PM, the RR stated Resident 79 had recently been admitted to Hospice services (end of life care) and during the admission learned from the hospice nurse that Resident 79 had lost a significant amount of weight. The RR stated they were upset that they were in communication with the facility often and no one had notified them of the resident's weight loss.</p> <p>Review of Resident 79's weight records from 04/08/2024 through 09/26/2024 showed the resident admitted on [DATE] with a weight of 132 lbs; on 05/06/2024, the resident weighed 120.3 lbs (a 9.73 percent weight loss in one month); and on 09/26/2024, Resident 79 weighed 92.5 lbs, (a 29.92 percent weight loss in the last six months).</p> <p>Review of the 07/24/2024 NAR meeting note (first meeting for Resident 79's weight loss), showed as of 07/08/2024 Resident 79 had severe weight loss since admission and was worsening. The note showed the provider was aware and did not show the RR had been notified.</p> <p>During an interview on 10/24/2024 at 12:45 PM, Staff U stated it was not their responsibility to report weight loss to the residents or the RRs, that would be the responsibility of Staff B, nursing, or the UMs.</p> <p>During an interview on 10/24/2024 at 1:48 PM, Staff J stated they would assume it was the responsibility of the RD to notify families or residents of weight loss. Staff J stated that was not something they ever did.</p> <p>During an interview on 10/24/2024 at 3:20 PM, Staff E stated they attended NAR meetings weekly so they could adequately follow and capture on the MDS a resident's weight loss, but they did not notify family or residents of weight loss identified on the assessments.</p> <p>During an interview on 10/29/2024 at 10:08 AM, Staff B stated when a resident experienced weight loss, the UMs should be notifying family or the residents and then documenting that notification in the resident's medical record.</p> <p>Reference: WAC 388-97-0320(1)(b)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30528</p> <p>Based on observation, interview, and record review, the facility failed to protect the personal privacy for 1 of 4 residents (Resident 245) observed for incontinent care and 1 of 1 resident (Resident 293) observed after a fall. This failure placed the residents at risk for loss of the right to personal privacy.</p> <p>Findings included</p> <p>Record review of the facility's policy titled, Privacy and Confidentiality, dated 07/2018, showed that each resident had the right to privacy during personal care.</p> <p>Record review of the facility's policy titled, Respect and Dignity, dated 09/20/2022, showed that the residents had the right to be treated with respect and dignity.</p> <p><Resident 245></p> <p>Record review showed Resident 245 was admitted on [DATE] with diagnoses to include stroke (when the blood supply to part of the brain is interrupted or reduced, preventing brain tissue from getting oxygen and nutrients), depression, and pain.</p> <p>Review of the incomplete comprehensive admission assessment showed that on 10/04/2024 the resident had moderate cognitive impairment was not continent of bowel or bladder.</p> <p>During a concurrent observation and interview on 10/18/2024 at 11:55 AM, Staff NN, Nursing Assistant (NA) changed Resident 245's brief. During the process, after removing the soiled brief and cleaning the resident, Staff NN left the resident exposed from the waist down when they left the bedside to change their gloves and wash their hands. Resident 245's brief was heavily soiled with urine and Staff NN stated that because they were so short staffed, this was the first time they could get to the resident for cares. After a clean brief was applied, the resident stated they felt cold.</p> <p><Resident 293></p> <p>Record review showed Resident 293 was admitted to the facility on [DATE] with diagnoses to include respiratory failure, bipolar disorder (a mood disorder that causes radical emotional changes and mood swings, from manic, restless highs to depressive, listless lows), Parkinson's Disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves), and acute kidney failure.</p> <p>Record review of the comprehensive admission assessment completed on 10/22/2024 showed Resident 293 had moderate cognitive impairment, required extensive staff assistance for transfers and had several non-injuries falls since admission.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 10/21/2024 at 1:42 PM, Staff Y, NA, responded to Resident 293 yelling help me, and stated the resident had just turned on the call light and found them on the fall mat. The resident was lying on the fall mat between their bed and the open door. The privacy curtain was open, and the resident was only wearing a brief. Staff P, Licensed Practical Nurse (LPN), also entered the room and saw Resident 293 lying on the floor mat. At 1:45 PM, Staff K, LPN/Unit Manager and Staff B, Director of Nursing Service (DNS), also entered the resident's room. The DNS directed the staff to pull the privacy curtain, shut the door and find a blanket to cover the resident.</p> <p>During an interview on 10/25/2024 at 11:29 AM Staff B stated Resident 293 should not have been exposed like that. All residents have the right to privacy.</p> <p>Reference: WAC 388-97-0360(d)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>48368</p> <p>Based on interviews and record review the facility failed to report an incident involving a missing resident in a timely manner to local law enforcement (LLE) and the State Agency (SA) as required for 1 of 5 residents (Resident 143) reviewed for missing persons. This failure disallowed an opportunity for LLE to assist in the search of Resident 143 and placed the residents at risk for harm related to unrecognized and uninvestigated abuse and/or neglect.</p> <p>Findings included .</p> <p>A review of the Nursing Home Guidelines or The Purple Book, dated October 2015 showed that facilities were required to report a missing resident to Law Enforcement and the State Agency Hotline in a timely manner.</p> <p><Resident 143></p> <p>Review of the medical record showed the resident was admitted to the facility with diagnoses including stroke (occurs when blood flow to the brain is cut off, which can damage and kill brain cells), frontal lobe deficit (causes personality changes, difficulty concentrating or planning, impulsivity), and psychoactive substance abuse (the use of illegal/legal drugs or alcohol for purposes other than for which they are meant to be used, or in excessive amounts). The 10/15/2024 Brief interview for Mental Status (BIMS) showed Resident 143 had moderately impaired cognition. Review of a nursing progress note, dated 10/23/2024, showed the resident required the assistance of two staff members for activities of daily living (ADLs).</p> <p>Review of a progress note, dated 10/24/2024, showed Resident 143 left the building at 4:30 PM with a family member.</p> <p>Review of a progress note, dated 10/24/2024 at 11:15 PM, showed Resident 143 had not returned from their outing. Staff K, Licensed Practical Nurse, completed a search of the facility, and Resident 143 was not found during the search. Further review showed no notification to LLE.</p> <p>Review of a progress note, dated 10/25/2024 at 1:54 AM, showed Staff K, contacted Resident 143's representative. Further review showed Resident 143's representative stated Resident 143 was not with them or any other family member. (nine hours and 54 minutes after Resident 143 left the facility).</p> <p>Review of a progress note, dated 10/25/2024 at 7:02 AM, showed Staff K called 911 and provided a description of the missing resident. (14 hours and 32 minutes after Resident 143 left the facility).</p> <p>Review of the SA complaint tracking system on 10/25/2024 showed no required report by the facility of the missing resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/25/2024 at 12:54 PM, Staff B, Director of Nursing Services, and Staff D, Regional Nurse Consultant, stated they did not report the missing resident to the SA, as they did not consider Resident 143 an elopement risk. Staff D stated they did not utilize the Purple Book during their investigation. Staff B stated that LLE was not contacted in a timely matter.</p> <p>Reference: WAC 388-97-0640 (6)(c)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642</p> <p>Based on interview and record review, the facility failed to thoroughly investigate an allegation of staff-to-resident abuse, for one of five sampled residents (Resident 4), reviewed for abuse. The failure to complete a thorough investigation placed the resident at risk for potential abuse and other negative health outcomes.</p> <p>Findings included .</p> <p>Review of the facility policy dated 11/2017, titled, Freedom from Abuse, Neglect and Exploitation showed when the facility had identified abuse, the facility should take appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. The policy discussed the need for taking steps to prevent further potential abuse, report the allegation to appropriate authorities within required timeframes, and conduct a thorough investigation of the allegation.</p> <p><Resident 4></p> <p>Review of the medical record showed they were admitted to the facility on [DATE] with diagnoses to include dementia (a loss of mental ability severe enough to interfere with normal activities of daily living), insomnia (trouble sleeping at night, staying asleep or both), and kidney failure. The comprehensive assessment, dated 07/01/2024, showed the resident required substantial assistance with activities of daily living (ADL's) and transfers. The assessment showed the resident's cognition was severely impaired.</p> <p>During an interview on 10/18/2024 at 10:30 AM, Staff B, Director of Nursing Services, provided investigation documents, dated 09/19/2024, with a completion date of 09/23/2024, that showed an incomplete incident report. The investigation did not contain other resident or staff interviews to rule out abuse. Staff B stated they needed to provide more information for the investigation, they just had to find the documentation of the staff education provided after the incident.</p> <p>Review of the facility incident report, dated 09/19/2024 at 5:00 AM, showed Resident 4 had reported to the day shift Nursing Assistant (NA) that Staff II, NA, was rude and rough with them during care. The investigation showed Staff II was immediately suspended until the investigation was completed, education for five staff and notifications to family and the physician were completed. Further review of the incident report showed no additional resident or staff interviews as required for a thorough investigation, had been completed to show how abuse was ruled out for Resident 4.</p> <p>During an interview on 11/04/2024 at 9:31 AM, Staff B stated normally their investigations were thorough, they had a system in place to investigate, but stated this investigation was difficult in that some of their residents had dementia. Staff B acknowledged that the incident investigation was incomplete.</p> <p>Reference: WAC 388-97-0640 (6)(a)(b)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922</p> <p>Based on interview and record review the facility failed to provide a written notice to the resident and/or their representative of the discharge for 5 of 5 residents (Residents 5, 54, 67, 18, and 51) reviewed for hospitalization . This failure placed the residents at risk for unmet discharge needs.</p> <p>Findings included .</p> <p><Resident 5></p> <p>Review of the medical record showed the resident was admitted to the facility with diagnoses to include left breast cellulitis (a bacterial skin infection that causes swelling, pain, warmth and redness) and a skin infection to their pannus (excess skin and fat hanging down from the abdomen). The 08/07/2024 comprehensive assessment showed Resident 5's cognition was intact.</p> <p>Review of nursing progress notes showed the resident was sent to the hospital on 10/10/2024 due to increased redness, pain, and swelling to their breasts. Resident 5 readmitted back to the facility on [DATE].</p> <p>Review of Resident 5's discharge documents showed no notice of transfer had been given to the resident or the resident representative (RR).</p> <p><Resident 54></p> <p>Review of the medical record showed they were admitted to the facility with diagnoses to include toxic encephalopathy (a brain dysfunction caused by toxic exposure in the absence of primary structural brain disease) and dementia (group of symptoms affecting memory, thinking and social abilities). The 08/07/2024 comprehensive assessment showed Resident 54's cognition was severely impaired.</p> <p>Review of nursing progress notes showed on 10/10/2024 Resident 54 was given another resident's medications and needed to be sent to the hospital. The resident readmitted to the facility on [DATE].</p> <p>Review of Resident 54's discharge documents showed no notice of transfer had been given to the resident or the RR.</p> <p>During an interview on 10/25/2024 at 1:10 PM, Staff J, Licensed Practical Nurse/Unit Manager, stated the notice of transfer was not a form they were familiar with and if it was not in the computer to complete on discharge, then it had not been done.</p> <p>30528</p> <p><Resident 67></p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 67's medical record showed they admitted to the facility with diagnoses to include dementia, anxiety (the mind and body's reaction to stressful, dangerous, or unfamiliar situations), and liver cirrhosis (severe scarring of the liver). The 06/30/2024 comprehensive assessment showed Resident 67 was independent for activities of daily living and had severe impaired cognition.</p> <p>Record review showed Resident 67 had a change of condition on 10/03/2024 and was transported to the hospital emergency department followed by a six day stay at the hospital.</p> <p>Record review showed no transfer notice provided to the resident or their RR at the time of the transfer to the hospital on 10/03/2024.</p> <p>During an interview on 10/24/2024 at 11:40 AM, Staff J stated they recalled sending Resident 67 to the hospital on 10/03/2024; however, they did not complete a transfer notice to give to the resident or RR at the time of transfer to the hospital.</p> <p>45642</p> <p><Resident 18></p> <p>Review of Resident 18's medical record showed they were admitted to the facility on [DATE] with diagnoses to include lymphedema (tissue swelling caused by an accumulation of protein-rich fluid that's usually drained through the body's lymphatic system), diabetes (a disease in which the body does not control glucose (a type of sugar) in the blood), severe obesity (excessive accumulation of body fat) and high blood pressure. The 06/20/2024 comprehensive assessment showed the resident dependent on staff for toileting hygiene, shower/bathing, bed mobility, and transfers. The comprehensive assessment showed the resident's cognition was intact.</p> <p>Review of the medical record showed Resident 18 had a change in condition on 06/10/2024 and was transported to the local hospital emergency department followed by a six day stay at the hospital.</p> <p>Record review showed no transfer notice had been given to Resident 18 or the RR at the time of transfer on 06/10/2024.</p> <p><Resident 51></p> <p>Review of Resident 51's medical record showed that they were admitted to the facility on [DATE] with diagnoses to include quadriplegia (complete immobility due to severe disability), scoliosis (a sideways curve of the spine), muscle weakness, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The comprehensive assessment dated [DATE] showed the resident required substantial assistance with toileting hygiene, bed mobility, transfers, and was dependent on staff for shower/bathing. The comprehensive assessment showed the resident's cognition was intact.</p> <p>Review of the medical record showed Resident 51 had a change in condition on 09/21/2024 and was transferred to the local hospital emergency department followed by a three day stay at the hospital.</p> <p>Record review showed no transfer notice had been given to Resident 51 or their RR at the time of transfer to the hospital on 09/21/2024.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/29/2024 at 10:03 AM, Staff B, Director of Nursing Services, along with Staff C, Administrator Designee, and Staff D, Regional Nurse Consultant, stated when a resident was discharged to the hospital they should have been given a notice of transfer. The notice should have been provided to the resident, family, or RR. Staff D stated they recognized this system was broken and would work on it.</p> <p>Reference: WAC 388-97-0140(1)(a)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922</p> <p>Based on interview and record review, the facility failed to issue a written notice of bed hold (holding or reserving a resident's bed while the resident was absent from the facility) at the time of a hospital transfer for 5 of 5 residents (Residents 5, 54, 67, 18, and 51) reviewed for hospital transfers. This failure placed the residents at risk for lack of knowledge regarding their right to hold their bed and any monetary charges associated with the bed hold while in the hospital.</p> <p>Findings included</p> <p>Record review of the facility's policy titled, Notice of Bed Hold Policy Before / Upon Transfer, dated 07/2018, showed that the bed hold notifications would be provided to the resident and their representative at the time of transfer and/or within 24 hours if the transfer were an emergency.</p> <p><Resident 5></p> <p>Review of the medical record showed the resident admitted with diagnoses to include an infection to their left breast. The 08/09/2024 comprehensive assessment showed Resident 5's cognition was intact.</p> <p>During an interview on 10/15/2024 at 11:02 AM, Resident 5 stated they had just returned on 10/14/2024 from a hospital stay for an infection to both breasts.</p> <p>Review of nursing progress notes 10/10/2024 showed the resident had a change in condition and was discharged to the hospital on 10/10/2024 and readmitted to the facility on [DATE].</p> <p>Review of the 10/10/2024 documents provided to the resident on discharge showed no bed hold had been offered, refused, or communicated to the resident or the resident representative (RR).</p> <p><Resident 54></p> <p>Review of the medical record showed the resident admitted with diagnoses to include dysphagia (difficulty swallowing) and malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets). The 08/07/2024 comprehensive assessment showed Resident 54's cognition was severely impaired.</p> <p>During an interview on 10/16/2024 at 2:16 PM, the RR's stated the resident had been sent to the hospital after receiving someone else's medications. The RR stated they did not know what a bed hold was nor was it offered when the resident was sent to the hospital.</p> <p>Review of the 10/10/2024 nursing progress notes on showed Resident 54 was given the wrong medicine and discharged to the hospital on 10/10/2024 and readmitted back to the facility on [DATE].</p> <p>Review of the 10/10/2024 documents provided to the resident on discharge showed no bed hold had been offered, refused, or communicated to the resident or the RR.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/23/2024, Staff J, Licensed Practical Nurse/Unit Manager, along with Staff L, Infection Preventionist, stated they were not aware of the bed hold that should be offered when a resident discharged to the hospital, and they did not provide them, send them with the resident, or offer it to them. Staff J stated they completed their discharge paperwork in the health record and that was not on the list of items. Staff L stated they should be in the discharge packet and offered it to the residents on discharge and if the resident was unable to sign, it was sent with them to the hospital so that family could complete and return them. Staff L stated if they could not be found in the record, they most likely were not done.</p> <p>30528</p> <p><Resident 67></p> <p>Review of Resident 67's medical record showed they admitted to the facility with diagnoses to include dementia (a loss of mental ability severe enough to interfere with normal activities of daily living), anxiety (the mind and body's reaction to stressful, dangerous, or unfamiliar situations), and liver cirrhosis (severe scarring of the liver). The 06/30/24 comprehensive assessment showed Resident 67 was independent for activities of daily living and had severe impaired cognition.</p> <p>Record review showed Resident 67 had a change of condition on 10/03/2024 and was transported to the hospital emergency department followed by a six day stay at the hospital.</p> <p>Record review showed no bed hold information communicated to the resident or their representative at the time of the transfer to the hospital on 10/03/2024.</p> <p>During an interview on 10/24/2024 at 11:40 AM, Staff J stated they recalled sending Resident 67 to the hospital on 10/03/2024; however, they did not provide the bed hold notice to the resident or representative and stated they were not aware it was their responsibility.</p> <p>45642</p> <p><Resident 18></p> <p>Review of Resident 18's medical record showed they were admitted to the facility on [DATE] with diagnoses to include lymphedema (tissue swelling caused by an accumulation of protein-rich fluid that's usually drained through the body's lymphatic system), diabetes(a disease in which the body does not control glucose (a type of sugar) in the blood), severe obesity (excessive accumulation of body fat) and high blood pressure. The 06/20/2024 comprehensive assessment showed the resident was dependent on staff for toileting hygiene, shower/bathing, bed mobility, and transfers. The comprehensive assessment showed the resident's cognition was intact.</p> <p>Review of the electronic medical record showed Resident 18 had a change in condition on 06/10/2024 and was transported to the local hospital emergency department followed by a six day stay at the hospital.</p> <p>Record review showed no bed hold information communicated to Resident 18 or their representative at the time of transfer on 06/10/2024.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><Resident 51></p> <p>Review of Resident 51's medical record showed that they were admitted to the facility on [DATE] with diagnoses to include quadriplegia (complete immobility due to severe disability), scoliosis (a sideways curve of the spine), muscle weakness, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The comprehensive assessment dated [DATE] showed the resident required substantial assistance with toileting hygiene, bed mobility, transfers, and was dependent on staff for shower/bathing. The comprehensive assessment showed the resident's cognition was intact.</p> <p>Review of the electronic medical record showed Resident 51 had a change in condition on 09/21/2024 and was transferred to the local hospital emergency department followed by a three day stay at the hospital.