

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505085	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2024
NAME OF PROVIDER OR SUPPLIER Crescent Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 505 North 40th Avenue Yakima, WA 98908	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>31168</p> <p>Based on observation, interview and record review the facility failed to provide access of an interpreter for 1 of 1 resident (Resident 1) reviewed for communication. This failure resulted in miscommunications between the resident, family and facility staff placing Resident 1 at risk for frustration and unmet care needs.</p> <p>Findings included .</p> <p>The undated facility policy Crescent Health Care Auxiliary Aids and Services for Persons with Disabilities showed for persons who are deaf or hard of hearing and who use sign language as their primary means of communication, the social services staff will provide white boards and pens for effective communication with residents.</p> <p>Persons who are deaf may request family members or friend as interpreters however, family members or friends will not be used as interpreters unless specifically requested by that individual and after and offer of an interpreter at no charge to the resident.</p> <p><Resident 1></p> <p>Review of the medical record showed the resident had diagnoses including deafness (complete hearing loss), heart disease, diabetes (when blood sugar is too high), and kidney disease. The 07/27/2024 comprehensive assessment showed the resident was deaf but able to make their needs known to staff by writing on a board and sign language. The resident required assistance of one staff member with Activities of Daily Living such as transferring, personal hygiene and oral care.</p> <p>Review of Resident 1's care plan showed the resident will utilize a white board to communicate needs. There were no additional instructions or interventions.</p> <p>During an observation on 09/05/2024 at 9:00 AM, Resident 1 was observed lying in bed with the head of the bed up at a 75-degree angle. The resident had a I-Pad (an electronic tablet used for visual communication) and used sign language with a friend online who also communicated with sign language.</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
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 09/05/2024 at 9:15 AM, the investigator with use of a white board and erasable marker asked the resident about their care. Resident 1 wrote, the staff do not take time to thoroughly communicate with them about what medications they were taking and was concerned about their pain medications. Resident 1 stated staff's inability to communicate adequately with them such as when turning or changing the resident's clothing or bed had been frustrating since they also had pain in their back and right leg. Some of the staff do not even use the white board to communicate. Resident 1 further stated they would like to move to another facility.</p> <p>During an interview on 09/05/2024 at 11:00 AM, Resident 1's Resident Representative (RR) stated they had asked Staff A, Administrator, for access to an interpreter for Resident 1 due to poor communications between some staff and the resident. The RR stated that the request for an interpreter was not in place yet.</p> <p>During an observation on 09/05/2024 at 12:51 PM, Staff B, Registered Nurse (RN) came into Resident 1's room to give medications to Resident 1. Resident 1 asked per white board what medications they were getting Staff B did not inform the resident of the name and type of medications as requested by Resident 1 prior to administration of medication.</p> <p>During an interview on 09/05/2025 at 1:20 PM, Staff F, stated they do not use the white board to communicate with Resident 1 and will just point to what they need to do. Staff F stated that they do not understand sign language. During an incident on 08/25/2024 Staff F had turned Resident 1 towards them while they had changed the resident's soiled sheets without use of the white board for communication which startled the resident due to lack of communication.</p> <p>During an interview on 09/05/2024 at 1:30 PM, Staff A, Administrator, stated they had looked for an interpreter for Resident 1 but had not found one and they are looking at options (3 months after admission).</p> <p>Reference 388-97-0180(1-4) For additional information reference F-684 Quality of Care</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</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** 31168</p> <p>Based on interview and record review the facility failed to assess a change in condition in a timely manner for 1 of 3 residents (Resident 1) reviewed for quality of care. This failure caused delay in treatment when they complained of abdominal pain. Additionally, there was no assessment for an allergic reaction to a prescribed antibiotic that resulted in pain and swelling to the mouth and throat. These failures placed Resident 1 at risk for unmanaged pain and medication side effects.