

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/20/2024
NAME OF PROVIDER OR SUPPLIER  Bridgeview Care		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46068</p> <p>Based on interview and record review, the facility failed to ensure sufficient licensed nurses were available to administer medications timely for 3 of 4 residents (Resident 1, 2 and 3) reviewed for sufficient staffing. This failure placed residents at risk for clinical complications, frustration and a diminished quality of life.</p> <p>Findings included .</p> <p>&lt;RESIDENT 1&gt;</p> <p>Resident 1 was admitted to the facility on [DATE]. The Minimum Data Set (MDS), an assessment tool, dated 08/02/2024, showed the resident was cognitively intact.</p> <p>On 08/06/2024 at 12:58 PM, Resident 1 said they had not received their medications on time. Resident 1 said for a long time they had been receiving them at 6:00 PM but lately it kept changing to different times, was inconsistent, and they had to wait a long time to receive medication needed for pain.</p> <p>Resident 1's Medication Administration Audit Report, dated 07/20/2024 through 08/20/2024, showed the following documentation:</p> <p>07/20/2024 medications scheduled for the morning at 8:00 AM were administered between 12:25 PM and 12:29 PM.</p> <p>07/23/2024 medications scheduled for the morning at 8:00 AM were administered between 12:38 PM and 12:39 PM.</p> <p>07/24/2024 medications scheduled for the morning at 8:00 AM were administered between 12:19 PM and 12:21 PM.</p> <p>07/26/2024 medications scheduled for the morning at 8:00 AM were administered between 2:48 PM and 2:50 PM.</p> <p>07/31/2024 medications scheduled for the morning at 8:00 AM were administered between 3:06 PM and 3:08 PM.</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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>08/01/2024 medications scheduled for 7:00 PM were administered on 08/02/2024 between 12:02 AM and 12:011 AM.</p> <p>08/03/2024 medications scheduled for the morning at 8:00 AM were administered at 1:09 PM.</p> <p>08/04/2024 medications scheduled for the morning at 8:00 AM were administered between 2:42 PM and 2:43 PM.</p> <p>08/05/2024 medications scheduled for the morning at 8:00 AM were administered at 7:37 PM.</p> <p>08/05/2024 medications scheduled for 7:00 PM were administered on 08/06/2024 between 12:10 AM and 12:13 AM.</p> <p>08/06/2024 medications scheduled for the morning at 8:00 AM were administered between 11:55 AM and 2:40 PM.</p> <p>08/14/2024 medications scheduled for the morning at 8:00 AM were administered between 7:33 PM and 7:34 PM.</p> <p>08/19/2024 medications scheduled for 7:00 PM were administered between 11:05 PM and 11:07 PM.</p> <p>&lt;RESIDENT 2&gt;</p> <p>Resident 2 was admitted to the facility on [DATE]. The MDS, dated [DATE], showed the resident was cognitively intact.</p> <p>On 08/06/2024 at 1:22 PM, Resident 2 said they had not received their medications timely. The resident said sometimes they received their bedtime medications at 8:00 PM and other times after midnight. Resident 2 said the staff were short handed, it was frustrating, and they could not chase them down to get the medications.</p> <p>Resident 2's Medication Administration Audit Report, dated 07/20/2024 through 08/20/2024, showed the following documentation:</p> <p>07/23/2024 medications scheduled for 7:00 PM were administered at 10:58 PM.</p> <p>08/01/2024 medications scheduled for 7:00 PM and 8:00 PM were administered on 08/02/2024 between 12:47 AM and 12:52 AM.</p> <p>08/08/2024 medications scheduled for the morning at 8:00 AM were administered between 12:26 PM and 12:27 PM.</p> <p>08/18/2024 medications scheduled for 7:00 PM and 8:00 PM were administered on 08/19/2024 between 12:05 AM and 12:26 AM.</p> <p>&lt;RESIDENT 3&gt;</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 3 was admitted to the facility on [DATE]. The MDS, dated [DATE], showed the resident was cognitively intact.</p> <p>On 08/06/2024 at 1:58 PM, Resident 3 said for the previous three days they had not received their morning medication until noon and at times when there were only two nurses on for the entire facility they received their evening medication after midnight. The resident said the facility did not have enough nurses to administer medications on time.</p> <p>Resident 3's Medication Administration Audit Report, dated 07/20/2024 through 08/20/2024 showed the following documentation:</p> <p>07/20/2024 medications scheduled for the morning at 8:00 AM were administered between 12:46 PM and 12:47 PM.</p> <p>07/26/2024 medications scheduled for 7:00 PM were administered between 11:50 PM and 11:55 PM.</p> <p>07/30/2024 medications scheduled for 7:00 PM were administered between 11:12 PM and 11:14 PM.</p> <p>07/31/2024 medications scheduled for the morning at 8:00 AM were administered at 8:22 PM.</p> <p>08/01/2024 medications scheduled for 7:00 PM were administered on 08/02/2024 between 12:20 AM and 12:30 AM.</p> <p>08/03/2024 medications scheduled for the morning at 8:00 AM were administered between 11:54 AM and 11:57 AM.</p> <p>08/04/2024 medications scheduled for the morning at 8:00 AM were administered between 2:50 PM and 2:51 PM.</p> <p>08/06/2024 medications scheduled for 7:00 PM were administered on 08/07/2024 at 12:47 AM.</p> <p>08/09/2024 medications scheduled for 7:00 PM were administered at 11:37 PM.</p> <p>08/13/2024 medications scheduled for the morning at 8:00 AM were administered at 7:19 PM.</p> <p>08/14/2024 medications scheduled for the morning at 8:00 AM were administered at 8:25 PM.</p> <p>&lt;FINAL INTERVIEWS&gt;</p> <p>On 08/20/2024 at 12:36 PM, Staff C, Resident Care Manager, said they worked as a floor nurse when needed and administered medications. Staff C said when they only had two nurses and a medication tech scheduled on the long term care units, the medications were probably not going to be administered on time, but if they had three nurses it would be able to be managed. Staff C said on the night shift when there were only two nurses scheduled instead of three, the medications were probably not going to be done on time, it was very challenging.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>At 3:00 PM, Staff B, Director of Nursing, said they would expect morning medications to be administered by 10:00 AM and the medications scheduled for bedtime should be administered no later than 10:00 PM. Staff B reviewed the Medication Administration Audit Report for Residents 1, 2 and 3. Staff B acknowledged the discrepancies between the scheduled times for the medications to be administered and the actual time of administration. Staff B said the discrepancies were related to the shortage of licensed nurses and said when they have adequate staffing the medications were administered on time. Staff B said they did not have enough licensed nurse staffing to meet the resident's needs timely and they were working on additional staffing.</p> <p>Reference WAC 388-97-1080 (1), 1090 (1)</p>		