</p> <p>Record review showed no bed hold information communicated to Resident 51 or their representative at the time of transfer to the hospital on 09/21/2024.</p> <p>During an interview on 10/29/2024 at 10:03 AM, Staff B, Director of Nursing Services, along with Staff C, Administrator Designee, and Staff D, Regional Nurse Consultant, stated the nursing staff needed to offer the bed hold policy on discharge to the hospital and then document it. Staff D stated they recognized that system was broken and needed to work on it.</p> <p>Reference: WAC 388-97-0120(3)(c);(4)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30528</p> <p>Based on interview and record review, the facility failed to ensure resident admission Minimum Data Sets (MDS, a required assessment and care planning tool) were completed within the required timeframes for 2 of 3 residents (Residents 293 and 245) reviewed for admission assessments. Failure to complete admission within the required timeframes placed residents at risk for a delay in identification of care needs and/or unmet care needs.</p> <p>Findings included .</p> <p>Review of the Resident Assessment Instrument (RAI, a manual that directs staff on requirements for completion of MDS's) showed the admission Assessment Reference Date (ARD, refers to the specific endpoint for the observation (or look-back) periods in the MDS assessment process) should be completed no later than the 14th calendar day of the resident's admission (admitted + 13 calendar days).</p> <p><Resident 293></p> <p>Record review showed Resident 293 was admitted to the facility on [DATE] with diagnoses to include respiratory failure, bipolar disorder (a mood disorder that causes radical emotional changes and mood swings, from manic, restless highs to depressive, listless lows), Parkinson's Disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves), and acute kidney failure.</p> <p>Record review of Resident 293's medical record showed an admission MDS had an ARD of 09/29/2024. Review of the assessment MDS completion date showed it was not completed until 10/22/2024 (27 days after the admission and 13 days late).</p> <p><Resident 245></p> <p>Record review showed Resident 245 was admitted on [DATE] with diagnoses to include stroke (when the blood supply to part of the brain is interrupted or reduced, preventing brain tissue from getting oxygen and nutrients), depression, and pain.</p> <p>Record review of Resident 245's medical record showed an admission MDS had an ARD of 09/29/2024. Review of the assessment MDS completion date showed it was not completed until 10/29/2024, 34 days after the admission and 20 days late.</p> <p>During an interview on 10/24/2024 at 2:40 PM, Staff E, Licensed Practical Nurse/MDS Coordinator, stated they were aware that many of the MDS assessments had not been completed and were late. They stated they were the only staff currently completing them as they recently lost their part time help.</p> <p>During an interview on 10/25/2024 at 11:30 AM, Staff B, Director of Nursing Services, stated they were aware of the late MDS assessments and were trying to get Staff E help.</p> <p>Reference: WAC 388-97-1000(3)(a)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>44922</p> <p>Based on observation, interview, and record review the facility failed to ensure a significant change assessment had been completed for 1 of 2 residents (Resident 79) reviewed for hospice and end of life care. This failed practice placed the resident at risk for unmet care needs due to their imminent decline in health.</p> <p>Findings included .</p> <p>Review of the Resident Assessment Instrument Manual (RAI, a manual directing staff on how to accurately assess the status of residents), dated 10/2023, showed a significant change assessment was required when a resident was placed on hospice for a terminal prognosis, with a life expectancy of six months or less.</p> <p><Resident 79></p> <p>Review of the resident's medical record showed the resident admitted to the facility with diagnoses to include malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets), delusions (fixed, false conviction in something that is not real or shared by other people), and hallucinations (an experience in which you see, hear, feel, or smell something that does not exist). The 07/15/2024 comprehensive assessment showed Resident 79's cognition was severely impaired, required substantial to maximum staff assistance with activities of daily living, and set-up for eating.</p> <p>Review of the 10/04/2024 hospice admission notes showed the resident had been admitted to hospice services on 10/04/2024 for diagnoses of malnutrition and an untreated urine infection the Resident Representative had chosen to not receive additional treatment interventions for.</p> <p>Review of Resident 79's comprehensive assessments showed a significant change assessment had not been completed as of 10/29/2024.</p> <p>During an interview on 10/22/2024 at 2:03 PM, showed Staff E, Licensed Practical Nurse/Minimum Data Set (MDS, a required assessment and care planning tool) Coordinator, stated they should have completed a significant change assessment on Resident 79 but they just had not gotten to them yet.</p> <p>During an interview on 10/29/2024 at 10:08 AM, Staff C, Administrator Designee, along with Staff B, Director of Nursing Services, and Staff D, Regional Nurse Consultant, stated they were aware the MDS assessments were behind and were trying to find a solution to get them caught up.</p> <p>WAC Reference: 388-97-1000 (3)(b)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assure that each resident's assessment is updated at least once every 3 months.</p> <p>30528</p> <p>Based on interview and record review, the facility failed to complete quarterly Minimum Data Set (MDS, a required assessment and care planning tool) assessments within the regulatory timeframes for 6 of 6 residents (Residents 2, 11, 1, 19, 49 and 71) reviewed for timeliness of assessments. The failure to ensure resident assessments were completed timely placed the residents at risk for delayed care planning, unidentified care needs and services, and a decreased quality of life.</p> <p>Findings included .</p> <p>Review of the 10/2023 Resident Assessment Instrument (RAI, a manual that directs staff on requirements for completion of MDS's) showed the quarterly Assessment Reference Date (ARD, refers to the specific endpoint for the observation (or look-back) periods in the MDS assessment process) should be completed no later than 92 calendar days from the previous quarterly MDS.</p> <p><Resident 2></p> <p>Record review of Resident 2's medical record showed Resident 2's quarterly MDS with an ARD of 09/06/2024 and showed it was completed on 10/11/2024 (35 days late).</p> <p><Resident 11></p> <p>Record review of Resident 11's medical record showed Resident 11's quarterly MDS with an ARD of 08/29/2024 and showed it was completed on 10/11/2024 (43 days late).</p> <p><Resident 1></p> <p>Record review of Resident 1's medical record showed Resident 1's quarterly MDS with an ARD of 09/02/2024 and showed it was completed on 10/11/2024 (38 days late).</p> <p><Resident 19></p> <p>Record review of Resident 19's medical record showed Resident 19's quarterly MDS with an ARD of 09/03/2024 and showed it was completed on 10/11/2024 (37 days late).</p> <p><Resident 49></p> <p>Record review of Resident 49's medical record showed Resident 49's quarterly MDS with an ARD of 09/03/2024 and showed it was completed on 10/11/2024 (37 days late).</p> <p><Resident 71></p> <p>Record review of Resident 71's medical record showed Resident 71's quarterly MDS with an ARD of 07/12/2024 and showed it was completed on 8/07/2024 (26 days late). Additionally, Resident 71's quarterly MDS with an ARD of 10/12/2024 was not completed as of 10/29/2024 (currently 17 days late).</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/24/2024 at 2:40 PM, Staff E, Licensed Practical Nurse/MDS Coordinator, stated they were aware that many of the MDS assessments had not been completed and were late. They stated they were the only one currently completing them as they recently lost their part time help.</p> <p>During an interview on 10/29/2024 at 8:21 AM, Staff B, Director of Nursing Services, and Staff D, Regional Nurse Consultant, stated they were aware that the MDS assessments were behind and were trying to get more help for the MDS coordinator.</p> <p>Reference: WAC 388-97-1020(5)(b)</p> <p>45642</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30528</p> <p>Based on observation, interview, and record review, the facility failed to develop and/or implement comprehensive resident centered care plans for 2 of 3 residents (Residents 73 and 18) reviewed for care planning in the areas of accident prevention and edema (extra fluid in the body caused by conditions such as heart failure, liver disease, and kidney disease). This failed practice put residents at risk for unmet care needs.</p> <p>Findings included .</p> <p><Accident Prevention></p> <p><Resident 73></p> <p>Record review showed Resident 73 was admitted with diagnoses to include dementia (a loss of mental ability severe enough to interfere with normal activities of daily living), and depression. Review of the 08/14/2024 comprehensive assessment showed the resident had severe cognitive impairment and was independent with meals.</p> <p>Record review of a 11/06/2023 nursing admission assessment showed Resident 73 was identified at a safety risk when drinking hot beverages and required lids on their coffee cups.</p> <p>Record review of Resident 73's care plan, dated 11/06/2023, showed they required lids on their cup when drinking hot beverages as part of their nutritional care plan and activities of daily living care plan.</p> <p>Record review of a 10/15/2024 incident report showed at 7:40 AM Resident 73 was served coffee with cream and sugar by Staff JJ, Nursing Assistant (NA) from a coffee carafe in the dining room. There was no lid on the cup of coffee, and it spilled in the resident's lap causing a second-degree burn (damage to the outer layer and the second layer of skin caused by heat, chemical or light source).</p> <p>During an interview on 10/16/2024 at 11:16 AM, Staff B, Director of Nursing Services, stated Resident 73 was assessed to have lids on their hot beverages, it was in their care plan and the care plan was not implemented.</p> <p><Edema></p> <p><Resident 18></p> <p>Review of the medical record showed they were admitted to the facility on [DATE] with diagnoses to include lymphedema (tissue swelling caused by an accumulation of protein-rich fluid that's usually drained through the body's lymphatic system), severe obesity (excessive accumulation of body fat) and high blood pressure. The 06/20/2024 comprehensive assessment showed the resident was dependent on staff for toileting hygiene, shower/bathing, bed mobility, and transfers. The comprehensive assessment showed the resident's cognition was intact.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and concurrent interview on 10/16/2024 at 10:40 AM, Resident 18 stated, they had swelling to both their lower legs all the time, had leg wraps, and took medication for their swelling. The resident did not have their leg wraps in place.</p> <p>Review of the physician orders, dated 10/09/2024, showed Resident 18 was to take a diuretic (a medication that helps reduce fluid buildup in the body) and nursing were to apply elastic bandage wraps to both legs lightly from knees to toes, and remove at bedtime.</p> <p>During an observation and concurrent interview on 10/17/2024 at 2:45 PM, Resident 18 stated they wore their leg wraps for about five to six hours a day. The resident stated that the nurses would apply the wraps when they get to it, usually every other day. Resident 18 stated they last wore the wraps a couple of days ago.</p> <p>During an observation and concurrent interview on 10/18/2024 at 3:36 PM, Resident 18 was lying in bed, both legs were uncovered, and the resident had no lymphedema wraps in place. Resident 18 stated the nurse had not come in to offer the wraps.</p> <p>During an observation and concurrent interview on 10/22/2024 at 9:04 AM, Resident 18 had their leg wraps to both legs. The resident stated that the nurses put them on and my legs feel good.</p> <p>Review of Resident 18's care plan, dated 03/18/2024, showed the resident was at risk for impaired nutrition related to their diagnoses of lymphedema. The care plan did not address the resident's lymphedema as a focus, there were no goals, and no specific interventions for their lymphedema.</p> <p>During an interview on 10/29/2024 at 8:30 AM, Staff B stated care plans were a team effort to get them done. The expectation was to get the care plan done right and timely. Staff B stated that for Resident 18 their lymphedema should have been addressed and care planned.</p> <p>Reference: 388-97-1020(1)(2)</p> <p>45642</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922</p> <p>Based on observation, interview, and record review the facility failed to provide the necessary care and services to ensure that dependent residents received assistance with dressing, personal hygiene, and shower/bathing for 4 of 5 residents (Resident 5, 83, 18, and 51). This failure placed the residents at increased risk for skin breakdown and unmet care needs.</p> <p>Findings included .</p> <p><Resident 5></p> <p>Review of the medical record showed the resident admitted with diagnoses to include diabetes (a chronic condition the occurs when the body has high levels of sugar in the blood) and kidney failure. The 08/09/2024 comprehensive assessment showed Resident 5's cognition was intact and required substantial to maximum assistance for hygiene and bathing.</p> <p>During an interview on 10/15/2024 at 10:40 AM, Resident 5 stated they were frustrated because they would like to have a shower more than twice a week but would like to at least get the two a week they were scheduled for. Resident 5 stated their shower days were on Wednesdays and Saturdays but often did not receive them due to the facility being short-staffed and the Nursing Assistants (NA) on the floor were too busy.</p> <p>Review of Resident 5's shower tasks, showed from 09/22/2024 to 10/16/2024 the resident received a shower on 09/25/2024, 10/02/2024 (seven days since previous shower), 10/09/2024 (seven days since previous shower), and 10/16/2024 (four showers total, with seven days since the previous shower). The tasks showed three other days that the activity did not occur .</p> <p>During an interview on 10/21/2024 at 10:20 AM, Staff Z, NA, stated they would complete showers if there was enough time to get to them without making other residents go without. Staff Z stated if just one person called in, that would throw the whole routine off because they normally were not replaced with someone else. Staff Z stated when a resident continued to refuse after two to three attempts, they would notify the nurse, and they would try as well.</p> <p>During an interview on 10/21/2024 at 10:25 AM, Staff N, Medication Assistant Certified, stated the NAs would let them know when a resident refused a shower, and they would attempt to approach the resident themselves. Staff N stated if the resident continued to refuse, they would inform the charge nurse who would attempt to offer a shower and then document the continued refusal in a progress note.</p> <p>During an interview on 10/23/2024 at 8:55 AM, Staff BB, NA, stated they were to chart resident refused if a resident refused to have a shower, not activity did not occur. Staff BB stated they documented NA (does not apply) if the resident's shower was coming up to chart on but it was not their scheduled day. Staff BB stated if the resident refused a shower the process was to try again later in the shift or have another NA attempt to offer and if they still refused, the nurse would be notified and document the refusal.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 5's 08/24/2023 care plan showed the resident was resistive to cares but had no behaviors documented for resisting care.</p> <p>Review of the 09/16/2024 through 10/16/2024 nursing progress notes showed no documentation that Resident 5 refused their showers.</p> <p><Resident 83></p> <p>Review of the medical record showed they admitted to the facility with diagnoses to include a right hip fracture and acute pain related to trauma. The 08/06/2024 comprehensive assessment showed Resident 83's cognition was moderately impaired and required one to two staff assistance for hygiene, grooming, and dressing.</p> <p>During an observation on 10/15/2024 at 9:56 AM, Resident 83 was lying on an unmade bed, no linens, a gray t-shirt on, and no pants, only an incontinence brief. Resident 83's grooming was disheveled (of a person's hair, clothes, or appearance), untidy; (disordered) and had black debris underneath their uncut fingernails.</p> <p>A concurrent observation and interview on 10/17/2024 at 11:24 AM, showed Resident 83 lying width wise, across their bed, feet on the floor, bed and pillows had no linens on them, and brown smears were dried on the blue mattress where the resident had just rolled over from. Resident 83 had black debris underneath their uncut nails, was wearing the same gray t-shirt with red and blue striped pants, and had yellow non-skid socks on with red, soaked through drainage to the left great toe area. Resident 83's beard was long, unkempt, with some of the hairs extending to the mid chest area. Resident 83 stated they had not normally kept their beard that long and had not had their beard trimmed in quite a while.</p> <p>During observations on 10/18/2024 at 8:35 AM and 10/21/2024 at 12:06 PM, Resident 83 was observed lying on their bed, no pants on and only a brief, meal tray sitting on the bedside table untouched and out of reach. Resident 83's hygiene was unkempt (having an untidy or disheveled appearance) along with black debris under their uncut fingernails.</p> <p>During an interview on 10/29/2024 at 8:33 AM, Staff Y, NA, stated they would attempt to provide care to Resident 83 and when they refused, they would get another NA to try, and if that failed, they would notify the nurse. Staff Y stated they had not provided care to Resident 83 for quite some time and had not been assigned to them or asked by any other NA for assistance with them.</p> <p>During an interview on 10/29/2024 at 9:08 AM, Staff C stated the NAs would notify them if a resident was refusing cares and then they would approach the resident themselves. Staff C stated the NAs had not informed them of any issues with Resident 83.</p> <p>During an interview on 10/29/2024 at 9:08 AM, Staff BB stated when fully staffed, they would be able to get to each resident and complete their hair, shaving, and trim their fingernails. Staff BB stated they would try to get to Resident 83 today.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/29/2024 at 10:06 AM, Staff B, Director of Nursing Services (DNS), stated the NAs needed to ensure they were providing personal hygiene, dressing, and care to the residents regardless of if other staff called in. Staff B stated they expected the licensed nurses (LNs) to be aware of those issues and help where needed. Staff B stated if the LNs could not assist with care then they needed to notify Staff B and they could have provided additional help. Staff B additionally stated with the high volume of residents with behavioral issues, the staff at times will become complacent (self-satisfied or unconcerned) and document refusals without even trying.</p> <p>45642</p> <p><Resident 18></p> <p>Review of Resident 18's medical record showed they were admitted to the facility on [DATE] with diagnoses to include diabetes (a disease in which the body does not control glucose [a type of sugar] in the blood), severe obesity (excessive accumulation of body fat) and high blood pressure. The 06/20/2024 comprehensive assessment showed the resident was dependent on staff for toileting hygiene, shower/bathing, and bed mobility. The comprehensive assessment showed the resident's cognition was intact.</p> <p>During an observation and concurrent interview on 10/15/2024 at 11:09 AM, Resident 18 was lying in bed wearing a hospital gown with a blanket over their chest, and their hair was oily and uncombed. Resident 18 stated the staff assisted them with a bed bath and was to receive a bed bath today. The resident stated they preferred bed baths but they had not had a bed bath in two weeks.</p> <p>During an interview on 10/16/2024 at 10:40 AM, Resident 18 stated they had not received their bed bath from the day before. The resident stated they were short staffed again. The resident had a hospital gown on and their hair was disheveled.</p> <p>Review of the NA's documented tasks from 09/08/2024 through 10/08/2024 showed Resident 18 was totally dependent on staff for showering. The documentation showed the resident received a bed bath one day out of 30, all other documentation showed the activity did not occur.</p> <p>In an interview on 10/24/2024 at 1:25 PM, Staff NN, NA, stated the residents had care plans and a Kardex (a nursing worksheet that includes a summary of resident information such as daily care) that individualized resident care directives for staff. Staff NN stated that Resident 18 had never refused care for them. Staff NN explained if there was a resident that refused care they would attempt a couple times and if no success then would ask a co-worker to try. If the co-worker was not successful then the LN was notified to attempt.</p> <p><Resident 51></p> <p>Review of Resident 51's medical record showed they were admitted to the facility on [DATE] with diagnoses to include quadriplegia (complete immobility due to severe disability), scoliosis (a sideways curve of the spine), muscle weakness, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The comprehensive assessment dated [DATE] showed the resident required substantial assistance with toileting hygiene, bed mobility, transfers, and were dependent on staff for shower/bathing. The comprehensive assessment showed the resident's cognition was intact.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation and concurrent interview on 10/16/2024 at 2:45 PM, Resident 51 was up in their wheelchair, their hair was long and oily in appearance, and they were fully dressed. The resident stated they had not had a shower or bath in about three weeks, and their toenails had only been trimmed twice in the current year.</p> <p>During an interview on 10/18/2024 at 9:10 AM, Resident 51 was sitting up in their wheelchair in their room, dressed ready for breakfast. Resident 51 stated they did not receive their shower yesterday. The resident's hair was oily and matted to the back of their head. The resident was upset about not receiving the shower and because no staff had come in to assist them with their breakfast.