STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505093	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Park Health Care & Rehab Center	4755 South 48th Tacoma, WA 98409

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39501 Based on interview and record review, the facility failed to identify, report, and investigate allegations of neglect for 2 of 5 residents (Residents 1 and 4) reviewed for abuse and neglect. This failure placed the residents at risk for ongoing neglect, unmet needs, unmanaged pain, and a decreased quality of life. Findings included . Resident 1 Review of the electronic medical record (EMR) showed that Resident 1 admitted to the facility on [DATE] after a leg amputation (surgical procedure to remove the leg), and had complications with healing, leading to rehospitalization in April 2024, with additional surgeries on the amputation site. Resident 1 had other diagnoses including fibromyalgia (a long-term condition that involves widespread body pain and tiredness), depression and anxiety. The EMR showed that Resident 1 was alert, oriented, and able to make their needs known. Review of the physician orders showed that Resident 1 had an active order for oxycodone (a prescription pain medication) to be given every six hours as needed for pain. Review of a facility grievance form, dated 09/06/2024, showed that Resident 1 had reported a concern that Staff E, Registered Nurse (RN), would not administer pain medication when it was requested and due to be given, but rather wait two to three hours before bringing it. During interview on 09/19/2024 at 10:52 AM, Resident 1 stated that not getting pain medication, in a timely manner after requesting it, was a continuing problem that they had been having with Staff E, RN. Review of the facility incident report log, dated September 2024, did not show that an allegation of neglect, related to Resident 1's complaint on 09/06/2024, was logged or reported to the State Agency. Resident 4 (continued on next page)

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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EMR showed that Resident 4 admitted to the facility on [DATE] with diagnoses to include chronic pain and polyneuropathy (damage or disease affecting nerves that can cause weakness, numbness and burning pain). The EMR showed that Resident 4 was alert, oriented, and able to make their needs known. Review of a facility grievance form, dated 09/12/2024, showed that Resident 4 had reported a concern that they had asked for Tylenol, on the night shift, on several occasions, and had not received it. During interview on 09/19/2024 at 12:28 PM, Resident 4 stated that two nights in a row, the nights before they filed the grievance, they had asked for Tylenol for shoulder pain, and had not received it. Review of the facility incident report log, dated September 2024, did not show that an allegation of neglect, related to Resident 4's complaint on 09/12/2024, was logged or reported to the State Agency. During interview on 09/19/2024 at 12:57 PM, Staff B, Director of Nursing Services (DNS) stated that allegations of abuse and neglect should be investigated and reported to the State Agency, and that Resident 1's and Resident 4's grievances could have been interpreted as allegations of neglect and, in those cases, should have been investigated and reported to the State Agency. During interview on 09/19/2024 at 1:15 PM, Staff A, Administrator, stated that all allegations of abuse and neglect should be reported to the State Agency, logged and investigated. Reference WAC 388-97-0640(5)(a).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39501 Based on observation, interview and record review, the facility failed to manage pain, in accordance with professional standards, and failed to administer ordered pain medications in a timely manner for 2 of 2 sampled residents (Residents 1 and 4) reviewed for pain management. This failure placed the residents at risk for unmanaged and increased levels of pain, interrupted sleep, decreased ability to participate in daily activities, and a diminished quality of life. Findings included . Resident 1 Review of the electronic medical record (EMR) showed that Resident 1 admitted to the facility on [DATE] after a leg amputation (surgical procedure to remove the leg), and had complications with healing, leading to rehospitalization in April, 2024, with additional surgeries on the amputation site. Resident 1 had other diagnoses including fibromyalgia (a long-term condition that involves widespread body pain and tiredness), depression and anxiety. The EMR showed that Resident 1 was alert, oriented, and able to make their needs known. Review of the physician orders showed that Resident 1 had an order for oxycodone (a prescription pain medication) to be given every six hours as needed for pain. During interview on 09/19/2024 at 10:52 AM, Resident 1 stated that they had last received their oxycodone at 5:00 AM that morning. Resident 1 stated that they would rate their pain at a 7, on a scale of 0-10 (with 0 being no pain, and 10 being excruciating pain), and they were planning to request their oxycodone again soon, since it could be taken again at 11:00 AM. Review of the medication administration record (MAR), dated September 2024, showed that Resident 1 had last received oxycodone 09/19/2024 at 5:00 AM. During follow-up interview on 09/19/2024 at 11:48 AM, Resident 1 stated that they had requested their pain medication at 10:55 AM, and they had not yet received it. Resident 1 stated that they would now rate their pain a 7-and-a-half, on a scale of 0-10. Observation on 09/19/2024 at 11:50 AM showed Staff E, RN, standing at a medication cart two doors down from Resident 1's room. During another follow-up interview on 09/19/2024 at 12:11 PM, Resident 1 stated that they still had not received the oxycodone they had requested at 10:55 AM. Resident 1 stated that they had also asked Staff C, Certified Nursing Assistant (CNA) and Staff D, CNA, if they could tell Staff E, RN, that pain medication had been requested. Observation on 09/19/2024 at 12:13 PM showed Staff E, RN, standing at a medication cart two doors down from Resident 1's room. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 09/19/2024 at 12:15 PM, Staff D, CNA, stated that they had told Staff E, RN, twice over the last hour, that Resident 1 had requested pain medication, and had left a note about the request on Staff E's medication cart. During interview on 09/19/2024 at 12:18 PM, Staff C, CNA, stated that they had told Staff E, RN, once over the last hour, that Resident 1 had requested pain medication. During another follow-up interview on 09/19/2024 at 12:30 PM, Resident 1 stated that they had received the oxycodone at 12:20 PM - 1 hour and 25 minutes after requesting it. During interview on 09/19/2024 at 12:33 PM, Staff E, RN, stated that when a resident asked for a pain medication, If they are due, then they should get them right away when they ask for it. Resident 4 Review of the EMR showed that Resident 4 admitted to the facility on [DATE] with diagnoses to include chronic pain and polyneuropathy (damage or disease affecting nerves that can cause weakness, numbness and burning pain). The EMR showed that Resident 4 was alert, oriented, and able to make their needs known. Review of the physician orders showed that Resident 4 had an order for Tylenol and tramadol (over-the-counter and prescribed pain medications) to be given every six hours as needed for pain. Review of a facility grievance form, dated 09/12/2024, showed that Resident 4 had reported a concern that they had asked for Tylenol, on the night shift, on several occasions, and had not received it. During interview on 09/19/2024 at 12:28 PM, Resident 4 stated that there was a nurse that did not give their Tylenol or tramadol when they ask for them. Resident 4 stated, I will have to wait until the nurse gives me my other scheduled medications, and they'll bundle them with those. Sometimes waiting three to four hours. During interview on 09/19/2024 at 12:54 PM, Staff B, Director of Nursing Services (DNS) stated that pain medication should be administered according to provider orders, and given as soon as possible after the resident made the request. Staff B, DNS, further stated that it was not acceptable practice for a nurse to wait, until scheduled medications would be due, to give the pain medication if it was due to be given sooner. Reference WAC 388-97-1060 (1).