</p> <p>Findings included .</p> <p><Resident 1></p> <p>Review of the medical record showed Resident 1with diagnoses including deaf-nonspeaking, urinary retention with urinary catheter, chronic Urinary Tract Infections (UTI), pain in right hip and knee, heart failure and kidney failure. The resident was alert and oriented used sign language, writing on a white board with an erasable marker for communication. Review of the comprehensive assessment dated [DATE] showed Resident 1 had a urinary catheter and required oxygen. The resident required assistance of one staff member with Activities of Daily Living.</p> <p><Urinary Catheter></p> <p>During an interview on 09/05/2024 at 9:10 AM, Resident 1 stated on 08/25/2024 Staff F, Nursing Assistant (NA) came into their room around 6:15 AM. Resident 1 pointed to their urinary catheter and complained of back pain to Staff F. Resident 1 stated Staff F came into their room turned them and changed their bedding related to their catheter leaking and did not return. Resident 1 stated they called their Resident Representative (RR) on their I-pad (an electronic tablet used to communicate with others by sign language) and stated no one came to back assess their pain and felt they needed to go to the emergency room .</p> <p>During an interview on 09/05/2024 at 11:00 AM, The RR stated they called Staff B, Registered Nurse (RN) on 08/25/2024 to assess Resident 1 who had called them complaining of pain. Staff B stated to the RR they were busy feeding other residents, and it would be a while to get everything ready to send them to the hospital.</p> <p>Record review of a progress note dated 08/25/2024 showed that the emergency ambulance arrived at 9:35 AM (3 hours after Resident 1 first complained of pain.)</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 09/05/2024 at 1:15 PM, Staff E, Nurse Technician (NT), stated they went into Resident 1's room on 08/25/2024 unaware of the exact time but stated it was around 7:00 AM to 7:15 AM and saw the resident was in pain. Staff E asked the resident in writing if they needed their urinary catheter flushed. Resident 1 shook their head no. Staff E stated the resident was very agitated but refused to have them flush the urinary catheter. Staff E went to get Staff B, RN, to assist with Resident 1. Staff B told Staff E they were busy feeding residents in the dining room and would get to the resident later. Staff E stated they went back to Resident 1's room and Resident 1 further communicated they felt pressure on their stomach. Staff B stated they flushed the resident's urinary catheter around 8:40 AM on 08/25/2024. The resident was still complaining of pain after they flushed the catheter and stated they wanted to go to the hospital.</p> <p>Record review of a Urologist visit progress note dated 08/14/2024 showed there was excessive sediment (which can indicate an infection or irritation of the bladder) in the resident's urine and acetic acid (a colorless liquid with same properties of vinegar) was to be used to flush the resident's urinary catheter.</p> <p>Record review of Resident 1's physicians orders showed there was no orders to flush Resident 1's catheter until 08/26/2024 (12 days after the order was received).</p> <p>During an interview on 09/05/2024 at 1:15 PM, Staff E, NT, stated they used normal saline (salt water) to flush Resident 1's catheter when needed, prior to 08/26/2024.</p> <p>During an interview on 09/05/2024 at 1:20 PM, Staff F, NA and Staff I, NA, stated they went into Resident 1's room it was before 7:00 AM on 08/25/2024. Staff F stated Resident 1 complained of pain also stated there was leakage from the urinary catheter and urine was on the residents under pad and bottom bed sheet. Staff F and Staff I stated did they did not report Resident 1's complaint it to the nurse.</p> <p>Review of the 08/25/2024 emergency room (ER) progress notes showed the resident had a UTI. Resident 1 returned to the facility on [DATE] at 2:30 PM with a prescription for Cefdinir (an antibiotic) for a urinary tract infection. Additionally, the resident's urinary catheter had to be removed and replaced.</p> <p>During an interview on 09/09/2024 at 10:30 AM, Staff C, Licensed Practical Nurse (LPN), stated they did not have a written policy for flushing a urinary catheter but looked online on their computer to find out the steps. Staff C could not give a resource reference used to flush Resident 1's urinary catheter. Staff C further stated that 08/26/2024 was the first time they had seen an order to flush Resident 1's catheter.