</p> <p>Review of the NA's documented tasks from 09/09/2024 through 10/09/2024 showed Resident 51 was totally dependent on staff for showering. The documentation showed the resident received a shower on two days out of 30, all other documentation showed the activity did not occur.</p> <p>During an interview on 10/28/2024 at 2:56 PM, Staff J, Licensed Practical Nurse/Unit Manager (UM), stated the residents were scheduled two times a week. Staff J stated if a resident refused, the NAs made a couple attempts and if no success a LN would speak to the resident. Staff J stated it may not be that day, it may be the next day, but the resident will get a bed bath if nothing else). Staff J stated the documentation should be in the nurse's notes, as the shower team documented in the computer.</p> <p>During an interview on 10/29/2024 at 8:46 AM, Staff B stated the UMs and team leaders were responsible to ensure the showers were being done. Staff B stated they should be doing rounds and discuss any issues in the clinical meetings. Staff B stated the NAs had education on the showering sheets and what they should be documenting. Staff B stated the UMs were to double check the shower sheets and talk with the resident if there was any issue with showering. Staff B stated if it's not documented it's not done.</p> <p>Reference: WAC 388-97-1060 (2)(c)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922</p> <p>Based on observation, interview, and record review, the facility failed to assess for change in conditions related to skin and constipation, follow hospice and physician orders, and obtain and report labs for 7 of 8 residents (Residents 83, 79, 12, 5, 4, 30, and 68) reviewed for quality of care. These failures placed all residents at risk for delay of treatment, unmet care needs, and negative health outcomes. Resident 83 experienced harm when they obtained a facility acquired pressure injury (PI, localized damage to the skin and underlying soft tissue, usually occurring over a bony prominence or related to medical devices). Additionally, Resident 79 experienced harm when they continued to have seizures when they did not receive medications indicated for seizures in a timely manner.</p> <p>Findings included .</p> <p>Review of a policy titled Skin Integrity dated 08/2018, showed staff would monitor the resident's skin and be alert to potential changes. The policy showed the changes would be reported and treatment interventions would be implemented and monitored to prevent worsening.</p> <p><Skin></p> <p><Resident 83></p> <p>Review of the medical record showed the resident admitted with diagnoses of a right hip fracture and dementia (a loss of mental ability severe enough to interfere with normal activities of daily living). The 08/06/2024 comprehensive assessment showed Resident 83 had moderately impaired cognition, required one to two staff assistance for dressing, grooming, bed mobility, and transfers.</p> <p>An observation on 10/15/2024 at 9:56 AM, Resident 83 was overheard from the hallway yelling out help me. The state investigator followed Staff N, Medication Assistant Certified, into the room and Resident 83 was observed lying on a bare mattress, there were no sheets or blankets on or around the bed, and the resident was stating they were freezing. Resident 83 had dried, white crusted areas of skin under their right and left eye, above the left eye lid, the right-side bridge of their nose, and to both ears. Staff N left and got a blanket and covered up Resident 83 but left them lying on the bare blue mattress. Staff N did not ensure the resident had their call light within reach when exiting the room, which was observed underneath the resident's bed on the floor.</p> <p>An observation and concurrent interview on 10/16/2024 at 11:35 AM, showed Resident 83 was observed lying in their bed, no pants on, partially covered with a sheet with only their feet exposed, both ears had white/brownish crusted areas to the entire outer and inner portion of the ears with dried red blood. The right eye had dried, crusted white areas surrounding the eye. An empty, soiled, urinal was on the floor in between the bed and the window, and the call light was under the bed on the floor. Resident 83's left eye was reddened with yellow/green drainage in the inner corner of the eye. The outer left great toe had thickened, dried red blood clumped at the corner of the outer nail bed and underneath the remaining four toes, there was dried red blood on the skin. Resident 83 stated when they required help, they would yell out help to get it.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An observation and concurrent interview on 10/17/2024 at 2:39 PM, showed Resident 83 lying in bed, moaning out and repeating help me, help me and the call light was underneath the bedside table on the floor. Resident 83 stated their right leg was very painful and was holding their right knee up towards their chest. Resident 83 was covered by a sheet and the Surveyor could not visualize their right leg.</p> <p>An observation on 10/17/2024 at 2:59 PM, showed Resident 83 was grasping their right leg and moaning ooh, aww when Staff CC, Nursing Assistant (NA), Staff DD, NA, and Staff RR, Registered Nurse, all walked by and did not stop to ask the resident what was wrong.</p> <p>Review of the October 2024 Treatment Administration Records (TARs), showed an order on 06/27/2024 for weekly skin checks to be completed on Thursdays with a Yes/No for new skin issues. If new skin issues were found there was to be a progress note, notification to the provider, obtain new orders for treatment, and placed on alert charting (the assessment on 10/10/2024 and 10/17/2024 showed a yes for new skin issues observed). The record showed no treatments or monitoring for the ears, eye, left toes, and the pain to the right leg.</p> <p>Review of Nursing progress notes showed on 10/10/2024 at 10:46 PM, Resident 83 had redness to both ears and their right eye with edema (swelling) to the outer and inner ears and open areas behind the ears with pus [typically white-yellow, yellow, or yellow-brown, formed at the site of inflammation during infections] drainage, and drainage to the right eye and S&S [signs and symptoms] of infection. Review of a note on 10/12/2024 at 9:09 am, showed the on-call provider was notified of the ears and right eye and gave new orders for Doxycycline (a brand of medication used to treat fungal infections) to be started. There were no orders documented to continue cleaning or monitoring the ears and the eye. There were no nursing progress notes for the skin check completed on 10/17/2024 even though there was documentation that showed new skin issues were found.</p> <p>An observation and concurrent interview on 10/18/2024 at 8:35 AM, showed Resident 83 was observed lying in their bed, no pants on, uncovered, the call light was under the bed on the floor, and their right leg from mid-calf to their ankle was bright red. Resident 83 had the same dried red blood to the outer left great toenail and on the skin, underneath the remaining four toes. Resident 83 stated they had intolerable pain, pointing to their right leg, from their ankle to their knee. Resident 83 was moaning and yelling out ooh, aww repeatedly and stated they yelled because it was their expression so people will know and help me. Staff FF, Housekeeping, and Staff I, Admissions Coordinator, both walked by Resident 83's room, stopped in front of the door, and Staff FF stated to Staff I, oh, that's just [Resident 83], they always yell like that and both walked away without asking the resident what they needed.</p> <p>During an interview on 10/21/2024 at 10:27 AM, Staff N, stated they would never hear Resident 83 moaning/crying out in pain, they only heard the resident when they would sing. Staff N further stated it was against their scope of practice to complete the skin checks and that the nurse unit managers completed them.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/22/2024 at 9:23 AM, Staff N stated when residents were found with new skin issues or had a change in their condition, the NAs were to report it to them and they, along with a nurse, would go and assess the resident. Staff N stated no one had reported Resident 83's redness to their right leg/ankle, the dried red blood to the toes, or the dried red blood to the ears. Staff N then retrieved Staff B, Director of Nursing Services, to assess Resident 83. Staff B assessed the resident and the provider, who was in the facility, were called to the room to further assess Resident 83.</p> <p>Review of the Provider's note on 10/22/2024 at 11:27 AM, showed during the physical exam the resident complained of pain when the right leg was moved and had restricted range of motion (the extent or limit to which a part of the body can be moved around a joint or a fixed point) to the knee, hip, and ankle. The examination showed redness from below the toes to above the ankle with slight fluctuance (alternate pressure by palpating fingers so as to suggest that the area being felt contains fluid) to the heel and was purple in color.</p> <p>Review of the Physician Orders for 10/22/2024 showed a new treatment order for a suspected deep tissue injury (intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often come before skin color changes) to the right heel.</p> <p>During an interview on 10/22/2024 at 4:34 PM, Staff B stated Staff K, Licensed Practical Nurse (LPN)/Unit Manager (UM, an Licensed Nurse (LN) that provided oversight and management of the nursing staff and residents within their units), completed the weekly skin check on 10/17/2024 and documented new skin issues were found. Staff B stated Staff K got busy and forgot to complete the process for the new skin issues found during that assessment and did not follow the correct process.</p> <p><Constipation></p> <p>Review of the undated facility policy Bowel Protocol and Bowel Tracking, showed residents who went without a regular bowel movement (BM) greater than three days would be physically assessed by nursing and the bowel protocol would be implemented. The policy showed the physician would be notified if no bowel movement results after implementing the bowel protocols, and the assessment and physician notification would be documented.</p> <p><Resident 12></p> <p>Review of the medical record showed the resident admitted with diagnoses to include heart failure and emphysema (lung condition that causes shortness of breath). The 08/04/2024 comprehensive assessment showed Resident 12 required one to two staff assistance with transfers and bed mobility, was incontinent of their bowels and their cognition was intact.</p> <p>During an interview on 10/16/2024 at 3:30 PM, Resident 12 stated they experienced constipation (a problem with passing stool, such as having fewer than three stools a week or hard, dry or lumpy stools) often and did not receive routine medication for them. Resident 12 stated they received a medication that caused constipation.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 12's bowel record showed as follows: from 09/17/2024 night shift through 09/25/2024 evening shift, the resident went seven days and two additional shifts with no BM (seven shifts showed no documentation); 09/26/2024 day shift through 09/30/2024 day shift, four days and one additional shift without a BM (nine shifts showed no documentation); from 10/01/2024 day shift through 10/08/2024 evening shift, seven days and two additional shifts without a BM (three shifts showed no documentation); and from 10/09/2024 day shift through 10/16/2024 day shift, seven days and two additional shifts without a BM (six shifts showed no documentation) (in the past 30 days Resident 12 had four bowel movements).</p> <p>Review of the September and October 2024 Medication Administration Records (MAR) showed the resident had six PRN (as needed) bowel medications that could be used when experiencing constipation. The medications were to be used when the resident did not have a BM in three days and continued until there were results. The September 2024 and October 2024 MARs showed no documentation that any of the PRN medications were administered.</p> <p>During an interview on 10/29/2024 at 8:33 AM, Staff Y, NA, stated they were alerted when charting if a resident needed to have a BM. Staff Y stated they would document every shift whether the resident had a BM or not and they would additionally document after each BM the resident had during their shift. Staff Y stated they would notify the nurses if the resident had a BM.</p> <p>During an interview on 10/29/2024 at 9:01 AM, Staff N stated they checked their alerts prior to the start of their shift for residents who had not had a BM in three days. Staff N stated after the third day they would start their bowel protocol by using the PRN bowel medications and document after each one was given. Staff N stated the nurses would complete bowel assessments, document them in the progress notes, and notify the provider if additional medications were needed or the current medications did not result in a BM.</p> <p>During an interview on 10/29/2024 at 9:08 AM, Staff BB, NA, stated when they documented, an alert would let them know that a resident had gone three days without a BM. Staff BB stated the nurses also would get the same alerts and let them know during their daily report if someone needed to be monitored. Staff BB stated they would monitor the resident and inform the nurses if the resident did or did not have a BM during their shift. Staff BB stated the process was to document each shift and after each BM.</p> <p>Review of the 09/17/2024 through 10/16/2024 nursing progress showed no documentation of bowel assessments, medications administered due to no BMs, or notification to the physician that Resident 12 experienced constipation and was not having regular bowel movements.</p> <p>During an interview on 10/21/2024 at 3:16 PM, Staff B stated the nurses should have been monitoring bowels when a resident was not having regular BMs, document their bowel assessment, notify the physician, and obtain new orders if what the resident currently had was not working.</p> <p><Hospice Services></p> <p><Resident 79></p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the medical record showed the resident admitted to the facility with diagnoses to include schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression and mania). The 07/15/2024 comprehensive assessment showed Resident 79's cognition was severely impaired. Further review of the medical record showed the resident was admitted to Hospice (a service for people with serious illnesses who choose not to get (or continue) treatment to cure or control their illness) services on 10/04/2024.</p> <p>Review of a provider note on 10/01/2024 showed Resident 79 was observed to be having several seizures (a sudden change in behavior, movement, and/or consciousness due to abnormal electrical activity in the brain) and provider diagnosed the resident with epilepsy (a disorder that causes seizures or unusual sensations and behaviors) and the plan was to start a nasal spray, Midazolam (a drug that helps prevent or stop seizures).</p> <p>Review of the October 2024 MAR showed an order on 10/01/2024 for Midazolam Nasal Spray, one spray in the nostril when actively having seizures, and could repeat the dose once (no uses of this medication had been documented and after a search, the medication could not be found in the facility).</p> <p>Review of Nursing progress notes showed on 10/07/2024 at 2:33 PM, Staff LL, LPN, documented the Hospice Nurse (HN) gave new orders for Ativan (a brand of medication used to treat trouble sleeping, severe agitation, active seizures, and anxiety [a feeling of worry, nervousness, or unease]) two milligrams (mg) four times daily and an additional order of Ativan four mg to be given now due to the continuance of seizures. Staff LL documented the HN reported almost 50 seizures while they were in the room with the resident. A follow-up note at 3:16 PM showed Staff LL documented, Resident 83 was having seizures majority of shift.</p> <p>Review of Hospice orders dated 10/04/2024, electronically signed by the provider, showed as follows; 1)Haldol (used to treat nervous, emotional, and mental conditions) two mg, two tablets by mouth every six hours for hallucinations; 2) Ativan one mg, one tablet by mouth every four hours PRN for anxiety, agitation, restlessness, or seizures (not processed until 10/09/2024, five days after ordered) 3) Haldol two mg, give one tablet by mouth every six hours PRN for nausea, agitation, or hallucinations (processed and discontinued on 10/09/2024, five days after ordered); 4) Ativan one mg, one tablet by mouth four times daily for anxiety (this order was a continued order from 04/08/2024); and reordered, 5) Midazolam nasal solution PRN for seizures. Again, on 10/07/2024 an order for Ativan two mg, give two tablets by mouth for a one time dose for seizure activity; Ativan one mg, give four tablets for a one time dose for seizures (order not processed); Ativan one mg, give two tablets by mouth every four hours PRN for seizures, restlessness, or agitation (not processed until 10/09/2024, two days after order given); and an order to discontinue Ativan one mg, give one tablet every four hours PRN (not discontinued until 10/9/2024).</p> <p>During an interview on 10/22/2024 at 9:16 AM, Staff N stated they worked the day shift on 10/07/2024 and observed Resident 79 actively seizing and had also been alerted by the Hospice Social Worker (HSW) that had been there. Staff N stated the HSW informed the HN of Resident 79's seizure activity, and the HN gave directions for the PRN Ativan to be administered, but Staff N did not have that order on Resident 79's current October 2024 MAR so could not administer it. When Staff N was asked about using the Midazolam nasal spray, which there was an order for, Staff N stated they were unaware that medication was on the MAR.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/22/2024 at 10:39 AM, a Collateral Contact from the consulting pharmacy, stated they had not received an order for the Midazolam Spray on or after 10/01/2024, therefore they did not fill it.</p> <p>During an interview on 10/22/2024 at 10:43 AM, Staff K stated when they processed an order it automatically transmitted to the pharmacy. Staff K stated they then had a report that they could use to track that the medication was delivered. Staff K then clarified through the report that the medication had never arrived from the pharmacy. Staff K stated there could have been a problem with obtaining that medication but would have received a fax from the pharmacy. Staff K could not produce a fax and stated they did not usually keep the faxes from the pharmacy because they had the reports in the computer to access.</p> <p>During an interview on 10/22/2024 at 11:05 AM, Staff RR, Medical Director, stated they had not been aware of Resident 79's seizure activity on 10/07/2024 and had no idea they had been seizing for that long. Staff RR stated Resident 79 probably should have been sent to the hospital since the medications/orders weren't working or available to at least keep them comfortable.</p> <p>During an interview on 10/24/2024 at 1:10 PM, Staff LL stated they had observed Resident 83 having seizures one after another. Staff LL stated the HN gave them additional orders, but they did not see them in Resident 79's MAR, so they were unable to administer them. Staff LL stated the HN was able to show them the orders they had given, and Staff LL was able to verify the orders, but when they attempted to process those orders, they ran into issues with the provider's prescribing number not being in their system.</p> <p>During an interview on 10/24/2024 at 12:06 PM, the HSW stated Resident 12 had been admitted to Hospice services on 10/04/2024 and at that time the facility had been given admission orders. The HSW stated they arrived at the facility shortly after 7:00 AM on 10/07/2024 and observed the resident having seizure type behaviors. The HSW stated the resident's head was hanging over the side of the bed and there was a puddle of vomit on the floor beside them. The HSW stated when they called the HN to inform them of the seizure activity, they were told to inform the facility to use the orders they were given on 10/04/2024, when they admitted Resident 79 to hospice services, but when the HSW communicated that to Staff N, they were told there were no orders in their EMAR to give other than the routine Ativan. The HSW further stated the HN arrived at the facility and took over the medication issue with the facility and the SW left the facility at nearly 11:00 AM and Resident 79 was still having seizures.</p> <p>Review of Hospice Admission orders, dated 10/04/2024, showed the orders were signed and acknowledged by Staff J, LPN/UM, and Staff Q, RN. The orders showed they were the same as the electronic, physician signed orders as listed above.</p> <p>During an interview on 10/29/2024 at 10:06 AM, Staff B stated they were not aware of Resident 79's on-going seizure activity or the issues that took place with inputting or obtaining hospice ordered medications. Staff B stated if the nurses were having issues processing orders under another provider's number, then the medical director should have been contacted and asked if they could have orders until the issue was resolved. Staff B also stated they would expect the unit managers to be monitoring and checking off that medications ordered were being delivered and accessible.</p> <p><hospitalization ></p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p><Resident 5></p> <p>Review of the medical record showed the resident was admitted with diagnoses to include diabetes (a condition where there is too much sugar in the blood) and kidney failure. The 08/09/2024 comprehensive assessment showed Resident 5's cognition was intact and required one to two person staff assistance with dressing and personal hygiene.</p> <p>During an interview on 10/15/2024 at 11:02 AM, Resident 5 stated they had just returned from a hospital stay for an infection to their breast. Resident 5 stated they had a yeast infection that worsened and the powder the nurses used didn't help, it only made it worse so they refused to let them use it.</p> <p>Review of the Provider's note on 09/25/2024 showed Resident 5 was observed to have blood blisters and open sores with pus (thick, milky fluid) and bloody drainage to their left breast and open sores to their stomach pannus (when excess skin and fat hang from the abdomen). The note showed orders as follows: 1) Cephalexin (a brand of antibiotic medication that kills bacteria) 500 mg every six hours for five days and then send an acute visit to reassess in one week on Tuesday 10/01/2024; 2) apply Caldesene (used to treat and prevent diaper rash and other minor skin irritations) powder underneath the pannus every shift for seven days and then PRN, prior to applying the powder, Betadine (a topical medication used on the skin to treat or prevent skin infection in minor cuts, scrapes, or burns) was to be applied to the open sores, and then covered with gauze and tape, and then apply interdry (moisture-wicking antimicrobial fabric dressing). Additionally, the powder was to be applied under both breasts folds every shift PRN for fungal infection. The provider's note also showed the resident did not want Nystatin (a brand of antifungal powder) used because they were allergic and made the yeast worse.