STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505123	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgeview Care	2701 Clare Avenue Bremerton, WA 98310

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46068

Based on observation, interview and record review, the facility failed to ensure residents who were dependent on facility staff for assistance with their Activities of Daily Living (ADLs) received assistance to eat their meals in the dining room for 2 of 3 sampled residents (Resident 1 and 2) reviewed for quality of care. This failure placed residents at risk for lack of stimulation, decreased meal intake and a diminished quality of life.

Findings included .

<RESIDENT 1>

Resident 1 was admitted on [DATE] with diagnoses including dementia, depression, and a nutritional deficiency. The Minimum Data Set (MDS), an assessment tool, dated 05/29/2024, showed Resident 1 had severe cognitive impairment and was dependent on staff for transfers and mobility in a wheelchair.

Resident 1's activity care plan, dated 12/22/2020, showed Resident 1 was dependent on staff for activities, cognitive stimulation, and social interaction. The care plan showed the resident spent much of their time sitting in the dining room, where they could chat, listen to music/tv, and watch out the window.

Resident 1's quality of life care plan, dated 12/17/2020, showed the resident enjoyed watching TV or listening to music in the assisted dining room.

Resident 1's activity of daily living care plan, dated 06/22/2022, showed the resident required one person assistance with meals; to get up to wheelchair and in was to have meals in the assisted dining room to promote intake.

Resident 1's physician order, dated 03/05/2024, showed the resident met the criteria for at risk for malnutrition.

Resident 1's progress notes, dated 05/31/2024, showed the resident had a 3% weight loss from the prior weight.

Resident 1's task documentation for meal intake, dated 06/15/2024 through 06/30/2024, showed the resident consumed 50% or less of their meals on 35 out of 48 opportunities.

