

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 02/20/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46068</p> <p>Based on observation, interview and record review the facility failed to ensure residents' mobility needs were addressed to access the community for 1 of 1 sampled resident (Resident 1) reviewed for accommodation of needs. This failure placed residents at risk of diminished independent functioning, socialization and mood disturbance.</p> <p>Findings included .</p> <p>Resident 1 was admitted on [DATE] with diagnoses including medically complex conditions and mood disorders. The Minimum Data Set, an assessment tool, dated 01/23/2025, showed Resident 1 was cognitively intact, had functional limitations with range of motion in their upper and lower extremities and utilized a power wheelchair for mobility.</p> <p>On 02/20/2025 at 10:18 AM, Resident 1 said they had made a mistake when they were threatened with physical harm by another resident, they became defensive and used their power wheelchair to run into the other resident. Resident 1 expressed remorse and said they knew it was wrong, but the facility had removed their power wheelchair and provided them a manual wheelchair. Resident 1 said they were not able to propel the manual chair independently and were now unable to ride the access bus into the community to visit their girlfriend and/or shop per their routine, I am stuck here. Resident 1 said they had requested to be allowed to use the power wheelchair outside of the facility to go on community outings, but the facility staff refused to allow them access to the chair.</p> <p>Review of a facility's online incident report, dated 01/31/2025, showed Resident 2 told Resident 1 they would kick their face and Resident 1 slammed their powered wheelchair into Resident 2's wheelchair. The report showed Resident 1's power wheelchair would be kept in the therapy gym and the resident would now use a regular wheelchair.</p> <p>Resident 1's activity care plan, revised 02/05/2025, showed an intervention that staff would support and encourage Resident 1 to go to visit their girlfriend in the community.</p> <p>Resident 1's power mobility indoor driving assessment, dated 02/08/2025, showed the assessor's opinion was the resident was able to drive the power wheelchair independently with no restrictions.</p> <p>Resident 1's progress note, dated 02/10/2025, showed the resident reported a declining mood due to not having their powered wheelchair.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 1's mobility care plan, revised 02/14/2025, showed the resident was totally dependent on staff for ambulation/locomotion in wheelchair and they were to use the manual wheelchair for locomotion and were currently not cleared for electric wheelchair.</p> <p>On 02/20/2025 at 10:59 AM, Staff D, Activity Director, said Resident 1 had used their power wheelchair to visit their girlfriend in the community and used to access bus to shop. Staff D said they could shop for Resident 1 but were unable to take the resident into the community to shop and/or visit their girlfriend because the facility currently had no bus driver and Staff D did not have staffing and/or time to meet the resident at a store and/or their girlfriend's residence. Staff D said they had not made any attempts to arrange alternative transportation and/or plans to assist Resident 1 in community outings, I feel bad that I didn't think of it, it is important for them to go into the community to shop and see their girlfriend.</p> <p>At 11:46 PM, Staff B, Social Service Director, said Resident 1 had used their power wheelchair to go into the community to visit their girlfriend and go shopping. Staff B said the resident had a life alert necklace and a cell phone. Staff B said they had no concerns with the resident's ability to navigate in the community and access transportation utilizing their power wheelchair. Staff B said they had requested the facility management allow Resident 1 to use their power wheelchair in the community and they were told the chair was a privilege and they had lost the privilege due to the incident with the other resident. When asked if Staff B had investigated other modes of transportation and/or alternatives to allow Resident 1 to visit their girlfriend in the community and shop, Staff B said they had not.</p> <p>At 12:13 PM, Staff C, Resident Care Coordinator, said Resident 1's power wheelchair was taken away from them after the resident used their power wheelchair to injure another resident. Staff C said Resident 1 was scheduled for a mental health consult and then the facility staff would decide if the Resident could utilize the power wheelchair in the facility. When asked if the resident had any incidents in the community and/or reports of issues, Staff C said they were not aware of any and they knew of no reason that Resident 1 should not utilize the power wheelchair in the community but at that time Resident 1 was not allowed to access the power wheelchair in the community.</p> <p>At 12:45 PM, Staff E, Director of Nursing, said the former facility Administrator had removed the power wheelchair from Resident 1 following the incident with Resident 2. Staff E said the facility staff were available to push the resident in the facility when requested in the manual wheelchair. Staff E said they were unaware Resident 1 wanted to use the power wheelchair for use in the community. Staff E said there was no reason Resident 1 was not allowed to use the power wheelchair in the community.</p> <p>At 1:10 PM, Staff A, Administrator, said they were not employed at the facility when Resident 1's power wheelchair was removed from them. Staff A said they just gave the power wheelchair back to Resident 1 for use in the community.</p> <p>WAC Reference 388-97-0860 (2)</p>		