</p> <p>Review of the nursing progress notes showed as follows: on 09/26/2024 at 10:30 PM, Resident 5 requested to be sent to the hospital due to worsening of their breast. Resident 5 was sent back from the hospital at 2:17 AM on 09/27/2024 with new orders for Fluconazole (an antifungal medication that may be used to treat serious fungal or yeast infections) twice daily for 14 days; on 10/10/2024 at 4:05 PM, Resident 5 was observed to have reddened and blistered areas under breast with the left breast painful, very red and hard to the touch. The note showed the provider was notified and gave orders for the resident to be sent to the hospital; a note on 10/14/2024 at 3:18 PM, showed Resident 5's hospital admission diagnosis was left breast cellulitis [a bacterial skin infection that causes swelling, pain, warmth and redness];</p> <p>Review of Resident 5's September 2024 and October 2024 MAR showed the Fluconazole order had not been processed until 09/30/2024 (four days [eight doses] were missed before first dose was received) with the last dose of the course to be completed on 10/10/2024 on the evening shift. The 09/25/2024 Cephalexin order had three doses not documented as given, and the betadine treatment showed no documentation it had been completed because when the order was processed, there wasn't a schedule added to the order so did not show as needing to be done. Additionally, the Caldesene powder showed no documentation it had been administered under the breasts even though the resident had symptoms of a fungal infection.</p> <p>Review of the discharge hospital summary on 10/14/2024 showed the resident was treated for left breast cellulitis and a fungal skin infection. The summary showed Resident 5 had worsening of their left breast swelling, redness, and pain and a severe fungal infection.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/29/2024 at 10:08 AM, Staff B stated the UMs would review the provider notes and process orders they received on that day. Staff B stated all nurses should be reviewing notes and documentation when a resident returns from the hospital and should process orders they reviewed and not leave them for the UMs to process.</p> <p><Laboratory/Diagnostic services></p> <p>Review of the facility's policy dated 11/2017, titled Laboratory and Diagnostics Services, showed the facility provides or obtains laboratory and other diagnostic services to meet the needs of the resident and were responsible for the quality and timelines of the services.</p> <p><Resident 4></p> <p>Review of Resident 4's medical record showed they were admitted to the facility on [DATE] with diagnoses to include dementia (a loss of mental ability severe enough to interfere with normal activities of daily living), insomnia (trouble sleeping at night, staying asleep or both), and kidney failure. The comprehensive assessment dated [DATE] showed the resident required substantial assistance with activities of daily living (ADL's) and transfers. The assessment showed the resident's cognition was severely impaired.</p> <p>Review of the physician visit notes showed on 08/08/2024 orders for a complete blood count (CBC, used to look at overall health and find a wide range of conditions, including anemia, infection) and a comprehensive metabolic panel (CMP, a blood test that gives doctors information on how well the kidneys and liver are working). Review of the medical record showed no test results.</p> <p>Review of the physician visits on 08/13/2024 showed current laboratory orders of a CBC and CMP, further review on 10/29/2024 showed there were no results in the resident's medical record.</p> <p>In an interview on 10/21/2024 at 10:20 AM, A Collateral Contact (CC) stated the facility's order process had been a problem since February 2024. The CC stated that they had requested lab orders on Resident 4 since August that had not been obtained, there were a few residents here that we had requested labs for and had not received results, so we keep ordering them.</p> <p><Resident 30></p> <p>Record review showed the resident was admitted with diagnoses to include Alzheimer's Disease (a common form of dementia, believed to be caused by changes in the brain, usually beginning in late middle age, characterized by memory lapses, confusion, emotional instability, and progressive loss of mental ability), anxiety disorder (the mind and body's reaction to stressful, dangerous, or unfamiliar situations) and End Stage Renal Disease (ESRD, when the kidneys can no longer function on their own).</p> <p>Review of the resident's 07/18/2024 comprehensive assessment showed they had severely impaired cognition and received medications including a diuretic (medication designed to increase the amount of water and salt expelled from the body as urine), an antianxiety (medication to relieve symptoms of anxiety), and an antipsychotic (medication treats symptoms of psychosis).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a 03/25/2024 provider visit showed a Basic Metabolic Panel (BMP, a blood test that checks the levels of different substances involved in metabolism and kidney function) lab test drawn to monitor Resident 30's kidney function.</p> <p>Record review of a 09/03/2024 visit note from Resident 68's behavioral health specialist showed the most current labs for review in the resident's medical record were from 10/18/2023. The specialist requested blood drawn for a CBC, CMP and a lipid profile (a blood test that measures the amount of certain fat molecules in the blood).</p> <p>Record review of a 10/02/2024 provider visit note showed they ordered labs to be drawn that included a CBC, CMP, lipid profile, Vitamin D level, Vitamin B 12 level and iron studies on the next facility lab draw.</p> <p>Record review of Resident 30's medical record on 10/22/2024 at 10:05 AM showed no laboratory results for the tests that were ordered on 03/25/2024, 09/03/2024 and 10/02/2024.</p> <p>Record review of the laboratory reports for Resident 30 sent to the facility on [DATE], after the DNS requested the results, showed blood samples ordered on 10/02/2024 were sent to the lab on 10/08/2024 and reported to the facility on [DATE].</p> <p><Resident 68></p> <p>Record review showed the resident was admitted to the facility with diagnoses to include dementia, anxiety disorder and failure to thrive (a progressive functional deterioration of a physical and cognitive nature).</p> <p>Review of the 08/23/2024 quarterly Minimum Data Set (MDS, a required assessment and care planning tool) showed that the resident had medications prescribed for dementia with behavioral disturbance and anxiety.</p> <p>Medical record review showed an order dated 04/03/2024 for a BMP and lipid panel on next facility [blood] draw day.</p> <p>Record review of a 05/03/2024 provider visit note, showed Resident 68's last laboratory results in their record were from 08/22/2023. The provider ordered a complete lipid panel and a BMP lab test to be completed. The provider also requested a referral be made to [a neurologist] for consultation on dementia.</p> <p>Record review of a 07/09/2024 provider visit note showed no recent labs were found in the medical record and the provider ordered a BMP blood test be completed.</p> <p>Record review of a 09/10/2024 provider visit note showed that they ordered a BMP to be drawn in one week.</p> <p>Record review of Resident 68's medical record on 10/22/2024 at 10:00 AM showed no laboratory results for the tests that were ordered on 04/03/2024, 05/03/2024, 07/09/2024, and 09/10/2024. Also, there was no documentation of a referral made to a neurologist from the 05/03/2024 order.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/22/2024 at 10:58 AM, Staff B stated that the night nurse was responsible to draw the resident's blood. Staff B stated they were aware we were behind on completing lab draws. Staff B stated they would call the lab and request any results for Resident 68 and Resident 30 since April 2024.</p> <p>Record review of the laboratory reports for Resident 68 sent on 10/22/2024 after the DNS requested the results showed blood samples were obtained:</p> <ul style="list-style-type: none"> - on 04/08/2024 the report was sent to the facility on [DATE] that included the tests ordered on 04/03/2024. There was no record these results were reviewed by the physician. - on 07/15/2024 the report was sent to the facility on [DATE] that included the test ordered on 07/09/2024. There was no evidence in the record that the test results were reviewed by the physician. <p>During an interview on 10/22/2024 at 11:05 AM, Staff B stated that orders for lab work or referrals that were included with medical visit notes, as their plan, was the same as a physician order that should be followed up on by the nursing unit manager. Staff B stated that they were not aware Resident 68 had an order to be referred to a specialist that was not completed.</p> <p>During an interview on 10/22/2024 at 1:58 PM, Staff K for Resident 68 stated that they were not aware there was an order for Resident 68 to receive a consultation by a specialist for their dementia.</p> <p>During an interview on 10/22/2024 at 5:34 PM, Staff B stated after lab work was drawn it would be sent to the laboratory. The results were reported through a fax and the nurses were supposed to monitor for the results. Staff B stated should there be a critical lab value, the laboratory would call the facility. The results were reviewed by the nurse, placed in a file for the physician to review during rounds. The physician then dates, signs and would include any follow up orders. After the reports are reviewed by the physician, the nurse would put the results in a box labeled to scan at the nurse's station. Medical records would then scan the results into the resident's medical record.</p> <p>During an interview on 10/24/2024 at 1:48 PM, Staff J stated when the physician's ordered labs, the UMs processed the orders and completed a lab slip. Staff J stated the night shift nurses would obtain the blood specimens for the lab orders, daily, and deliver the specimens to the lab the following morning. When Staff J was asked what the stack of incomplete labs in the medication room were for, Staff J stated those were labs that were not obtained and still needed to be completed (the labs had varying dates ranging from April 2024 thr [TRUNCATED])</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30528</p> <p>Based on observation, interview, and record review, the facility failed to prevent the development of a pressure ulcer (PU, localized damage to the skin and underlying soft tissue usually over a bony prominence. The injury can present as intact skin or an open ulcer and may be painful) for 1 of 3 residents (Resident 293) reviewed for pressure ulcers. This failure placed the resident at risk for worsening of the wound, increased discomfort and a diminished quality of life.</p> <p>Findings included .</p> <p>Record review of the facility's policy titled, Skin Integrity, dated 08/2018, showed that the facility would provide care, consistent with professional standards of practice, to prevent pressure ulcers, promote healing and prevent new ulcers from developing. Pressure ulcers would be staged according to professional standards of practice.</p> <p>Review of The National Pressure Ulcer Advisory Panel (NPUAP) April 2016, showed Pressure Ulcer Stages as follows:</p> <p>Stage 1- Intact skin with a localized area of non- blanchable erythema (refers to redness on the skin that can be pressed and temporarily disappears), presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.</p> <p>Stage 2- pressure ulcer is partial-thickness skin loss with exposed dermis (thick layer of living tissue below the skin). The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister.</p> <p>Deep Tissue Pressure Injury (DTI)- Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed. Pain and temperature change often precede skin color changes. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface.</p> <p><Resident 293></p> <p>Record review showed Resident 293 was admitted to the facility on [DATE] with diagnoses to include respiratory failure, bipolar disorder (a mood disorder that causes radical emotional changes and mood swings, from manic, restless highs to depressive, listless lows), Parkinson's Disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves), and acute kidney failure.</p> <p>Record review of the comprehensive admission assessment completed on 10/22/2024 showed Resident 293 had moderate cognitive impairment, required extensive staff assistance for bed mobility, transfers and had several non-injuries falls since admission. The resident was assessed at risk for PU; however, the assessment did not document the presence of their sacral (area located at the bottom of the spine and ends at the tailbone) PU documented at admission.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the 09/25/2024 nursing admission assessment showed that Resident 293 was admitted with a skin impairment and directed the nurse to complete a wound assessment. Record review showed no wound assessment was completed; however, review of the September 2024 treatment record showed a 09/30/2024 order to cleanse the sacral open area with normal saline and cover with a silicone border dressing (a type of dressing that adheres to the skin without causing trauma upon removal). The treatment was documented as being completed on 09/30/2024 and on 10/03/2024, 10/05/2024, 10/07/2024, 10/11/2024, and 10/13/2024 (No measurements or staging documentation were found in the record).</p> <p>Record review of a 10/14/2024 admission physician exam showed Resident 293 denied pain, only complaint was the bottom of the right heel hurts, [had] no sores.</p> <p>Observations of Resident 293's positioning:</p> <p>10/15/2024 at 10:27 AM- lying in bed on their back with the head of bed (hob) elevated, feet pushed against the foot board, and heels on the mattress.</p> <p>10/15/2024 at 12:00 PM- lying in bed in the same position as 10:27 AM</p> <p>10/16/2024 at 9:02 AM- lying in bed on their back with the hob elevated, heels were on the mattress</p> <p>10/16/2024 at 2:10 PM- lying in bed on their back with the hob elevated, heels were on the mattress</p> <p>During an observation and interview on 10/17/2024 at 11:27 AM, Resident 293 was lying in bed on their back in bed with the hob elevated and their heels were on the mattress. The resident stated that they had pain in their right heel.</p> <p>During an interview on 10/17/2024 at 2:21 PM, Staff SS, Registered Nurse (RN), stated the resident had a dressing change to the sacrum (The large triangle-shaped bone in the lower spine) every other day and it was due that day.</p> <p>During an observation and interview on 10/17/2024 at 2:24 PM, Resident 293 was lying on their back, with the head of bed elevated, and their heels were on the mattress. The resident agreed to have their sacral dressing changed. When asked if they had any pain, the resident stated their right heel hurt.</p> <p>On 10/17/2024 at 2:25 pm Staff SS completed the sacral dressing change as ordered, there were two red areas that Staff SS stated one area was 0.5 centimeters (cm) by 0.5 cm and the second red area was 2.0 cm by 1.0 cm and not open. When asked about Resident 293's heels, the RN uncovered the blankets and looked at the resident's heels (they did not check for blanching or areas of pain). Staff SS stated there were no open areas on the heels. Both heels were observed pink, the right outer heel appeared darker pink than the left heel. Staff SS then found a pillow, placed under the resident's lower legs and informed the resident they needed to keep their heels off the mattress.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/21/2024 at 1:39 PM, Resident 293 was found lying on their left side on the floor mat. Staff P, Licensed Practical Nurse (LPN), Staff B, Director of Nursing Services (DNS), and Staff K, LPN / Unit Manager, were present while the resident was observed on the fall mat. The resident's bare feet showed a dark purple area on the outer aspect of the right heel. The right heel appeared dark pink.</p> <p>During an interview on 10/22/2024 at 1:58 PM, Staff K stated they observed the dark purple area on Resident 293's right heel the previous day when the resident was lying on the fall mat. They stated they were not aware this was a new skin change for the resident.</p> <p>Record review of a 10/22/2024 skin injury assessment by Staff B showed the resident had a deep tissue injury caused by pressure on the right heel. Resident 293 had persistent, non-blanchable purple discoloration on the right heel that measured 1.0 cm by 0.9 cm. The resident was educated to float their heels on a pillow.</p> <p>Record review of a 10/26/2024 skin injury assessment showed the right heel DTI size increased to 0.9 cm by 1.8 cm.</p> <p>Record review of a 10/27/2024 treatment order showed to clean, and cover the wound to the right heel with border dressing every day shift.</p> <p>During an interview on 10/25/2024 at 11:30 AM, Staff B stated they were not aware Resident 293's sacral wound was not measured or staged on admission, and it should have been. The DNS stated that the heel wound should not have happened. The resident should have had a heel boot and floated heels.</p> <p>Reference: WAC 388-97-1060 (3)(b)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642</p> <p>Based on observation, interview and record review, the facility failed to ensure care and services were provided for 1 of 2 residents (Resident 51), reviewed for restorative nursing and limited range of motion [(ROM) the extent the joint can move within the expected (normal) range of values]. This failure placed the residents at risk for a decrease in mobility, developing/worsening of contractures (a permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen), and unmet care needs.</p> <p>Findings included .</p> <p>Review of a policy titled, Restorative Nursing programs, revised 06/2018, showed the goal of the Restorative Program was to assist residents in obtaining and maintaining their highest practicable functional levels, prevent unnecessary declines, and provide an active and healthy living environment.</p> <p><Resident 51></p> <p>Review of the medical record showed Resident 51 was admitted to the facility on [DATE] with diagnoses to include quadriplegia (complete immobility due to severe disability), scoliosis (a sideways curve of the spine), muscle weakness, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The comprehensive assessment dated [DATE] showed the resident required substantial assistance with toileting hygiene, bed mobility, transfers, and was dependent on staff for shower/bathing. The comprehensive assessment showed the resident's cognition was intact.</p> <p>In an interview on 10/15/2024 at 10:37 AM, Resident 51 stated I'm tired of it! they (therapy department) won't give me therapy. Resident 51 stated their foot was frozen on the left side, and they did not wear a brace for it. Resident 51 had shoes on, and their feet were internally rotated while sitting up in their wheelchair.</p> <p>During a follow up interview on 10/16/2024 at 3:33 PM, Resident 51 stated they were not receiving any type of therapy. The resident stated therapy/restorative nursing would come in two to three times a week, but no longer worked with them. Resident 51 stated they have not had therapy in months.</p> <p>Review of Resident 51's medical record showed their care plan dated 05/15/2024 for limited physical mobility, with intervention of an exercise program: Restorative Program: Passive Range of Motion (PROM) lower and upper extremities 10 times five to seven days per week.</p> <p>During an interview on 10/17/2024 at 10:51 AM, Staff T, Therapy Director, stated the facility did not have restorative staff, or a fully staffed therapy department. Staff T stated if there was a restorative program the NACs would be tasked to follow up with the restorative care plan, placement of the braces/splints, and documenting tasks in the computer. Staff T stated they needed a bigger area for therapy and a restorative program. Staff T stated they were not sure if Resident 51 wore a brace, and stated the resident was not on their caseload.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/18/2024 at 3:30 PM, Resident 51 stated they had seen the doctor this week and had a referral to see the orthopedic doctor to fix their feet. The resident's feet internally rotated due to their contractures, had shoes on, and there were no braces/splints in place.</p> <p>During an interview on 10/21/2024 at 10:28 AM, Staff AA, Nursing Assistant (NA), and Staff WW, NA, both stated they have not been instructed to do a restorative program for the residents. Staff AA stated they have seen different people do therapy within the facility. Staff AA stated that they did not apply or remove braces or splints for the resident. Staff WW stated if there was a resident who was refusing treatment or to allow staff to apply braces, they would report it to the resident's nurse.</p> <p>During an interview on 10/22/2024 at 11:25 AM, Staff T stated the therapy assessments were done via tele-health (allows talking with your health provider on the phone or using video) both physical and occupational assessments were done that way. Staff T stated that they did not currently have a Physical Therapist (a health care professional who provides therapy to preserve, enhance, or restore movement and physical function that are impaired or threatened by disease, injury, or disability). Staff T stated they were not aware of Resident 51's contractures to their feet. Staff T stated Resident 51 had not been on treatment/therapy since they started in July of this year (2024).</p> <p>During an interview on 10/29/2024 at 8:46 Staff B, Director of Nursing Services, and Staff D, Regional Nurse Consultant, stated the facility had a restorative program and the program currently was not robust (minimal staff). Staff B stated, it's a lost area, we are trying. Staff B stated the care givers do range of motion when delivering resident care. Staff D stated they were aware the restorative nursing program was an issue.