(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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/01/2024 at 9:55 AM, Resident 1 was observed in bed, dressed in a shirt with the covers pulled up and the resident's eyes were closed. At 11:13 AM, Resident 1 was observed lying on their back in bed, with their eyes open and staring at the wall. At 11:47 AM, Resident 1 was observed lying on their back in bed, with their eyes open and staring at the wall. At 12:36 PM, Resident 1 was observed lying in bed with the head of the bed elevated, the meal tray was in front of them on an over the bed table and Staff A, Certified Nursing Assistant, was standing to the side of the bed assisting the resident to eat. At 12:38 PM, when asked why Resident 1 was not up in their wheelchair and in the dining room for lunch, Staff A said, she gets up every single day, so I wanted her to relax today in bed. <RESIDENT 2> Resident 2 was admitted on [DATE] with diagnoses of dementia, depression, and muscle weakness. The MDS, dated [DATE], showed the resident had severe cognitive impairment, required staff assistance for eating, was incontinent of urine and was dependent on staff for bed mobility and wheelchair mobility. Resident 2's activity of daily living care plan, dated 09/24/2020, showed the resident required a mechanical lift to transfer from the wheelchair to the bed, did not use the toilet, and required assistance of staff to reposition in bed before and after every meals and had to be checked and changed for incontinence. Resident 2's nutrition care plan, dated 05/18/2023, showed the resident had a nutrition risk or potential risk and the resident appeared to take meals best in the dining room with total assistance. On 07/01/2024 at 09:55 AM Resident 2 was observed sitting in their wheelchair in the dining room. At 11:17 AM, Resident 2 was observed lying in bed, receiving wound and incontinent care. At 12:37 PM, Resident 2 was observed lying in bed with the head of the bed elevated. Staff B, CNA, was sitting next to the bed and assisting the resident with their meal. At 12:49 PM, when asked why Resident 2 was not up in their wheelchair and in the dining room for lunch, Staff B said they laid the resident down for wound care so they figured they would have them eat lunch in bed and they would get them up at dinner time. On 07/01/2024, at 1:06 PM, Staff D, Resident Care Manager, said Resident 1 and Resident 2 should have been in their wheelchairs and in the dining room for their meals. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/01/2024, at 2:42 PM, Staff C, Director of Nursing, said they expected staff to follow the care plan when caring for residents. Staff C said residents should eat their meals in their wheelchairs and in the dining rooms unless there was a clinical reason they couldn't and/or the resident refused. Staff C said Resident 2 had to be laid down after breakfast for repositioning and changing regardless of the wound care and should have been assisted to their wheelchair for lunch. Staff C said they would have preferred Resident 1 and Resident 2 to have eaten their meals in the dining room. Reference WAC 388-97-1060 (2)(c)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 46068 Based on observation, interview and record review, the facility failed to prevent the development of a pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure) when they failed to consistently complete pressure ulcer care for 1 of 3 sampled residents (Resident 2) reviewed for pressure ulcers. Resident 2 experienced harm when they developed an unstageable pressure ulcer (a pressure injury that is a full thickness skin and tissue loss to which the extent of the tissue damage cannot be seen) to their right buttock that required debridement (a medical procedure that removes dead, damaged, or infected tissue from a wound). These failures placed residents at risk for infection, medical complications and a diminished quality of life. Findings included . According to the Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Manual, dated October 2023, pressure ulcers/injuries occur when tissue is compressed between a bony prominence and an external surface. In addition, external factors, such as excess moisture and tissue exposure to urine or feces, can increase the risk. Resident 2's potential for pressure ulcer care plan, initiated on 09/03/2017 and revised on 09/29/2023, showed interventions to educate resident/family/caregivers as to the cause of skin breakdown: including transfer/positioning requirements, importance of taking care during mobility, good nutrition, and frequent repositioning. The care plan showed staff were to provide max assistance for turning and repositioning. Resident 2's functional incontinence care plan, revised 07/24/2023, showed a goal the resident would remain free from skin breakdown due to incontinence. Staff were to check and change the resident after incontinence episodes. Review of Resident 2's care plan, progress notes and assessments on 07/01/2024, showed no documentation the resident refused incontinent care and/or turning and repositioning. Review of the facility's incident report, dated 03/14/2024, showed staff had reported a purple area on Resident 2's right buttock. The report showed the resident had a pressure ulcer to the right side of the sacrum (bony structure at base of spine) and the Wound Specialist would evaluate the wound. Resident 2's Wound Specialist Progress Report, dated 03/18/2024, showed the resident had a new unstageable pressure ulceration on their right medial sacrococcyx (upper area of their right buttock). The wound evaluation in the report showed 5.84% necrotic tissue (dead tissue) was in the wound bed and the wound measured 1.97 centimeters (cm) in width x 1.87 cm in length with a depth of 0.1 cm. The report showed the wound was debrided by mechanical means and devitalized tissue (dead tissue) was removed. Resident 2's Wound Specialist Progress Report, dated 06/24/2024, showed the unstageable pressure ulceration on the right buttock had 17.7% necrotic tissue and measured 1.98 cm in length x 1.51 cm in width and 0.3 cm in depth. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/01/2024, at 11:20 AM, Staff E, Registered Nurse, was observed turning Resident 2 in bed, Resident 2 made no verbalizations and did not resist the turning and/or repositioning. At 11:40 AM, Staff B, Certified Nursing Assistant, said they were assigned to Resident 2 frequently and the resident was not able to reposition themselves in bed and required staff to assist to turn and reposition them in bed. Staff B said the resident allowed care and they were able to reposition the resident without any issue and were able to provide incontinent care. When asked if Resident 2 had ever refused turning and repositioning, Staff B said no. At 1:06 PM, Staff D, Resident Care Manager (RCM), said they had no reports of Resident 2 refusing care and/or turning/repositioning. <Wound Care> Resident 2's physician orders, dated 06/04/2024, showed orders for staff to cleanse the right buttock pressure ulceration, apply medication and cover with a dressing. Resident 2's Treatment Administration Record (TAR), dated 06/01/2024 through 06/30/2024, showed on 06/07/2024 and 06/14/2024 no documentation the wound care to the resident's right buttock pressure ulcer was completed. The entries on the TAR for the wound care to the right buttock on 06/07/2024 and 06/14/2024 showed see nurse's notes. Resident 2's nursing progress note, dated 06/07/2024, showed the licensed nurse was unable to complete the wound care due to time constraints related to short staffing and so deferred the wound care to night shift. Resident 2's nursing progress note, dated 06/14/2024, showed the wound care was endorsed to night shift. On 07/01/2024 at 1:06 PM, Staff D, RCM, reviewed Resident 2's electronic medical record. Staff D said there was no documentation the wound care was completed on 06/07/2024 and 06/14/2024. Staff D said when staff completed wound care they documented it in the progress notes and/or the TAR. <Final Interview> On 07/01/2024 at 1:50 PM, Staff C, Director of Nursing, said they reviewed Resident 2's medical record and there was no documentation the wound care was completed on 06/07/2024 and 06/14/2024. Staff C said they expected if the licensed nurse completed the wound care they would have documented in the MAR and/or progress notes. Staff C said they could not speak to why Resident 2 acquired a pressure ulcer. Reference WAC 388-97-1060 (3)(b)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46068 Based on observation, interview, and record review, facility staff failed to follow accepted infection control practices during the provision of wound care for 1 of 3 residents (Residents 2) reviewed for wound care. This failure placed residents at risk for facility acquired or healthcare-associated infections and related complications. Findings included . Review of the Centers for Disease Control and Prevention's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated 11/29/2022, showed staff should wear gloves when they come in contact with non-intact (open) skin and perform hand hygiene immediately after glove removal and before moving from work on a soiled body site to a clean body site on the same person. Resident 2 was admitted on [DATE] with diagnoses of dementia and muscle weakness. The quarterly Minimum Data Set (MDS), an assessment tool, dated 05/14/2024, showed the resident had an unstageable pressure injury (a pressure injury that is a full thickness skin and tissue loss to which the extent of the tissue damage cannot be seen) that was not present on admission. Resident 2's physician orders, dated 06/04/2024, showed orders for staff to cleanse the right buttock pressure ulceration, apply medication and cover with a dressing. On 07/01/2024 at 11:20 AM, Staff E, Registered Nurse, was observed providing wound care to Resident 2's right buttock pressure ulcer. Staff E donned gloves and removed the resident's brief and the soiled dressing from the buttock. Staff E changed their gloves, without performing hand hygiene, cleansed the wound, applied medication and the new dressing. Staff E removed their gloves, and without performing hand hygiene, reached into the pocket of their uniform, obtained a pen, wrote the date on the wound dressing, and placed the pen back in their pocket. Staff E donned new gloves and continued care of the resident. At 11:31 AM, Staff E, said they should have washed their hands after removing the brief and the soiled dressing and stated, I failed. At 12:25 PM, Staff F, Infection Preventionist, said after removing soiled dressings on wound, they expected licensed nurses to remove their gloves and perform hand hygiene and don new gloves prior to applying a clean dressing. Staff F said when staff remove gloves they should perform hand hygiene. Staff F said staff should not obtain objects out of their uniform products with hands that have not been washed. On 07/01/2024 at 1:50 PM, Staff C, Director of Nursing, said they expected the licensed nurses to wash their hands after cleaning a wound and after removing their gloves. Reference WAC 388-97-1320 (1)(c)