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	11/19/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46068 Based on observation, interview and record review, the facility failed to ensure services provided met professional standard of practice when medications were discontinued without authorization from a medical provider, and physician's orders were not followed for 3 of 4 residents (Resident 1, 2, and 3). This failure placed residents at risk for medical complications, infection and discomfort. Findings included . <RESIDENT 1> Resident 1 was admitted on [DATE] with diagnoses including medically complex conditions and heart disease. Resident 1's provider orders for Nursing Home Transfer, dated 11/1/2024, showed the resident was transferred from the hospital to the facility with medication orders on the 'After Visit Summary Medication List. ' Resident 1's 'After Visit Summary,' dated 11/01/2024, showed the resident had multiple medications to be administered every morning. Resident 1's progress notes, dated 11/01/2024 at 7:27 PM, showed the resident was readmitted to the facility and the orders were noted and faxed. Resident 1's Medication Administration Record (MAR), dated 11/01/2024 through 11/30/2024, showed no documentation the residents morning medications were administered on 11/02/2024. On 11/14/2024 at 1:05 PM, Staff F, Medical Director, said they were the attending physician for Resident 1, and they were not notified that Resident 1 had not received their medications on the morning of 11/02/2024, until 11/14/2024. Staff F said the resident should have received their mediations per the After Visit Summary from the hospital because they are the admitting physician orders. On 11/14/2024 at 3:03 PM, Staff D, Medication Assistant, said the morning of 11/02/2024, they were helping administer medications for the unit that Resident 1 resided on. Staff D said they noticed that Resident 1 had no medications showing in the electronic medical record (EMR). Staff D said they notified Staff E, Licensed Practical Nurse (LPN). Staff D said Staff E told them they would fix it. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/15/2024 at 12:30 PM, Staff E, LPN, said they were the nurse assigned to Resident 1 on the morning of 11/02/2024. Staff E said they became aware Resident 1 had no medications showing in the EMR on the morning of 11/02/2024. Staff E said when they looked in the EMR they discovered that Resident 1's medication orders had not been confirmed and they were not accurate. Staff E said they re-entered the medication orders into the EMR and notified the on-call manager and put a note in the physician's box. When asked if Resident 1 received their morning medications on 11/02/2024, Staff E said they did not. On 11/19/2024 at 3:16 PM, Staff A, Director of Nursing (DNS), said they were not aware that Resident 1 had missed medications on 11/02/2024. Staff A said they had inputted the orders on the day of admission, 11/01/2024. Staff A said they let the admission and/or nurse care manager know that the orders had been entered into the EMR and needed to be confirmed. Staff A said the orders had to be confirmed for the medications to show up for the nurses to administer the medications. Staff A said they were not notified by the nursing staff that Resident 1's morning medications were not administered on 11/02/2024 and were unaware of the omission. Staff A said when they reviewed the record Staff E had discovered the error at approximately 9:40 AM and should have administered the morning medications at that time. <RESIDENT 2> Resident 2 was admitted on [DATE] with diagnoses of respiratory failure, diabetes (a condition that affects blood sugar levels), and a surgical procedure. The Minimum Data Set (MDS), an assessment tool, dated 10/30/2024, showed the resident was cognitively intact. On 11/14/2024 at 1:05 PM, Staff F, Medical Director, said they were reviewing Resident 2's orders on 11/07/2024, and discovered several medication orders had been discontinued in the electronic medical record. Staff F said they had not given orders for the medications to be discontinued, and their medical staff, Staff I, (Nurse Practitioner, NP) had not either. Staff F said the resident's insulin (medication to control blood sugar levels), pain medication and potassium (an electrolyte supplement) were discontinued without authorization from a medical practitioner. Staff F said they reinstated the orders upon discovery of the error on 11/07/2024. On 11/14/2024 at 2:45 PM, Resident 2 said something happened with their medication orders about a week ago and they did not receive their insulin and pain medication for a few days. Resident 2 said they experienced pain during that time and the staff only offered Tylenol (mild pain medication). Resident 2 said they were very upset, and their doctor apologized for the error. Resident 2's Insulin Glargine (a medication for diabetes) order audit report, dated 11/05/2024 at 11:57 AM, showed Staff I, Nurse Practitioner (NP), had ordered Insulin Glargine 32 units to be administered at bedtime daily. The report further showed that at 2:15 PM, Staff J, LPN, had discontinued the order. The report showed the order was reinstated by Staff F, Medical Director on 11/07/2024. Resident 2's hydromorphone (pain medication) order audit report, dated 11/05/2024 at 11:55 AM, showed Staff I, NP, had ordered the hydromorphone to be given every four hours as needed for pain. The report showed at 2:16 PM, Staff J, LPN, had discontinued the order. The report showed the order was reinstated by Staff, F, Medical Director on 11/07/2024. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 2's potassium (electrolyte supplement) order audit report, dated 11/04/2024 at 9:02 AM, showed Staff F, Medical Director had ordered potassium every morning. The report showed at 9:06 AM, Staff K, LPN, had discontinued the order. The report showed the order was reinstated by Staff, F, Medical Director on 11/07/2024. Resident 2's MAR, dated 11/01/2024 through 11/30/2024, showed Insulin Glargine 32 units was not given until 11/07/2024. The MAR showed hydromorphone was not given after it was discontinued on 11/05/2024 at 11:55 AM until 11/07/2024. The MAR showed the potassium was not given until 11/07/2024. Resident 2's provider note, dated 11/07/2024, showed the medical provider had discovered that Resident 2's insulin glargine, hydromorphone, and potassium orders had been inadvertently discontinued in the previous 48 hours and had been reinstated upon their discovery. On 11/19/2024, at 11:01 AM, Resident 2 said they had talked with their physician more than a week prior and had requested a humidifier (a device used to humidify oxygen) for their oxygen because their nose was dried out. Resident 2 said they still had not received it. Observation of Resident 2's oxygen concentrator (a device that delivers oxygen) showed no humidifier attached to it. Resident 2's provider note, dated 11/07/2024, showed Resident 2 had complained their O2 [oxygen] was causing them a dry nose and transient (lasting a short time) epistaxis (bleeding from the nose). The note showed the medical provider discussed with the LPN and verbally ordered an in-line humidifier for the resident's O2 concentrator. Resident 2's provider note, dated 11/14/2024, showed Resident 2 had c/o [complained of] intermittent epistaxis, likely secondary to NC [nasal cannula (tube that delivers oxygen into the nose)] O2. The note showed the provider requested an in-line humidifier from nursing for the resident. On 11/19/2024 at 3:20 PM, Staff A, DNS, said they were notified by Staff F, Medical Director that Resident 2's insulin, hydromorphone and potassium were discontinued without authorization. Staff A said the investigation showed Staff J, LPN, had discontinued the insulin and hydromorphone inadvertently in the electronic medical record, when they had attempted to confirm the order but had discontinued it instead. Staff A said they did not know the reason that Staff K, LPN had discontinued the potassium because Staff K would not discuss the error with them. Staff A said licensed nurses cannot discontinue medication orders without a physician and/or medical provider's authorization. Staff A said a humidifier should have been placed when Resident 2 requested it. <RESIDENT 3> Resident 3 was admitted on [DATE] with diagnosis of dementia. The MDS, dated [DATE], showed the resident had multiple pressure ulcers (injury to skin and underlying tissue resulting from prolonged pressure). Resident 3's physician order, dated 08/08/2024, showed staff were to provide wound care to the resident's leg and heel daily. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/21/2024 at 10:00 AM, Collateral Contact (CC1), said they visited Resident 3 usually three to four days per week. CC1 said they had issues with the wound care provided by the facility for months. CC1 said the resident's wound dressing was supposed to be changed daily and when they arrived on 10/06/2024 they found the resident lying in their dirty brief and the wound dressing had not been changed and the date on the dressing was 10/03/2024. On 11/19/2024 at 11:42 AM, Staff G, LPN, said they had changed Resident 3's wound dressing on 10/03/2024, dated and initialed the dressing. Staff G said on 10/06/2024 they were alerted that CC1 had discovered Resident 3's wound dressing had not been changed and when they arrived to care for the wound, they observed the resident's dressing had the date of 10/03/2024 and their initials on it. Review of the facility's incident report, dated 10/06/2024, showed documentation that Resident 3's wound dressing was changed on 10/04/2024 by Staff H, LPN. Included in the incident report was a witness statement by Staff H that showed they had assumed the wound care had been completed by a wound team, so they had signed off the wound care was completed without observing the dressing. On 11/19/2024 at 3:20 PM, Staff A, DNS, said licensed nurses should not sign the completed a task, including wound care, when they had not completed it. Staff A said Resident 3 had not received their wound care per the physician orders and because staff signed it complete, they were unaware the dressing was not changed and were not alerted until CC1 made the discovery on 10/06/2024. WAC reference 388-97-1620 (2)(b)(i)(ii), (6)(b)(i)

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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 interview, observation and record review, the facility failed to ensure infection control standards were followed related to the use of required personal protective equipment with residents on enhanced barrier precautions (EBP, an infection control method that involves wearing gowns and gloves during high-contact interactions with residents in nursing homes) and hand hygiene during wound care for 1 of 3 residents (Resident 4) reviewed for wound care. This failure placed residents at risk of contracting and spreading infections. Findings included . Review of the facility's policy titled, Enhanced Barrier Precautions, revised 04/2024, showed EBP were to be used for residents with wounds. The policy showed that gowns and gloves were required when staff completed wound care. Review of the facility's policy titled, Dressings, Dry/Clean, revised 09/2013, showed that gloves were to be discarded after removal of a wound dressing and hand hygiene performed prior to donning clean gloves and applying a new dressing. Resident 4 was admitted to the facility on [DATE] with diagnoses including methicillin-resistant staphylococcus aureus (MRSA, an infection). Resident 4's physician orders, dated 10/04/2024, showed the resident was on EBP related to wounds and MRSA to their eye. Resident 4's physician order, dated 11/01/2024, showed staff were to cleanse the wound on the resident's thumb and apply a dressing every day and as needed. An observation on 11/13/2024 at 12:33 PM, showed a sign adjacent to Resident 4's door for EBP and staff were to wear gloves, and a gown with any wound care requiring a dressing. Staff B, Licensed Practical Nurse, was observed entering Resident 4's room to perform wound care. Staff B performed hand hygiene and donned gloves. Staff B did not put on a gown. Staff B removed the resident's wound dressing from their thumb, cleansed the wound, discarded the dressing and gloves. Staff B, without performing hand hygiene, put on new gloves and proceeded to cleanse the wound and applied a clean dressing. On 11/14/2024 at 12:37 PM, Staff C, Infection Preventionist and Assistant Director of Nursing, said that Resident 4 was on EBP, and the staff should wear a gown and gloves when completing wound care. Staff C said that after Staff B removed the old dressing and their gloves, they should have performed hand hygiene prior to putting on new gloves. WAC Reference 388-97-1320 (1)(c)(2)(b)