</p> <p>Reference WAC 388-97-1060(3)(d)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48368</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents received assessments and supervision for 2 of 5 residents (Resident 84 and 143) reviewed for elopement/missing person, implement risk assessments and supervision for 1 of 3 residents (Resident 73) reviewed for hot liquids, and implement safety interventions for 1 of 2 residents (Resident 12) reviewed for smoking to prevent accidents and hazards. This failed practice placed residents at risk for accidents, injuries, and the potential risk of fire. The lack of a system to ensure the elopement process was followed timely, resulted in an Immediate Jeopardy (IJ) when Resident 84 went missing from the facility between the hours of 11:30 PM on [DATE] and 2:00 AM on [DATE], and was later located at 8:11 AM on [DATE] deceased in the community. Additionally, Resident 73 experienced harm when they were served hot coffee without a lid and suffered a second-degree burn (involves the first two layers of skin, may present as deep reddening of the skin, pain, blisters, glossy appearance from leaking fluid, and possible loss of some skin).</p> <p>On [DATE] at 3:57 PM the facility was notified of an IJ at, F689 42 CFR S483.25(d)(1)(2), Free from accidents and adequate supervision, when a resident left the facility unattended and unaccounted for without staff knowledge. It was determined that the IJ began on [DATE] and the immediacy was removed on [DATE] with an onsite verification from investigators. The facility removed the immediacy by Nursing staff identifying all residents at risk for elopement who also had diagnoses of Substance Use Disorder (SUD, the inability to control the use of a particular substance or substances despite harmful consequences) and updated the care plan, implemented education on the elopement/missing person policy and process, identifying and recognizing at risk resident's and the process for resident's who wished to access the community. All education was to be completed prior to all staff's next scheduled shift. The measures put in place by the facility ensured that all staff were educated and trained and all at risk residents were identified.</p> <p>Findings included .</p> <p><Elopement/Missing Person Policies></p> <p>Record review of an undated facility policy titled Elopement, showed the elopement procedure was to ensure that in an event a resident was missing every measure possible would be taken to ensure the safe return of that resident. The policy directed the staff to immediately: .overhead page the code word for all staff to report to the named location. Begin searching inside, outside and surrounding areas in a block radius. If unable to locate after following directives in attempt to locate resident, the Administrator and Director of Nursing Services needed to be notified, and staff were required to call 911 .</p> <p>Record review of a policy titled Quality of Care, Accidents/Hazards/Supervision/Devices, dated ,d+[DATE], showed .the facility would recognize the high-risk nature of the facility population and setting. All level of staff would be trained on safety and individualized care plans with interventions would be developed to reduce the potential for accidents. Evaluate for a history of SUD on admission, develop an appropriate care plan with interventions to address risk . Additionally, the policy showed for wandering and elopement risk residents the facility</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>would: .Identify potential safety issues for residents who wander, evaluate to identify root cause, develop a care plan for those identified at risk with interventions to minimize the risk of a resident leaving a safe area .</p> <p><Hot Liquids Policy></p> <p>Record review of the facility's policy titled, Hot Beverage Temps dated [DATE], showed hot beverages must not exceed a temperature of 160 degrees Fahrenheit (F) when leaving the kitchen and prior to placing on serving cart, the temperature will be monitored with an environmental thermometer to assure the 160-degree F temperature.</p> <p><Smoking Policy></p> <p>Review of the policy titled Smoking Policy for Independent and Supervised dated ,d+[DATE], showed residents assessed to smoke supervised and/or assisted would have their smoking materials kept by staff in a large lock box. The policy showed residents assessed to not be independent would be provided assistance/supervision during all smoking activities. Lastly, the policy showed there would be no smoking or use of smoking allowed on the grounds except for in the Fireside Courtyard (the patio used for smoking at designated times).</p> <p><Elopement/Missing Resident></p> <p><Resident 84></p> <p>Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including encephalopathy (a brain disorder that effects how the brain functions, thinks, feels, and acts), myoclonus (brief, sudden, and involuntary muscle jerks or twitches that a person cannot control, and diabetes (a chronic condition the occurs when the body has high levels of blood sugar). Review of the [DATE] comprehensive assessment showed the resident required the assistance of one staff member for activities of daily living (ADLs) and had a moderately impaired cognition.</p> <p>Record review of the [DATE] admissions assessments showed no elopement risk assessment had been completed for Resident 84 on admission.</p> <p>Record review of the care plan dated [DATE], showed no care plan was in place for SUD/Elopement.</p> <p>Review of a progress note dated [DATE] at 9:05 AM, showed Staff F, Social Service Director, (SSD), was notified that Resident 84 was missing and 911 was called with a description of the resident.</p> <p>During an observation on [DATE] at 9:08 AM, a Code Vegas (a code word for a missing resident) was called over the facility intercom system for Resident 84. Upon entering Resident 84's room (112) the television was on, the blanket and sheet were pulled back on the bed, and the bathroom was clear. All staff started searching inside the facility for Resident 84.</p> <p>An observation and concurrent interview on [DATE] at 9:10 AM, showed staff expanded the search to the outside and the surrounding areas. Staff C, Administrator Designee, (AD), stated Resident 84 was last seen at midnight and was not recognized as missing until their Significant Other (SO) came to take them out around 8:30 AM. Staff C stated the facility had called the police.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an Interview on [DATE] at 9:12 AM, Staff CC, Nursing Assistant (NA) and Staff M, Licensed Practical Nurse (LPN), stated they did not know what Code Vegas meant and had to ask other employees. Staff CC and Staff M stated it was not normal for Resident 84 to leave the facility without checking out.</p> <p>During an interview on [DATE] at 9:16 AM, Staff B, Director of Nursing Services, (DNS), stated they had last seen Resident 84 at 11:30 PM last night on [DATE]. Staff B stated they were unaware what time they were last seen by staff after that. Staff B stated they were notified of Resident 84 missing between 8:15 AM and 8:30 AM on [DATE] when their significant other (SO) came to take them out for an appointment.</p> <p>During an interview on [DATE] at 9:53 AM, Staff B stated Resident 84 was found deceased by Local Law Enforcement (LLE) at 8:11 AM that morning. Staff B stated Resident 84 always signed out when they were leaving, and this was the first time they had left on their own. Staff B stated the process was for staff to visually observe and provide care for the residents every two hours.</p> <p>During an interview on [DATE] at 10:10 AM Staff M, LPN, stated they noticed Resident 84 was missing when they did their first rounds at 7:20 AM. Staff M stated they checked Resident 84's room, the 100, 200 hallway and an outside perimeter check and did not find Resident 84. Staff M stated they were waiting to see if the SO came to the facility at the scheduled outing time before calling them. Staff M stated the SO came to the facility between 8:10 AM and 8:15 AM. Staff M stated the SO went into Resident 84's room and noticed they were not there. Staff M stated the SO had not heard from Resident 84 since bringing them back to the facility the previous night. Staff M notified Staff B, and the administrative staff completed a search of the facility and the grounds. Staff M stated when Resident 84 was not found, Code Vegas, the missing resident alert was sent out (at 9:08 AM).</p> <p>During a telephone interview on [DATE] at 10:51 AM, Staff O, NA, stated they were assigned to the 100 hallway and were responsible for Resident 84 during the night shift on [DATE]. Staff O stated they were short staffed, and were the only NA assigned to the 100 hallway with 25 residents to care for. Staff O stated the last time they had seen Resident 84 was between 1:00 AM and 2:00 AM in the lobby, by the front entrance, watching television. Staff O stated Resident 84 did not have a history of leaving the facility on night shift. Staff O stated they started their last rounds at 4:00 AM and did not see Resident 84 in their room (112), as the blankets on Resident 84's bed were pulled down and they just assumed they were somewhere in the facility. Staff O stated they should have notified the nurse, but they did not think nothing of it. Staff O further stated they had not had any training on what to do for an elopement or a missing resident.</p> <p>During a telephone interview on [DATE] at 1:48 PM, Resident 84's SO stated they got to the facility between 8:00 AM and [DATE]:00 AM that morning to pick up Resident 84 for an appointment. The SO stated two NAs approached them on their way to Resident 84's room and stated Resident 84 was not in the facility. The SO stated this caught me by surprise. The SO stated Resident 84 would never leave the facility without them or another family member. The SO stated they verified the resident did not leave with any other family. The SO stated the last known communication they had knowledge of was an electronic transaction that was made by Resident 84's bank card close to 6:00 AM. The SO stated they were upset they had not been notified when Resident 84 was first noticed missing. The SO further stated they were informed from LLE close to 9:15 AM that Resident 84 was deceased .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 4:35 PM, Staff PP, NA and Staff HH, NA, stated they had not received any training on hire or during their employment on the process if a resident went missing. Staff PP and Staff HH stated they did not know what Code Vegas meant and they were not educated how to initiate that process.</p> <p>Review of the employee files showed Staff PP had a hire date of [DATE] and Staff HH had a hire date of [DATE]</p> <p>During an interview on [DATE] at 4:46 PM, Staff QQ, Maintenance Director, stated they had recently completed an elopement drill ([DATE]). Staff QQ further stated they were unsure if new employees received the elopement training on hire.</p> <p>Record review of the Employee Participation Log for an elopement drill completed by Staff QQ, dated [DATE], showed 16 of the 144 staff members participated in the drill. Staff O, Staff M, Staff K, LPN/Unit Manager, Staff PP and Staff HH, were not on the participation log sign in sheet.</p> <p>During an interview on [DATE] at 10:47 AM, Staff E, LPN/Minimum Data Set Coordinator, stated their process was to do an elopement risk assessment the day of admission on all new residents. Staff E stated they did not complete an elopement assessment on Resident 84, and they did not follow the correct process.</p> <p>During an interview on [DATE] at 9:33 AM, Staff B stated the process for an elopement/missing resident was to notify the nurse immediately to ensure the elopement process was implemented in a timely manner. Staff B stated Staff O and Staff M did not follow the correct process for the elopement/missing resident, Resident 84.</p> <p><Resident 143></p> <p>Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including stroke (occurs when blood flow to the brain is cut off, which can damage and kill brain cells), frontal lobe deficit (causes personality changes, difficulty concentrating or planning, and impulsivity), diabetes, and psychoactive substance abuse (the use of illegal/legal drugs or alcohol for purposes other than for which they are meant to be used, or in excessive amounts). The [DATE] Brief Interview for Mental Status (BIMS, a standardized assessment tool that's used to screen the cognitive functioning of residents), showed Resident 143 had moderately impaired cognition. Review of a nursing progress note, dated [DATE], showed the resident required the assistance of two staff members for ADLs.</p> <p>Record review of the care plan, dated [DATE], showed no care plan was in place for SUD.</p> <p>Review of a progress note, dated [DATE], showed Resident 143 left the building at 4:30 PM on the afternoon of [DATE] and verbalized to staff they were leaving with their family member.</p> <p>Review of a progress note, dated [DATE] at 11:15 PM, showed Resident 143 had not returned from their outing. An elopement drill was started at 11:15 PM by Staff K. All staff completed a search of the facility and Resident 143 was not found during the drill. Further review of the progress note showed no notification to the administration or LLE.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of a progress note, dated [DATE] at 1:54 AM, showed Resident 143's family member was contacted by Staff K. Staff K wrote the family member verified the resident was not with them or any other family member (nine hours and 54 minutes after Resident 143 left the facility).</p> <p>Review of a progress note, dated [DATE] at 7:02 AM, showed Staff K called 911 and provided a description of the missing resident (14 hours and 32 minutes after Resident 143 left the facility).</p> <p>During an interview on [DATE] at 8:00 AM, Staff C stated they had another missing resident last night ([DATE]), Resident 143. Staff C stated they went out for an outing and never returned.</p> <p>During a telephone interview on [DATE] at 11:18 AM, Resident 143's representative stated they did not pick Resident 143 up from the facility and they were concerned that Resident 143 was still confused from the stroke and did not have any identification on them. Resident 143's representative further stated they had called other family members, and was told the resident was not with them, and no other family members had picked Resident 143 up from the facility.</p> <p>During an interview on [DATE] at 9:33 AM, Staff B stated the process for elopement/missing person for Resident 143 was not followed correctly by Staff K. During a follow up interview at 12:54 PM, Staff B stated, Staff K had not notified LLE in a timely manner. Staff B stated LLE located Resident 143 and the resident informed them they had no plan to return to the facility.</p> <p><Hot Liquids></p> <p><Resident 73></p> <p>Record review showed Resident 73 was admitted with diagnoses to include dementia (a loss of mental ability severe enough to interfere with normal ADLs), and depression. Review of the [DATE] comprehensive assessment showed the resident had severe cognitive impairment and was independent with meals.</p> <p>Record review of a [DATE] nursing admission assessment showed Resident 73 was identified as a safety risk for impaired cognition related to dementia when drinking hot beverages and required lids on their coffee cups.</p> <p>Record review of Resident 73's care plan, dated [DATE], showed they required lids on their cup when drinking hot beverages.</p> <p>Record review of a [DATE] incident report showed at 7:40 AM on [DATE], Resident 73 was served coffee with cream and sugar by Staff JJ, NA, from a coffee carafe in the dining room. There was no lid on the cup and coffee spilled in the resident's lap.</p> <p>Record review of a [DATE] skin assessment showed a second-degree burn measuring 4.7 centimeter (cm, a unit of measure) by 1.8 cm on the right middle thigh and 5.5 cm by 4.0 cm on the left thigh with intact blisters.</p> <p>On [DATE] at 12:04 PM Resident 73 was observed seated in their wheelchair (w/c) eating lunch on an overbed table. Resident 73 appeared comfortable with no facial expression of discomfort. Staff KK, NA, stated Resident 73 now had lids on their coffee cups after the spill this morning and had been doing fine.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 11:16 AM, Staff B stated Resident 73 had a hot liquid assessment that required lids on their coffee cup. The coffee carafe temperature was 157 degrees Fahrenheit (F, unit of measure) right after the spill. Resident 73 did not express they were in pain, so they obtained an order for routine Tylenol for the next four days.</p> <p>During an interview on [DATE] at 9:14 AM, Staff R, Dietary Manager, stated the coffee carafes went out to the dining rooms at about 6:00 AM and they had not been consistently checking the temperatures prior to leaving the kitchen. Staff R stated the carafes should not go out above 160 degrees F for resident safety.</p> <p>During an observation on [DATE] at 11:22 AM, Staff LL, LPN, removed the dressings on Resident 73's inner thighs. The blisters were now flat, and the skin showed no drainage or signs of infection.</p> <p>During an interview on [DATE] at 11:29 AM, Staff B stated that Resident 73's burn should not have happened.</p> <p><Smoking></p> <p><Resident 12></p> <p>Review of the resident's medical record showed the resident was admitted with diagnoses to include chronic obstructive pulmonary disease (COPD, a lung condition caused by damage to the airways that limit airflow in and out of the lungs) and emphysema (a lung condition that causes shortness of breath). The [DATE] comprehensive assessment showed Resident 12's cognition was intact and dependent on staff for transfers, did not walk, and used an electric w/c for mobility.</p> <p>A concurrent observation and interview on [DATE] at 11:51 AM, Resident 12 was observed outside, in the parking lot, sitting in their electric w/c behind a parked vehicle, smoking a cigarette. Resident 12 stated that was where they were designated to smoke if they wanted to smoke. To the right of area, stood a gazebo with seating and an ashtray receptacle that was not accessible for a w/c. Resident 12 stated that was where the employees smoked.</p> <p>A concurrent observation and interview on [DATE] at 10:30 AM, Resident 12 was observed in their electric w/c, out in the hallway, and stated they were headed outside to smoke. Resident 12 had a purple blanket propped up under their left side, their upper body leaned towards the left, over the top of the w/c armrest. Resident 12 then exited out the back door of the facility with the help of staff. Resident 12 was followed out of the facility by two staff, one identified as Staff L, Infection Preventionist, who reminded the resident they needed to go off the facility property to smoke. Resident 12 stated they kept their own cigarettes in their room, locked up in a drawer. Resident 12 stated they were given designated smoking times they could smoke out on the facility patio, with the other smokers, but if they wanted to smoke outside of those designated times, they had to go outside of the facility to smoke. Resident 12 went to extinguish their first cigarette smoked by flicking off the end of the burning cigarette with their fingers, which landed on the ground, and placed the remnants of the cigarette into their black sweat jacket made of terry cloth or cotton (both highly flammable clothing material). Resident 12 then lit a second cigarette and extinguished it in the same manner as the first one and then re-entered the facility and went to their room.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the [DATE] and [DATE] smoking safety assessments, showed Resident 12 required a smoking apron and staff supervision while smoking.</p> <p>During an observation on [DATE] at 1:38 PM, Resident 12 was observed outside the back door that led directly to an alleyway and the parking lot. Resident 12 was sitting in the entrance/exit of the alleyway faced towards the street, with their back to the alleyway behind them. A silver car was observed attempting to exit the alleyway onto the street and had to turn into the parking lot to exit a different side of the parking lot. There was no staff supervision.</p> <p>During an interview on [DATE] at 4:10 PM, Staff L stated they assessed Resident 12's smoking safety on [DATE]. Staff L stated Resident 12 should have been smoking in a supervised area with a smoking apron on due to their left leaning while in their w/c that appeared not safe. Staff L stated Resident 12 would often go outside of the facility to smoke and they were not responsible for ensuring the resident's safety once they signed themselves out in the sign-out book. Staff L stated they were not aware the resident was smoking on facility grounds nor were they aware the resident extinguished their cigarettes in the manner that they were and then bringing them back into the facility.</p> <p>During an interview on [DATE] at 4:27 PM, Staff B, DNS, stated they were not aware Resident 12 was assessed to smoke supervised. Staff B stated the resident had previously been assessed to be an independent smoker but because they had been giving cigarettes to other residents that required supervision, and they had to re-evaluate Resident 12. Staff B stated Resident 12 was not given a designated device or area they could dispose of their cigarettes prior to re-entering the facility nor were they given a smoking apron to utilize when they went outside to smoke. Staff B stated they needed a better process.</p> <p>During an observation on [DATE] at 9:59 PM, Resident 12 and another resident were signing themselves out of the facility to go smoke. Two staff, Staff AAA, Scheduler/NA, and Staff E, Minimum Data Set Coordinator, followed both residents out and did not ensure Resident 12 had a smoking apron on or an extinguishing device.</p> <p>During an interview on [DATE] at 10:23 PM, Staff C, AD, stated they were upset they arrived at the facility and observed the two residents outside smoking without smoking aprons on and supervised by staff. Staff C stated they did not know how the other resident with Resident 12 got cigarettes to smoke because their cigarettes were locked up in the Activities room. Staff C also stated when they asked Resident 12 where their extinguishing device was, Resident 12 told them they had left it in their room. Staff C stated they are not supposed to be in their room they were supposed to be given to the nurse upon re-entering the facility so the nurse could ensure the cigarettes had been completely extinguished. Staff C stated further education needed to be completed with the staff on that process.</p> <p>Reference WAC: [DATE](3)(g)</p> <p>30528</p> <p>44922</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>44922</p> <p>Based on observation, interview, and record review, the facility failed to consistently monitor or implement interventions per Registered Dietician (RD) recommendations for 2 of 4 residents (Residents 79 and 83) reviewed for nutrition. This failure placed the residents at risk for continued significant weight loss and the loss of nutritional satisfaction.</p> <p>Findings included .