</p> <p><Medication Management></p> <p>A nursing progress note on 09/02/2024 at 1:44 PM, written by Staff J, RN, showed the resident complained of throat pain and difficulty swallowing. Further review showed no assessment of Resident 1's mouth or throat was completed or notification to the RR or provider at this time.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>A nursing progress note on 09/02/2024 at 3:26 PM, written by Staff B, RN, showed the resident continued to complain of a sore throat and swelling. Staff B called the pharmacy and physician after administering the Cefdinir to update them on the possibility of an allergic reaction to the medication. Further review of the progress note showed no further direction.</p> <p>Review of Resident 1's Medication Administration Record (MAR) on 09/02/2024 showed the resident received a onetime dose of Benadryl (medication to relieve allergy symptoms) for side effects of Cefdinir (an antibiotic) prescribed on 08/25/2024 for a UTI.</p> <p>During an interview on 09/05/2024 at 1:00 PM, Resident 1 wrote that a medication was given to them on 09/02/2024 that knocked them out and was unaware of the type of medication they were given or why. Resident 1 wrote that they had had a severe sore throat for a few days.</p> <p>During an interview on 09/11/2024 at 9:30 AM, Staff B, RN, stated Resident 1 complained of throat pain after they gave the medication Cefdinir. Staff B called the physician, pharmacy and Emergency Management Services (EMS) thinking the resident had a reaction to the Cefdinir. Staff B stated EMS arrived and assessed Resident 1 mouth and throat and determined the resident had [NAME] (a secondary fungal infection that causes white patches in their mouth) caused by the antibiotic. Staff B stated they did not assess the resident's mouth or condition. Staff B stated the resident was not sent to the ER and remained in the facility. The Benadryl medication had been given to the resident. Staff B stated they were unaware that the Cefdinir had been assessed for continued use previously on 08/26/2024 by the pharmacy and on 08/28/2024 by the physician for continued use. Additionally, an anti-fungal medication was ordered for Resident 1's [NAME] infection for their mouth and throat.</p> <p>Reference WAC 388-97-1060(1)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31168</p> <p>Based on observation and interview the facility failed to provide a cleanable and sanitary environment for 3 of 10 resident rooms (rooms [ROOM NUMBER]) the tiles were worn with cracks between the tiles that were not cleanable. There was a black sticky substance between the tiles on the flooring. This failure placed staff and residents at an increased risk for infectious diseases and non-functional resident environment related to uncleanable flooring surfaces.</p> <p>Findings included .</p> <p><room [ROOM NUMBER]></p> <p>During an observation on 09/05/2024 at 10:20 AM, the flooring in room [ROOM NUMBER] located on the right side of the resident's bed showed a five feet (ft-unit of measure) by four ft area of white tile that was discolored to a blackish-brown color. There were several areas of black sticky substance between the square floor tiles. The under flooring was showing through the seams of the tiles. There were multiple indentations in the flooring that were uncleanable.</p> <p>During an interview on 09/05/2024 at 10:30 AM, Resident 1 stated their room (room [ROOM NUMBER]) was dirty and the floor was not able to be cleaned properly.</p> <p><room [ROOM NUMBER]></p> <p>During an observation on 09/05/2024 at 10:45 AM, the flooring in room [ROOM NUMBER] by the left side of the resident's bed showed a three ft by three ft area that had worn tiles, and several indentation marks were in the tile. There were several areas between the square tiles that had black sticky substance.</p> <p><room [ROOM NUMBER]></p> <p>During an observation on 09/05/2024 at 11:35 AM, the flooring in room [ROOM NUMBER] showed, worn, discolored tile four ft by four ft area by the resident's bed on the right side with several indentation marks and had a black sticky substance between the square tiles.</p> <p>During an interview on 09/05/2024 at 12:51 PM, Staff H, Environmental Manager, stated that rooms [ROOM NUMBER] were not cleanable and that the black sticky substance between the floor tiles was the glue coming up from the under flooring where the tiles were glued. Staff H stated they knew that these were uncleanable surfaces and were old and worn.</p> <p>Reference WAC 388-97-3220(1)</p>		