</p> <p><Resident 79></p> <p>Review of the resident's medical record showed they were admitted with diagnoses of schizoaffective disorder (a mental health disorder with symptoms of delusions [fixed, false conviction in something that is not real or shared by other people] and hallucinations [an experience in which you see, hear, feel, or smell something that does not exist]) and malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets). Review of the 07/15/2024 comprehensive assessment showed Resident 79's cognition was severely impaired and required set-up assistance for eating.</p> <p>During an observation on 10/17/2024 at 12:32 PM, Resident 79 was sitting at the side of the bed eating their lunch. Resident 79 appeared thin and frail. Resident 79 was taking big drinks of their white fluids and coughing after each drink to the point that they were spitting out the fluids. The resident was not helped or cued by staff during the mealtime.</p> <p>During an observation on 10/21/2024 at 12:26 PM, Resident 79 was sitting up in the bed, the bedside table was in front of them with their lunch tray. Resident 79 was holding the utensil in their hand and stared at their food without taking any bites. No staff assistance or cueing was provided during the mealtime.</p> <p>Review of the 10/22/2024 Kardex (a quick reference care plan used by nursing staff), showed Resident 79 required substantial to maximum assistance of one staff person for eating meals.</p> <p>Review of Resident 79's weight log showed on admission, 04/08/2024, the resident weighed 132 pounds (lbs. , a unit of measure), less than one month later on 05/06/2024 120.3 lbs. (an 8.86 percent weight loss), and six months later on 10/21/2024, 95.5 lbs. (an 27.65 percent weight loss).</p> <p>Review of the 04/09/2024 nutrition at risk care plan showed significant weight loss was identified as five percent in one month and ten percent in six months and Resident 79 ate independently with set-up and/or supervision cueing (which was not the same assistance documented in the Kardex).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Nutrition at Risk (NAR) notes showed on 05/10/2024 Resident 79 was identified as having severe weight loss and Resident 79 varied from supervision/set-up assistance to total assistance with meals. Staff U, Registered Dietician, recommended to follow the diet per ST [Speech Therapist, assists people with communication and swallowing disorders], continue with 120 milliliters (ml, a unit of measure) health shakes with meals (an order since 04/09/2024), and one on one assistance with meals, encourage intake, and weigh the resident weekly. Staff U also recommended a Speech Language Pathologist (SLP, work to prevent, assess, diagnose, and treat speech, language, social communication, cognitive-communication, and swallowing disorders) evaluation to determine a safe diet for the resident. Additional notes on 07/09/2024, 08/08/2024, 08/22/2024, 09/05/2024, and 09/19/2024 showed the ST and SLP evaluations still had not been completed. The NAR notes on 09/05/2024 and 09/19/2024 showed a discussion to add an appetite stimulant that had not been completed. On 09/05/2024 notes, Resident 79 complained of not liking the pureed (paste or thick liquid suspension usually made from finely grounded cooked food) and the thickened liquids.</p> <p>Review of nursing progress notes on 08/30/2024 and again on 09/01/2024 showed Resident 79 requested a diet change due to not liking the pureed diet and thick liquids. On 09/05/2024 a nursing progress note showed, will review Remeron [a brand of anti-depressant medication sometimes used as an appetite stimulant] and review in one week (Resident 79 had an order for Remeron since 05/14/2024 for an unrelated diagnoses). A 09/13/2024 nursing progress note showed a request for an ST evaluation to upgrade the diet. A 09/13/2024 nursing progress note showed to consider a speech therapy evaluation and feeding tube (a tube inserted through the nose or the abdomen to provide nutritional support) referral. There were no further notes regarding the review of the increase in Remeron to assist in increasing the appetite nor were there any further notes regarding the requests or consideration for the ST evaluation.</p> <p>During an interview on 10/22/2024 at 2:01 PM, Staff T, Therapy Director, stated they had no record of an ST evaluation referral for Resident 83. Staff T stated they had been able to obtain ST's to come work at the facility on an as needed basis at times but did not know one was needed for Resident 83.</p> <p>During an interview on 10/24/2024 at 1:48 PM, Staff J, Licensed Practical Nurse/Unit Manager, stated they reviewed the NAR notes and would process orders for recommendations made by the RD and update the provider. If the resident had a ST evaluation they would process the order, give it to the scheduler, and they would schedule the appointment. Staff J got up from the conversation and went to the scheduler to inquire about Resident 79's ST evaluation referral. Staff J returned and stated the scheduler had not received an ST referral for Resident 79.</p> <p><Resident 83></p> <p>Review of the medical record showed the resident admitted with diagnoses to include a fracture of the right hip and malnutrition. The 08/06/2024 significant change assessment showed Resident 83's cognition was moderately impaired and independent with eating meals.</p> <p>An observation on 10/17/2024 at 12:34 PM, showed Resident 83's lunch tray was placed on the bedside table, the resident's head of their bed was lowered to almost a lying position and they could not reach the food on the table. There was no staff assistance during the mealtime.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on 10/18/2024 at 8:35 AM, showed Resident 83 lying in bed, their breakfast placed on the bedside table that was placed to their side, in between the window and the bed, and the resident was unable to place the table in front of them so could not access their food.</p> <p>An observation on 10/21/2024 at 12:06 PM, showed Resident 83 was lying down in bed, their lunch tray had been delivered to the room and placed on the bedside table beside their bed, out of their reach.</p> <p>Review of Resident 83's weight log showed as follows: on 06/27/2024, on admission, the resident weighed 174 lbs.; less than a month later, on 07/11/2024 159 lbs (an 8.62 percent weight loss); on 08/30/2024 156 lbs (a 10.34 percent weight loss). No other weights were obtained after 08/30/2024.</p> <p>Review of the NAR notes showed on 09/12/2024, Resident 83 was a new risk (63 days after weights identified a significant weight loss), required varied assistance from independent to partial assistance, severe malnutrition, and continue to monitor weights closely. Additional nutritional supplements were added, and follow-up in one month; on 10/10/2024 there was a new weight pending and continue to monitor weights closely, follow-up in one month, and Resident 83's condition was stable (there were no other weights obtained after 08/30/2024).</p> <p>Review of the 07/02/2024 care plan showed Resident 83 was independent for eating meals and on 08/09/2024 a nutritional supplement twice daily between meals.</p> <p>During an interview on 10/21/2024 at 12:15 PM, Staff BB, Nursing Assistant, stated they had daily weights they obtained and then the nurses would give them a list of names to obtain weights on. Staff BB did not recall when they had last obtained Resident 83's weight and was normally completed when they had a shower.</p> <p>During an interview on 10/21/2024 at 12:21 PM, Staff AA, NA, was asked to obtain a weight on Resident 83 if the resident would allow. Staff AA stated they would try. (Resident 83's weight was not obtained).</p> <p>During an interview on 10/23/2024 at 8:23 AM, Resident 83 stated if they received something to help with their pain they would agree to get out of bed for a weight.</p> <p>During an interview on 10/23/2024 at 8:35 AM, Staff C, Medication Assistant Certified, was informed of Resident 83's request for pain relief and the request for a weight to be obtained.</p> <p>During a follow-up review of Resident 83's weight log showed a weight had been obtained on 10/23/2024 at 12:52 PM. The weight was 144 lbs (less than four months after admission, Resident 83 showed a 17.24 percent weight loss).</p> <p>Review of provider notes on 08/13/2024 and 10/07/2024 showed Resident 83's appetite was satisfactory and no significant weight change.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/24/2024 at 12:45 PM, Staff U stated NAR meetings were held every Thursday and each resident reviewed for significant weight loss would be weighed weekly. Staff U stated they reviewed the alerts for weight loss and if a weight was not obtained, they would give nursing a paper with a list of names that needed their weight, and they would ensure they got done. Staff U stated they would write up the recommendations, but it was nursing's responsibility for ensuring the recommendations and weight loss were addressed with the providers and followed through with. Staff U stated they were aware the facility struggled with obtaining ST evaluations.</p> <p>During an interview on 10/24/2024 at 3:20 PM, Staff E, Minimum Data Set (a required assessment and care planning tool) Coordinator, stated they attended the weekly NAR meetings to ensure accurate assessments of resident's nutritional status. Staff E stated residents with significant weight loss were to be weighed weekly and if they did not have one, they would ensure the NAs went back and obtained them.</p> <p>During an interview on 10/29/2024 at 10:11 AM, Staff B, Director of Nursing Services, stated when Staff U wrote recommendations, they were considered orders, and the UMs should have processed them as such. Staff B stated the UMs were responsible for notifying the providers and family of the weight loss and the plans. Staff B stated the facility did not provide ST services and would have needed to be referred to an outside provider. Staff B stated residents with significant/severe weight loss should have been weighed weekly and should have been documented in the progress notes if the resident had refused their weights.</p> <p>Review of the nursing progress notes showed a note on 08/22/2024 that showed a new weight would be obtained and Resident 83 met the criteria for malnutrition. The notes showed no resident refusals of getting weighed.</p> <p>Reference WAC: 388-97-1060(3)(h)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642</p> <p>Based on interview and record review, the facility failed to ensure dialysis services met professional standards of care for 1 of 1 resident (Resident 193) reviewed for dialysis (the kidneys no longer function and require a process to remove waste and excess fluids from the blood stream). This failure placed residents receiving dialysis at risk for unmet care needs and medical complications.</p> <p>Findings included .</p> <p>The facility's policy titled Quality of Care Dialysis, dated 05/2019, showed the facility would provide residents who require dialysis care and services consistent with professional standards of practice. The facility and the dialysis center would collaborate to assure that the resident's needs related to dialysis treatments were being met. There would be ongoing communication and collaboration between the nursing home and dialysis staff for the development and implementation of the dialysis care plan.</p> <p><Resident 193></p> <p>Review of Resident 193's medical record showed the resident was admitted to the facility on [DATE], with diagnoses to include diabetes (a disease in which the body does not control glucose (a type of sugar) in the blood), end stage renal disease (where kidney function has declined to the point that the kidneys can no longer work on their own), heart failure, and anxiety (a feeling of worry, nervousness, or unease). Review of Resident 193's comprehensive assessment, dated 09/22/2024, showed the resident's cognition was intact and they required substantial assistance with activities of daily living.</p> <p>Review of Resident 193's care plan, dated 09/18/2024, showed the resident required dialysis on Tuesdays, Thursdays and Saturdays. Since admission, the resident had 17 visits at the dialysis center. Further review of the medical record showed no communication between the facility and dialysis center.</p> <p>Review the medical record showed the facility had completed a weight for Resident 193 on 09/18/2024; the resident weighed 275.6 pounds. There were no other weights documented in the resident's medical record as of 10/29/2024.</p> <p>During an interview on 10/16/2024 at 8:50 AM, Resident 193 stated they received a sack lunch before going to dialysis and after dialysis they would receive a meal. The resident stated they were unaware of how the facility communicated to the dialysis center. Resident 193 stated sometimes the nurses would check on them when they returned from dialysis, if the nurses were not too busy.</p> <p>During an interview on 10/22/2024 at 2:59 PM, Staff M, Licensed Practical Nurse (LPN), stated they had Resident 193 return from the dialysis center twice when working. Staff M stated after the resident's dialysis treatment, the only thing they had received were the resident's face sheet and our form we sent that were not filled out. Staff M stated they did not call for a post dialysis report from the dialysis center.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/22/2024 at 3:05 PM, Staff SS, Registered Nurse (RN) stated they had sent Resident 193 to dialysis with a face sheet, a med list and their last vitals obtained prior to them leaving. Staff SS stated there should be pre and post visit communication with dialysis. Staff SS stated they have not received any communication from dialysis when the resident returned. Staff SS stated they had not called the dialysis center for a post dialysis report.</p> <p>During an interview on 10/24/2024 at 3:21 PM, Staff UU, Nursing Assistant (NA), stated they were assigned to scanning documents that the facility received into the resident's charts once the nurses place them in the scan bin (a storage container for paperwork to be scanned into the medical record). Staff UU stated they had not seen any documents from the dialysis center.</p> <p>During an interview on 10/24/2024 at 3:22 PM Staff J, LPN/Unit Manager (UM), stated that Resident 193 had not been in the facility very long. Staff J stated they had not seen any paperwork from the dialysis center.</p> <p>During an interview on 10/24/2024 at 7:56 PM, Staff K, LPN/UM, stated they would do a quick review of the dialysis communication and then place the form in the scan bin for medical records to scan in the resident's chart. Staff K stated the resident's case manager from the dialysis center would call or send the resident to the hospital if the resident was not doing well.</p> <p>During an interview on 10/25/2024 at 11:58 AM, Resident 193 stated, they gave their dialysis report from Tuesday (10/22/2024) to the nurse. The resident stated it was the first time that they had brought back information to the facility.</p> <p>During an interview on 10/29/2024 at 8:46 AM, Staff B, Director of Nursing Services (DNS), and Staff D, Regional Nurse Consultant/Infection Preventionist (RNC/IP), both acknowledged there was an issue with the communication between the facility and the dialysis center. Staff B stated the nurses should obtain the pre and post communications from the dialysis center, the nurses should be documenting when a resident goes in and out of the facility and the communication obtained from the resident's visits.</p> <p>Reference WAC 388-97-1900(1), (6) (a-c)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>48368</p> <p>Based on observation, interview, and record review, the facility failed to ensure there were sufficient numbers of nursing staff to provide care and services for 17 of 17 residents (Residents 293, 245, 79, 2, 11, 1,19, 49, 71, 5, 83, 18, 51, 84, 3, 244 and 54). These failures placed residents at risk of not having their needs met and potential negative outcomes to their physical and mental health.</p> <p>Findings included .</p> <p>< F 636 Resident Comprehensive Assessments and Timing></p> <p>The facility failed to ensure resident admission Minimum Data Sets (MDS, a required assessment and care planning tool) were completed within the required timeframes.</p> <p><Resident 293></p> <p>Record review of Resident 293's medical record showed an admission MDS had an admission Assessment Reference Date (ARD, refers to the specific endpoint for the observation [or look-back] periods in the MDS assessment process) of 09/29/2024. Review of the MDS completion date showed it was not completed until 10/22/2024 (27 days after the admission and 13 days late).</p> <p><Resident 245></p> <p>Record review of Resident 245's medical record showed an admission MDS had an ARD of 09/29/2024. Review of the assessment MDS completion date showed it was not completed until 10/29/2024, 34 days after the admission and 20 days late.</p> <p><F 637 Comprehensive Assessment after Significant Change></p> <p>The facility failed to ensure a significant change MDS assessment had been completed.</p> <p><Resident 79></p> <p>Review of hospice admission notes showed Resident 79 had been admitted to hospice services on 10/04/2024.</p> <p>Review of Resident 79's comprehensive assessments showed a significant change assessment had not been completed as of 10/29/2024.</p> <p><F 638 Quarterly Assessments at Least Every Three Months></p> <p>The facility failed to complete quarterly MDS assessments within the regulatory timeframes.</p> <p><Resident 2></p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Record review of Resident 2's medical record showed a quarterly MDS with an ARD of 09/06/2024 and showed it was completed on 10/11/2024 (35 days late).</p> <p><Resident 11></p> <p>Record review of Resident 11's medical record showed a quarterly MDS with an ARD of 08/29/2024 and showed it was completed on 10/11/2024 (43 days late).</p> <p><Resident 1></p> <p>Record review of Resident 1's medical record showed a quarterly MDS with an ARD of 09/02/2024 and showed it was completed on 10/11/2024 (38 days late).</p> <p><Resident 19></p> <p>Record review of Resident 19's medical record showed a quarterly MDS with an ARD of 09/03/2024 and showed it was completed on 10/11/2024 (37 days late).</p> <p><Resident 49></p> <p>Record review of Resident 49's medical record showed a quarterly MDS with an ARD of 09/03/2024 and showed it was completed on 10/11/2024 (37 days late).</p> <p><Resident 71></p> <p>Record review of the medical record showed Resident 71's quarterly MDS with an ARD of 07/12/2024 and was completed on 8/07/2024 (26 days late). Additionally, Resident 71's quarterly MDS with an ARD of 10/12/2024 was not completed as of 10/29/2024 (17 days late).</p> <p>During an interview on 10/24/2024 at 2:40 PM, Staff E, Licensed Practical Nurse/MDS Coordinator, stated they were aware that many of the MDS assessments had not been completed and were late. They stated they were the only staff currently completing them as they recently lost their part time help.</p> <p>During an interview on 10/25/2024 at 11:30 AM, Staff B, Director of Nursing Services, stated they were aware of the late MDS assessments and were trying to get Staff E help.</p> <p><Quality of Life></p> <p>< F 677 ADL Care Provided for Dependent Residents></p> <p>The facility failed to consistently provide assistance with bathing and grooming for dependent residents.</p> <p><Resident 5></p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 10/15/2024 at 10:40 AM, Resident 5 stated they were frustrated because they would like to have a shower more than twice a week but would like to at least get the two a week they were scheduled for. Resident 5 stated their shower days were on Wednesdays and Saturdays but often did not receive them due to the facility being short-staffed and the Nursing Assistants (NA) on the floor were too busy.</p> <p>Review of Resident 5's shower tasks, showed from 09/22/2024 to 10/16/2024 the resident received a shower on 09/25/2024, 10/02/2024 (seven days since previous shower), 10/09/2024 (seven days since previous shower), and 10/16/2024 (four showers total, with seven days since the previous shower). The tasks showed three other days that the activity did not occur .</p> <p>During an interview on 10/21/2024 at 10:20 AM, Staff Z, Nursing Assistant (NA), stated they would complete showers if there was enough time to get to them without making other residents go without. Staff Z stated if just one person called in, that would throw the whole routine off because they normally were not replaced with someone else. Staff Z stated when a resident continued to refuse after two to three attempts, they would notify the nurse, and they would try as well.</p> <p><Resident 83></p> <p>A concurrent observation and interview on 10/17/2024 at 11:24 AM, showed Resident 83 lying width wise, across their bed, feet on the floor, bed and pillows had no linens on them, and brown smears were dried on the blue mattress where the resident had just rolled over from. Resident 83 had black debris underneath their uncut nails, was wearing the same gray t-shirt with red and blue striped pants, and had yellow non-skid socks on with red, soaked through drainage to the left great toe area. Resident 83's beard was long, unkempt, with some of the hairs extending to the mid chest area. Resident 83 stated they had not normally kept their beard that long and had not had their beard trimmed in quite a while.</p> <p>During an interview on 10/29/2024 at 9:08 AM, Staff BB, NA, stated when fully staffed, they would be able to get to each resident and complete their hair combing/brushing, shaving, and trim their fingernails. Staff BB stated they would try to get to Resident 83 today.</p> <p><Resident 18></p> <p>During an observation and concurrent interview on 10/15/2024 at 11:09 AM, Resident 18 was lying in bed wearing a hospital gown with a blanket over their chest, and their hair was oily and uncombed. Resident 18 stated the staff assisted them with a bed bath and was to receive a bed bath today. The resident stated they preferred bed baths, but they had not had a bed bath in two weeks.</p> <p>During an interview on 10/16/2024 at 10:40 AM, Resident 18 stated they had not received their bed bath from the day before. The resident stated they were short staffed again. The resident had a hospital gown on, and their hair was disheveled.</p> <p>Review of the NA's documented tasks from 09/08/2024 through 10/08/2024 showed Resident 18 was totally dependent on staff for showering. The documentation showed the resident received a bed bath one day out of 30, all other documentation showed the activity did not occur.</p> <p><Resident 51></p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An observation and concurrent interview on 10/16/2024 at 2:45 PM, Resident 51 was up in their wheelchair, their hair was long and oily in appearance, and they were fully dressed. The resident stated they had not had a shower or bath in about three weeks, and their toenails had only been trimmed twice in the current year.</p> <p>Review of the NA's documented tasks from 09/09/2024 through 10/09/2024 showed Resident 51 was totally dependent on staff for showering. The documentation showed the resident received a shower on two days out of 30, all other documentation showed the activity did not occur.</p> <p><Quality of Care></p> <p><F 684> The facility failed to ensure facility staff provided care and services to meet resident's needs including skin conditions and pain.</p> <p><Skin></p> <p><Resident 83></p> <p>An observation and concurrent interview on 10/16/2024 at 11:35 AM, showed Resident 83 was observed lying in their bed, no pants on, partially covered with a sheet with only their feet exposed, both ears had white/brownish crusted areas to the entire outer and inner portion of the ears with dried red blood. The right eye had dried, crusted white areas surrounding the eye. An empty, soiled, urinal was on the floor in between the bed and the window, and the call light was under the bed on the floor. Resident 83's left eye was reddened with yellow/green drainage in the inner corner of the eye. The outer left great toe had thickened, dried red blood clumped at the corner of the outer nail bed and underneath the remaining four toes, there was dried red blood on the skin. Resident 83 stated when they required help, they would yell out help to get it.</p> <p>An observation and concurrent interview on 10/17/2024 at 2:39 PM, showed Resident 83 lying in bed, moaning out and repeating help me, help me and the call light was underneath the bedside table on the floor. Resident 83 stated their right leg was very painful and was holding their right knee up towards their chest. Resident 83 was covered by a sheet and the Surveyor could not visualize their right leg.</p> <p>An observation on 10/17/2024 at 2:59 PM, showed Resident 83 was grasping their right leg and moaning ooh, aww when Staff CC, NA, Staff DD, NA, and Staff RR, Registered Nurse, all walked by and did not stop to ask the resident what was wrong.</p> <p>During an interview on 10/22/2024 at 4:34 PM, Staff B, Director of Nursing Services, stated Staff K, Licensed Practical Nurse (LPN)/Unit Manager (UM, a Licensed Nurse (LN) that provided oversight and management of the nursing staff and patients within their units), completed the weekly skin check on 10/17/2024 and documented new skin issues were found. Staff B stated Staff K got busy and forgot to complete the process for the new skin issues found during that assessment and did not follow the correct process.</p> <p><F 686></p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facility failed to prevent the development of a pressure injury (PI-localized damage to the skin and underlying soft tissue over a boney prominence).</p> <p><Resident 293></p> <p>Observations of Resident 293's positioning:</p> <p>10/15/2024 at 10:27 AM- lying in bed on their back with the head of bed (hob) elevated, feet pushed against the foot board, and heels on the mattress.</p> <p>10/15/2024 at 12:00 PM- lying in bed in the same position as 10:27 AM</p> <p>10/16/2024 at 9:02 AM- lying in bed on their back with the hob elevated, heels were on the mattress</p> <p>10/16/2024 at 2:10 PM- lying in bed on their back with the hob elevated, heels were on the mattress</p> <p>An observation and concurrent interview on 10/17/2024 at 11:27 AM, Resident 293 was lying in bed on their back in bed with the hob elevated and their heels were on the mattress. The resident stated that they had pain in their right heel.</p> <p>An observation and concurrent interview on 10/17/2024 at 2:24 PM, Resident 293 was lying on their back, with the head of bed elevated, and their heels were on the mattress. The resident agreed to have their sacral dressing changed. When asked if they had any pain, the resident stated their right heel hurt.</p> <p>Record review of a 10/22/2024 skin injury assessment by Staff B showed the resident had a deep tissue injury caused by pressure on the right heel. Resident 293 had persistent, non-blanchable purple discoloration on the right heel that measured 1.0 cm by 0.9 cm. The resident was educated to float their heels on a pillow.</p> <p>During an interview on 10/25/2024 at 11:30 AM, Staff B stated they were not aware Resident 293's sacral wound was not measured or staged on admission, and it should have been. The DNS stated that the heel wound should not have happened. The resident should have had a heel boot and floated heels.</p> <p><F-688 Prevent/Decrease in Range of Motion (ROM, how far you can move a joint or muscle in various directions)/Mobility></p> <p>The facility failed to ensure staff provided care and services to maintain ROM and prevent contractures.</p> <p><Resident 51></p> <p>During an interview on 10/15/2024 at 10:37 AM, Resident 51 stated I'm tired of it! they (therapy department) won't give me therapy. Resident 51 stated their foot was frozen on the left side, and they did not wear a brace for it. Resident 51 had shoes on, and their feet were internally rotated while sitting up in their wheelchair.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a follow-up interview on 10/16/2024 at 3:33 PM, Resident 51 stated they were not receiving any type of therapy. The resident stated therapy/restorative nursing would come in two to three times a week, but no longer worked with them. Resident 51 stated they have not had therapy in months.</p> <p>During an interview on 10/17/2024 at 10:51 AM, Staff T, Therapy Director, stated the facility did not have restorative staff, or a fully staffed therapy department. Staff T stated if there was a restorative program the NACs would be tasked to follow up with the restorative care plan, placement of the braces/splints, and documenting tasks in the computer. Staff T stated they needed a bigger area for therapy and a restorative program. Staff T stated they were not sure if Resident 51 wore a brace, and stated the resident was not on their caseload.</p> <p>During an interview on 10/29/2024 at 8:46 Staff B, and Staff D, Regional Nurse Consultant, stated the facility had a restorative program and the program currently was not robust (minimal staff). Staff B stated, it's a lost area, we are trying. Staff B stated the care givers do range of motion when delivering resident care. Staff D stated they were aware the restorative nursing program was an issue.</p> <p><F 689 Free from Accident Hazards/Supervision/Devices></p> <p>The facility failed to ensure residents received assessments and supervision, and staff received adequate training to prevent elopements.</p> <p><Resident 84></p> <p>Record review of the 07/18/2024 admissions assessments showed no elopement risk assessment had been completed for Resident 84 on admission.</p> <p>Record review of the care plan dated 07/18/2024, showed no care plan was in place for SUD/Elopement.</p> <p>During an interview on 10/23/2024 at 9:16 AM, Staff B stated they had last seen Resident 84 at 11:30 PM last night on 10/22/2024. Staff B stated they were unaware what time they were last seen by staff after that. Staff B stated they were notified of Resident 84 missing between 8:15 AM and 8:30 AM on 10/23/2024 when their significant other (SO) came to take them out for an appointment.</p> <p>During a telephone interview on 10/23/2024 at 10:51 AM, Staff O, NA, stated they were assigned to the 100 hallway and were responsible for Resident 84 during the night shift on 10/22/2024. Staff O stated they were short staffed, and were the only NA assigned to the 100 hallway with 25 residents to care for. Staff O stated the last time they had seen Resident 84 was between 1:00 AM and 2:00 AM in the lobby, by the front entrance, watching television. Staff O stated Resident 84 did not have a history of leaving the facility on night shift. Staff O stated they started their last rounds at 4:00 AM and did not see Resident 84 in their room (112), as the blankets on Resident 84's bed were pulled down and they just assumed they were somewhere in the facility. Staff O stated they should have notified the nurse, but they did not think nothing of it. Staff O further stated they had not had any training on what to do for an elopement or a missing resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 10/23/2024 at 4:35 PM, Staff PP, NA and Staff HH, NA, stated they had not received any training on hire or during their employment on the process if a resident went missing. Staff PP and Staff HH stated they did not know what Code Vegas meant and they were not educated how to initiate that process.</p> <p>During an interview on 10/28/2024 at 10:47 AM, Staff E, LPN/Minimum Data Set Coordinator, stated their process was to do an elopement risk assessment the day of admission on all new residents. Staff E stated they did not complete an elopement assessment on Resident 84, and they did not follow the correct process.</p> <p>Review of the facility's 10/2024 Resident Roster, showed 67 residents were on hallways 100, 200, and 300, and 27 of those residents required transfer assistance and two-person assistance with cares.</p> <p><Resident Council Meeting></p> <p>On 10/16/2024 at 10:02 AM, during the resident council meeting, Residents 8, 71, and 51 complained of lack of staffing, long wait times for call lights, they had not received showers, they received cold food, and did not receive enough restorative care (an exercise program to maximize and maintain a person's level of function, enabling them to retain their skills and level of independence).</p> <p><Resident observations/interviews></p> <p>A concurrent observation and interview on 10/18/2024 at 9:22 AM, showed Resident 3 sitting up in their bed, their brief was halfway off with the right side of the brief being unfastened. Resident 3's brief was yellow and brown in color, soaked, clumping, and sagging to the right side. Resident 3 was asking for help to use the restroom. Resident 3's breakfast tray was sitting on their bedside table not within reach of the resident. Staff R, Dietary Manager, was also present at the time of the observation, and stated the resident's tray was delivered at 8:15 AM. Resident 3's breakfast tray had been sitting out of reach of them for one hour and seven minutes.</p> <p>An observation and concurrent interview on 10/18/2024 at 9:36 AM, showed Resident 3 grabbing a snack (fruit bar) out of their bedside nightstand drawer. Resident 3 stated they were hungry and would like to eat. Resident 3 stated they would be able to eat if staff would place their breakfast tray in front of them, I can't reach it.</p> <p>An observation on 10/18/2024 at 10:15 AM, showed Staff NN, NA, entered Resident 3's room to provide them assistance (2 hours after breakfast tray was delivered and one hour after Resident 3 was first observed asking for help).</p> <p>During an interview on 10/18/2024 at 10:33 AM, Resident 3 stated they did not get their breakfast before it was cold, this happens often. Resident 3 stated staff get to doing other things and they just forget and by the time they get back to change them, and get them up to eat, their meals were cold. Resident 3 stated this happens a lot.</p> <p>An observation on 10/18/2024 at 11:55 AM, Staff NN changed Resident 245's brief that was heavily soiled with urine. Staff NN stated due to being so short staffed that morning, that was the first time that shift that Resident 245 received cares. The day shift started at 6:00 AM. (five hours and 55 minutes into the shift).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 10/18/2024 at 11:57 AM, Resident 84 stated that they had to wait to use their urinal that morning. The resident stated they turned on their call light for assistance and had to wait a long time, so long they fell back to sleep. Resident 84 stated it was close to an hour before staff came in and woke them up to see why they had their call light on. The resident stated they had suggested to quit moving staff around. The resident stated it seemed like every day there was a different nurse, and did not know how to provide care for them.</p> <p>An observation on 10/18/2024 at 12:08 PM, showed Resident 244 was asleep, their breakfast meal tray was untouched, and sat on a bedside table next to the resident. An observation at 12:49 PM, showed Staff BB, NA, removed Resident 244's breakfast tray. Staff BB stated the resident did not eat anything. Staff BB stated they attempted to assist Resident 244 to eat but the resident was too sleepy. Staff BB stated they had been really busy and did not notify the nurse of the resident not eating their breakfast or that they were not awake for their lunch meal.</p> <p>An observation on 10/18/2024 at 12:10 PM, showed Resident 54's lunch tray was delivered and was sat down on the bedside table away from resident. The resident was asleep in their bed. Further observation at 12:34 PM, showed Resident 54's lunch tray sitting on bedside table away from the resident (24 minutes after tray delivered).</p> <p>During an interview on 10/23/2024 at 8:43 AM, Resident 18 stated the care they received depended on the shift and the call-ins. Resident 18 stated the evening shift and the weekend shifts were really bad, and they were always short staffed. Resident 18 stated the facility had two to four call-ins a day making it hard for the residents to receive care. Resident 18 stated the call light wait times were long and sometimes they would have to wait 40 minutes for help they just do not have enough staff here.</p> <p><Staff Interviews/Observations></p> <p>During an interview on 10/18/2024 at 10:28 AM, Staff BB stated they did not feel the facility was appropriately staffed and if they had to be honest they did not feel they were able to care for the residents appropriately. Staff BB stated they were short staffed a lot on the weekends.</p> <p>An observation and concurrent interview on 10/18/2024 at 12:04 PM, showed Staff BB doing personal cares on Resident 24. Resident 24's brief was soaked with urine, was yellow and brownish in color and was sagging. Staff BB removed Resident 24's brief; the brief was filled with a bowel movement (BM). The BM was hard, the size of a baseball, between the buttocks and BM was dried and stuck on the outside of Resident 24's buttocks. Staff BB stated this was the first time during the start of their shift they had time to care for Resident 24 because they were short staffed. Staff BB stated they started their shift at 6:00 AM. Staff BB stated they did not do first rounds on any of their residents yet (six hours and four minutes into their shift).</p> <p>During an interview on 10/18/2024 at 10:12 AM, Staff NN stated they had call-ins from three staff members. Staff NN stated the first part of the morning they worked with two staff members in the 100 hall and one staff member on the 300 hall. Staff NN stated they never know how their day will be due to the call-ins, and it caused a hardship to get all the care done for all of their residents.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An observation and concurrent interview on 10/18/2024 at 12:52 PM, Staff BB donned their PPE and entered to assist Resident 54 with their lunch tray (42 minutes after the lunch tray was delivered). Staff BB stated they were unaware of when the tray was delivered, and they were so busy they had just gotten the time to assist Resident 54 with their meal.</p> <p>During an interview on 10/20/2024 at 8:52 PM, Staff GG, NA, stated staffing on the weekends was pretty scary and there were a lot of call-ins. Staff GG stated it was difficult to get the work done when they had low staff. Staff GG stated they were asked to stay longer than their shift often. Staff GG stated they worked a double last night (10/19/2024) due to the call-ins and had just been asked to stay to work the night shift for tonight (10/20/2024).</p> <p>During an interview on 10/21/2024 at 10:20 AM, Staff Z, NA stated they would complete showers if there was enough time to get to them without making other residents go without. Staff Z stated if just one person called in, that would throw the whole routine off because they normally were not replaced with someone else. Staff Z stated when a resident continued to refuse after two to three attempts, they would notify the nurse, and they would try as well.</p> <p>During an interview on 10/23/2024 at 8:57 AM, Staff UU, NA, stated they worked short staffed a lot on the weekends, evening shift, and the night shift. Staff UU stated they had not been able to give the residents the care they needed because they were short staffed more often than not.</p> <p>During an interview on 10/23/2024 at 9:03 AM, Staff CC stated the weekends were short staffed most of the time and they were unable to give the residents the care they needed. Staff CC stated they were only able to provide the residents with the necessities when that happened.</p> <p>During an interview on 10/29/2024 at 9:08 AM, Staff BB stated when fully staffed, they would be able to get to each resident and complete their hair, shaving, and trim their fingernails. Staff BB stated they would try to get to Resident 83 today.</p> <p><Resident Representative interview></p> <p>During an interview on 10/16/2024 at 1:42 PM, Resident 68's Representative stated they had visited on both weekdays and weekends and thought the facility was short of direct care staff on weekends.</p> <p>During an interview on 10/18/2024 at 3:03 PM, Staff B and Staff AAA, Scheduler/NA, stated the direct care nursing positions that were vacant were for eight Licensed Nurses, four-night shift NAs, ten evening shift NAs, five-day shift NAs (27 direct care nursing staff in total needed). Staff B stated, right now, we have to use multiple agencies [contracted nurse staffing]. Staff B stated they expected all their staff to be out on the floor helping out until they could get the issue (staffing) under control. Staff AAA stated they were not usually notified of the call-ins until after the shift started. Staff AAA stated they were not aware of the three call-ins for that day, 10/18/2024 (total of four), until 6:30 AM (day shift starts at 6:00 AM) so it was hard for them to get coverage. Staff B stated they expected staff to call them when they had that many call-ins, but staff did not notify them this time.</p> <p>Reference: WAC 388-97-1080(1)</p> <p>45642</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>44922</p> <p>Based on interview and record review the facility failed to ensure a resident was free from significant medication errors for 1 of 5 residents (Resident 54) reviewed for hospitalization . Resident 54 experienced harm when they received an antipsychotic medication (a class of drugs used to treat symptoms of psychosis and other mental health disorders) that caused acute toxic encephalopathy (indicates brain dysfunction caused by toxic exposure in the absence of primary structural brain disease) and increased sleepiness that resulted in a four-day hospitalization .</p> <p>Findings included .</p> <p>Review of Lippincott's Guide to Preventing Medication Errors dated 11/15/2002, showed the five rights of nursing drug administration are the right patient, the right drug, the right dose, the right route, and the right time.</p> <p><Resident 54></p> <p>Review of the medical record showed the resident admitted with diagnoses to include dementia (the loss of cognitive functioning that interferes with daily life and activities). The 08/07/2024 comprehensive assessment showed Resident 54's cognition was severely impaired and required one to two person staff assistance with activities of daily living.</p> <p>During an interview on 10/16/2024 at 2:16 PM, the Resident's Representative (RR) stated Resident 54 had received the wrong medications and ended up in the hospital and was real sick.</p> <p>Review of a hospital discharge summary on 10/14/2024 showed Resident 54 admitted to the hospital on 10/10/2024 for receiving another resident's medication. The summary showed the resident received an antipsychotic (a collection of symptoms that affect your ability to tell what's real and what isn't) medication (Seroquel, a medication used for managing symptoms including delusions, hallucinations, paranoia or disordered thoughts). The summary showed the resident had a low blood pressure at 66/24 millimeters of mercury ([mmHg, a unit of measure], where the normal range for an adult is 120/80 mmHg) and required the administration of intravenous (through the vein) fluids. Resident 54 was diagnosed with acute toxic encephalopathy from receiving an antipsychotic medication in error.</p> <p>Review of a facility incident investigation on 10/10/2024 at 12:00 PM, showed Staff VV, Licensed Practical Nurse, had mixed up Resident 54's medications with their roommate's medications. Staff VV realized they had made the error and called the physician who gave orders to send the resident to the hospital. The investigation showed a follow-up note on 10/14/2024 that the resident had no negative outcome and would remain at the hospital for observation. The investigation showed Staff VV did not follow the five rights of medication administration, which are right resident, right drug, right dose, right route, and right time which should have been verified prior to administering medications to any resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0760 Level of Harm - Actual harm Residents Affected - Few	<p>During an interview on 10/29/2024 at 10:28 AM, Staff B, Director of Nursing Services, stated they followed up with the hospital and was informed the resident was at their baseline and there were no negative effects for Resident 54 receiving the wrong medications. Staff B stated they did not review the hospital records on readmission and should have. Staff B stated Staff VV did not follow the correct steps when administering medications.</p> <p>WAC Reference: 388-97-1060 (3)(k)(iii)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>44922</p> <p>Based on observation and interview, the facility failed to ensure drugs and biologicals were labeled in accordance with currently accepted professional principles and discarded when expired on one of two medication carts (Halls 1 and 2) and one of two medication rooms (Main Nurse's station), reviewed for medication storage. This failure placed the residents at risk for receiving compromised or ineffective medication.</p> <p>Findings included .</p> <p><Main Nurse's Station></p> <p>A concurrent observation and interview on 10/22/2024 at 3:46 PM, showed as follows:</p> <p>two glucagon (a medication that controls sugar in the blood) shots that expired on 08/20/2024 and 06/05/2024, and one unlabeled glucagon shot.</p> <p>50 Needles Size 18 gauge (refers to the thickness of the needle and the size of the hole that the medication passes through) expired 08/31/2024.</p> <p>Resident 16's Valproic Acid (a brand of medication used for seizures) one full bottle, and one opened bottle with 200 milliliters (ml, a unit of measure) that expired on 06/22/2024</p> <p>Medication refrigerator:</p> <p>12 hemorrhoidal suppositories (a medication used for swollen veins in the anus) that expired 09/2024</p> <p>five Prevnar (a vaccine used to prevent pneumococcal disease, a serious bacterial infection) 0.5 ml injections expired on 03/10/2024</p> <p>three Basaglar (a brand of insulin used to control sugar in the blood) 100-unit pens belonged to discharged Resident 29</p> <p>one Lispro (a brand of medication used to control sugar in the blood) Kwikpen, opened with a date of 04/27/2024 for Resident 9</p> <p>In the same observation, Staff J, Licensed Practical Nurse/Unit Manager (UM), stated they destroyed medications as a team and when they were available. Staff J stated they tried to destroy medication at least weekly, but it had not been done timely. Staff J stated they thought the pharmacist monitored for expired medications or when they got stocked, they should have been checked and rotated.</p> <p><Hall 1></p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation of the medication cart on 10/22/2024 at 4:43 PM, showed one opened bottle of Acidophilus (a supplement used for gastrointestinal health) 30 capsules and another full bottle of 100 capsules unopened that expired 06/2024.</p> <p><Hall 2></p> <p>An observation of the medication cart on 10/22/2024 at 5:01 PM, showed as follows:</p> <p>an opened bottle of Lantus (a brand of medication used to control sugar in the blood) 100 units per bottle, half full, and no opened date belonging to Resident 36.</p> <p>two glucagon pens that expired on 02/02/2024 and 07/11/2024.</p> <p>one bottle of fluticasone (a medication used for sinus allergies) with an opened date of 06/27/2024 for Resident 3.</p> <p>one bottle of fluticasone with an opened date of 06/24/2024 for Resident 5.</p> <p>During an interview on 10/29/2024 at 10:31 AM, Staff B, Director of Nursing Services, stated UMs were responsible for ensuring discontinued medications or discharged resident medications were destroyed weekly. Staff B stated when the medications got ordered and stocked, they should have been rotated out and checked for expired meds. Staff B stated the consulting pharmacy also monitors the expired meds every two weeks. Staff B stated insulins, nasal sprays should have an opened date and discarded within the appropriate time and be stored in a bag.</p> <p>WAC Reference: 388-97-1300(2)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>48368</p> <p>Based on observation and interview the facility failed to serve meals that were at a safe temperature and appetizing for 2 of 5 residents (Residents 3 and 1) reviewed for food quality. This failed practice placed the residents at risk for decreased nutritional intake and food borne illness.</p> <p>Findings included .</p> <p>Review of the undated policy titled, Record of Food Temperatures, showed that food was to be served in such a manner that temperatures were safe and acceptable to residents. The hot foods would be held at a minimum of 135 degrees Fahrenheit (F- a unit of measure) and cold foods would be held at a maximum of 41 degrees F. Further review showed that no food will be served that does not meet the food code standard temperatures.</p> <p><Resident Council></p> <p>During a resident council meeting on 10/16/2024 at 10:02 AM Residents 51, 71, 8, 7 and 28 were in attendance 3 of the 5 residents reported the following concerns:</p> <p>Resident 51 stated they had not had a hot meal in years.,</p> <p>Resident 71 stated the food was cold and the breakfast was the worst and always cold.</p> <p>Resident 8 stated the food was always cold, for all meals.</p> <p><Resident 3></p> <p>An observation and concurrent interview on 10/18/2024 at 9:22 AM showed Resident 3's breakfast tray sitting on their bedside table not within reach of the resident. Staff R, Dietary Manager, performed a temperature check on Resident 3's breakfast tray with results as follows: Coffee 91.1 degrees F, hot cereal 100.2 degrees F, pureed fruit salad 70.1 degrees F, pureed eggs 79.4 degrees F, pureed biscuits and sausage gravy at 81.5 degrees F. Staff R stated the 100 hallway was the second cart that was out from the kitchen and would have been delivered at 8:15 AM. Staff R stated the temperatures were out of the safe temperature range.</p> <p>An observation and concurrent interview on 10/18/2024 at 10:24 AM showed Resident 3 sitting up in their chair with their bed side table directly in front of them with the same breakfast tray that Staff R did a temperature check on. Resident 3 stated to Staff I, Admissions Coordinator, This breakfast has sat here for a while this is all cold, while pointing at their tray.</p> <p>During an interview on 10/18/2024 at 10:33 AM, Resident 3 stated they did not get their breakfast before it was cold. Resident 3 stated their food was cold a lot of the days.</p> <p>Staff are doing other things, and they forget.</p> <p><Resident 1></p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation and concurrent interview on 10/18/2024 at 9:44 AM, Showed Staff NN, Nursing Assistant, taking Resident 1's breakfast tray to them. Staff ZZ, Dietary Aide, tested Resident 1's tray for safe serving temperatures with the following results:</p> <p>Whole milk 57.7 degrees F</p> <p>Health shake 63.3 degrees F</p> <p>Hot cereal 96.5 degrees F</p> <p>Scrambled eggs 90.6 degrees F</p> <p>Biscuits and sausage gravy 96.2 degrees F.</p> <p>During the same observation, Staff NN stated the temperature was not within the acceptable temperature range and they would get Resident 1 a new breakfast tray.</p> <p>< Test Trays></p> <p>On 10/16/2024 at 12:37 PM a test tray was checked for temperatures by Staff R, DM, with the following results:</p> <p>Breaded chicken 130 degrees F</p> <p>Rice 122.5 degrees F</p> <p>Cooked cabbage 120.4 degrees F</p> <p>Vanilla pudding 58.5 degrees F</p> <p>Whole milk 45.9 degrees F</p> <p>Apple juice 47.7 degrees F</p> <p>On 10/18/2024 at 9:13 AM a test tray was checked for temperatures by Staff R, with the following results:</p> <p>Fruit salad 57.9 degrees F</p> <p>Super shake (meal replacement) 56.0 degrees F</p> <p>Apple juice 51.9 degrees F</p> <p>Health shake 53.5 degrees F</p> <p>Thickened apple juice 51.9 degrees F</p> <p>Biscuits and sausage gravy 101.0 degrees F</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Scrambled eggs 98.6 degrees F</p> <p>During an interview on 10/25/2024 at 9:38 AM, Staff R stated the holding temperatures for hot foods was 135 degrees F and 41 degrees F for cold foods. Staff R stated the process for foods outside of the acceptable temperature range would be to re heat the tray or obtain a new tray if the food had been sitting for over an hour to prevent foodborne illness. Staff R stated the test trays were not within a safe temperature range. Staff R further stated that Resident 1 and Resident 3's breakfast trays were not within a safe temperature range and the correct process was not followed.</p> <p>Reference: WAC 388-97-1100 (3)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48368</p> <p>Based on observation, interview, and record review the facility failed to identify and properly discard foods after the expiration date for 1 of 1 dry food storage rooms and 1 of 1 walk in refrigerators reviewed for kitchen and food safety. This failure placed the residents at risk for food borne illness (fever, chills, stomach cramps, diarrhea, nausea, and vomiting caused by the ingestion of contaminated food and/or beverages).</p> <p>Findings included .</p> <p>Review of the facility's ,d+[DATE] policy titled Food and Nutrition Services, Food Safety showed dry foods will be rotated and refrigerated foods will be labeled, dated and discarded on the expiration date.</p> <p>An observation on the initial kitchen tour with Staff R, Dietary Manager, on [DATE] at 8:20 AM, showed the refrigerator and dry storage room contained the following expired foods:</p> <ul style="list-style-type: none"> -Two-pound bag organic greens, unopened, expired on [DATE] -Three-pound box of Spring mix salad blend, unopened/unsealed, expired on [DATE] -Two-pound bag Greens Fresh Onions, unopened, expired on [DATE] -Two boxes of green mountain coffee roasters 24 count individual cups, unopened, expired on [DATE] -One box of green mountain coffee roasters 18 count individual cups (box showed quantity of 24) expired on [DATE] <p>During an interview on [DATE] at 9:38 AM, Staff R stated the process for putting away stock foods (dry and refrigerated) was for all staff to follow a first in, first out system for rotating stock to prevent the expiration of foods. Staff R stated the cooks were assigned to walk through the freezer/refrigerators every shift to check for dates including expiration dates and they must have missed those items. Staff R stated they did not check the dry storage, they should pay more attention to the stuff they did not use often, and they needed a better system in place.</p> <p>Reference: WAC [DATE](3)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30528</p> <p>Based on interview and record review the facility failed to ensure each resident's medical record was complete and accurately documented their Physician Orders for Self-Sustaining Treatment (POLST, a form that communicates a person's wishes for health care treatments during a medical emergency) for 2 of 3 residents (Resident 67, 73) reviewed for advanced directives. This failure put residents at risk for staff not knowing if they want cardiopulmonary resuscitation, (CPR, an emergency, lifesaving procedure) or do not resuscitate, (DNR, an order that a person had decided not to have CPR if their breathing and heart stopped.)</p> <p>Findings included .</p> <p>Record review of the facility's policy titled, Resident Records - Identifiable Information, ,d+[DATE], showed that the facility would maintain a complete and accurate medical record in accordance with accepted professional standards and practices.</p> <p><Resident 67></p> <p>Medical record review showed Resident 67 was admitted with diagnoses to include chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), hepatic encephalopathy (a permanent or temporary brain damage, disorder, or disease), and liver cirrhosis (severe scarring of the liver). Review of the [DATE] quarterly nursing assessment showed the resident had severe cognitive impairment.</p> <p>Review of Resident 67's electronic part of their medical record on the computer showed their code status was DNR, and comfort focused. When selecting the advance directive hyperlink in the medical record, next to their code status, a scanned (electronic copy) document became available. Review of the [DATE] scanned document showed a POLST order to attempt CPR that included selective treatment.</p> <p>Review of Resident 67's care plan, dated [DATE], showed that a copy of the resident's completed advance directive was placed in the medical record.</p> <p>Record review of a [DATE] emergency department physician note showed they discussed the resident's POLST that indicated the resident wanted CPR with selective treatment. The resident stated they did not want CPR or intubation (a medical procedure that involves inserting a flexible plastic tube down a person's throat to assist with breathing), but they would be okay with procedures and hospitalizations to help them survive.</p> <p>During an interview on [DATE] at 10:24 AM, Staff P, Licensed Practical Nurse (LPN), stated when they needed to know a resident's code status, they would look for the order on the computer and if they were sending a resident to the hospital, they would send a copy of the POLST obtained from a binder at the nurse's station.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident 67's POLST located in the binder at the nurse's station showed the POLST in the binder indicated a DNR order signed by their guardian and physician dated [DATE] and matched the electronic record.</p> <p><Resident 73></p> <p>Medical record review showed Resident 73 was admitted with diagnoses to include dementia (a loss of mental ability severe enough to interfere with normal activities of daily living) and depression. Review of the [DATE] quarterly nursing assessment showed the resident had severe cognitive impairment.</p> <p>Review of Resident 73's electronic part of their medical record showed their code status was DNR, and comfort focused. When selecting the advance directive hyperlink on the computer medical record, next to their code status, a scanned document became available. Review of the [DATE] scanned document showed a POLST with an order to attempt CPR with full treatment.</p> <p>Review of the binder at the nurse's station showed no POLST or forms for Resident 73.</p> <p>During an interview on [DATE] at 8:37 AM, Staff V, Medical Records, stated they were the only staff working in medical records, about one year ago there was an additional 1.5 staff in the department. Staff V stated they currently had a light duty nursing assistant helping with scanning into resident records.</p> <p>On [DATE] at 8:41 AM, Staff V looked up Resident 67's advance directive in their medical record and confirmed the order was for DNR. Then Staff V selected the hyperlink to the POLST saved in the resident's record and confirmed the order was for the resident to receive CPR. After review of the binder at the nurse's station that included the [DATE] POLST, Staff V stated, the newest one must not have been scanned into the record and this could cause staff confusion.</p> <p>On [DATE] at 8:44 AM, Staff V looked up Resident 73's medical record and the order was for DNR, and comfort measures. When the advance directive hyperlink was selected, the POLST dated [DATE] showed and order for CPR and full treatment. Staff V stated, it looked like there was something broken in the system. I have done audits on all of the residents to ensure each had a POLST, however, I had not matched the dates like this.</p> <p>On [DATE] at 5:38 PM, Staff B, Director of Nursing Service, stated they were not aware there had been a problem with the POLST forms until now.</p> <p>Reference: WAC [DATE](1)(a)(i)(ii)(iii)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48368</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff compliance with current infection control guidelines and standards of practice by staff not following the guidance for a sign that was posted on the transmission based precaution (TBP) rooms for donning (putting on) personal protective equipment (PPE); and not adhering to fit testing (to ensure a proper fit) guidelines for an N-95 respirator (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) for 3 of 5 staff (Staff AA, T, and K). During a COVID- 19 (an infectious disease-causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases, difficulty breathing, that could result in severe impairment or death) outbreak. These failures placed residents at an increased risk for exposure to cross contamination (harmful spread of illness) and transmission of diseases.</p> <p>Findings included .</p> <p>Review of the Centers for Disease Control and Prevention (CDC), Health care workers who enter the room of a resident with sign and symptoms or who have tested positive for the COVID-19 virus, dated 06/24/2024, were to use an N-95 respirator, gown, gloves and eye protection.</p> <p>Review of the facility policy titled Respirator Management Program, dated 07/13/2022, showed employees with beards, or facial hair would not be permitted to wear a respirator mask, as they might interfere with the fit and effectiveness of the respirator.</p> <p>Review of the Centers for Disease Control and Prevention Airborne precaution signage, located outside of the COVID-19 positive rooms, showed everyone must put on gown, gloves, and a fit tested N-95 or higher-level respirator before entering the room. Staff were to remove their gown, gloves and face shield before leaving the room and remove the respirator after exiting the room.</p> <p><PPE></p> <p>An observation and concurrent interview on 10/15/2024 at 9:13 AM showed Staff BBB, Nursing Assistant (NA), exited room [ROOM NUMBER] (a COVID-19 positive room) with a surgical mask applied over their N-95 respirator. Staff BBB stated they did not know if that was the right thing to do, as it was what they did so they did not have to get a new N-95 respirator every time.</p> <p>An observation on 10/15/2024 at 10:22 AM, showed Staff J, Unit Manager (UM), entered room [ROOM NUMBER] with an N-95 respirator on. Staff J did not don a gown, gloves or eye wear. Staff J exited room [ROOM NUMBER] at 10:49 AM with the same N-95 respirator on and walked through the facility back to the nurse's station.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation and concurrent interview on 10/15/2024 at 10:24 AM showed Staff, WW, NA, exited room [ROOM NUMBER] with a surgical mask applied over their N-95 respirator. Staff WW stated they wore the surgical mask over their N-95 respirator, so they did not have to get a new one. Staff WW stated they did not have to wear all of the PPE (N-95, gown, gloves, and eye wear) in room [ROOM NUMBER] unless they were working with the resident that was positive for COVID. The other two roommates were not positive for the COVID-19 virus. Staff WW proceeded to go into room [ROOM NUMBER] with the same contaminated N-95 respirator on.</p> <p>During an interview on 10/15/2024 at 10:26 AM, Staff Z, NA, stated they only wore all the PPE if they were taking care of the COVID-19 positive residents in a room, they might wear a gown for the other residents in the room just to be safe. Staff Z stated they were instructed by Staff H, Licensed Practical Nurse (LPN) to only wear all of the PPE for the infected people.</p> <p>During an interview on 10/15/2024 at 10:40 AM, Staff N, Medication Assistant Certified (MAC) stated they were instructed by Staff N to wear all of the PPE if they were caring for the COVID-19 positive resident in the room. Staff N stated they would not have wear all of the PPE to take care of the residents who had not tested positive in the same room.</p> <p>An observation on 10/15/2024 at 11:20 AM, showed Staff L, Infection Control Preventionist, (ICP) pushing a resident in their wheelchair into room [ROOM NUMBER] (a COVID-19 positive room) with only their N-95 respirator mask on no other PPE. Staff L exited room [ROOM NUMBER], did not perform hand hygiene (HH) and proceeded down hallway 200 with the same soiled N-95 mask.</p> <p>During an observation and concurrent interview on 10/16/2024 at 2:56 PM, Staff DDD, NA, entered room [ROOM NUMBER] with only their N-95 respirator. Staff DDD stated they were instructed by Staff H, LPN, to only wear full PPE if they were taking care of the COVID-19 positive resident. Staff DDD stated, they did not have to wear full PPE if they were taking care of the COVID-19 negative residents in the same room.</p> <p>An observation and concurrent interview on 10/20/2024 at 8:35 PM, Staff CCC, NA, entered room [ROOM NUMBER] with only their N-95 respirator on no other PPE. Staff CCC exited room [ROOM NUMBER] with the same contaminated N-95 respirator mask on. Staff CCC stated they usually changed their N-95 respirator, but they were busy and forgot. Staff CCC further stated they did not put all their PPE on because they just wanted to get in their (room [ROOM NUMBER]) fast.</p> <p>During an interview on 10/15/2024 at 2:20 PM, a Collateral Contact with the Department of Health, stated it was required for all staff to don full PPE to be prior to going into a COVID-19 positive room no matter which resident staff were caring for.</p> <p>During an interview on 10/29/2024 at 9:33 AM , Staff B, Director of Nursing Services, stated they would expect Staff L, ICP, and Staff H, LPN, to follow CDC guidelines and the regulations for infection control and provide education and training on hire, annually, periodically and when an outbreak occurred for the proper use of PPE in TBP rooms. Staff B stated they were aware staff were not following the CDC signage for the proper PPE in the COVID-19 positive rooms and were unsure why.</p> <p><Fit Testing></p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Garden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 206 South Tenth Avenue Yakima, WA 98902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation and concurrent interview on 10/21/2024 at 9:41 AM, showed Staff AA, NA, wearing an N-95 respirator with a facial beard. Staff AA stated they had their fit testing about a month ago with their facial hair present. Staff AA stated Staff H performed their fit test and they were unaware they would have to shave their current beard when wearing an N-95 mask or when getting fit-tested .</p> <p>Record review of Staff AA's Respirator Fit Test Record, dated 09/19/2024, showed Staff AA was marked no on the question that asked if staff was clean shaven. The instructions for the N-95 mask fit test, guided the tester if answered no, the fit test could not be done unless clean shaven.</p> <p>An observation and concurrent interview on 10/21/2024 at 9:51 AM, showed Staff T, Therapy Director, wearing an N-95 respirator with a facial beard. Staff T stated they were fit tested with their facial hair about two weeks ago. Staff T stated Staff H performed the fit testing and did not educate them or mention their facial hair.</p> <p>Record review of Staff T's Respirator Fit Test Record, dated 8/09/2024, showed that Staff AA was marked yes on the question that asked if staff was clean shaven.</p> <p>An observation and concurrent interview on 10/21/2024 at 10:10 AM, showed Staff K, UM, wearing an N-95 respirator with a full facial beard. Staff K stated they were fit-tested without a beard but had grown one since. Staff K stated they knew there would be some disruption with the N-95 respirator fit after growing their beard.</p> <p>During an interview on 10/22/2024 at 11:00 AM, Staff H, LPN, stated they knew the Respiratory Fit Test form they used directed them to not perform the fit test if they were not clean shaven and they did not follow the form correctly. Staff H stated if staff were not properly fit tested related to facial hair, they would not be cleared to work in COVID-19 positive rooms. Staff H stated they were unaware Staff AA, T, and K were going into COVID- 19 positive rooms and they needed to educate staff.</p> <p>During an interview on 10/22/2024 at 10:40 AM, Staff L, ICP, stated staff should be clean shaven when getting fit tested for an N-95 respirator. Staff L stated they were aware an N-95 mask would not be as effective if staff had facial hair. Staff L stated anyone who had facial hair should not be assigned to work with COVID-19 positive residents and they were unaware staff who had facial hair had been working with the COVID-19 positive residents. Staff L stated they would have expected Staff H to follow the CDC guidelines for fit testing. Staff L further stated Staff H was not following the Fit Testing form correctly.</p> <p>Reference: WAC 388-97-1320(1)(a)</p>		