STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505151	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cashmere Post Acute	817 Pioneer Avenue Cashmere, WA 98815

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 44922 Based on interview and record review, the facility failed to thoroughly investigate an incident involving a missing resident for 1 of 3 residents (Resident 1) reviewed for elopement (when a resident leaves the premises or a safe area without authorization or appropriate supervision). The failure to complete a thorough investigation placed the resident at risk for re-elopement and other negative health outcomes. Findings included . <Resident 1> Review of the resident's medical records showed they were admitted to the facility with diagnoses to include an infection to their right lower extremity and a substance use disorder (a medical condition that is defined by the inability to control the use of a particular substance or substances despite harmful consequences). The 11/27/2024 comprehensive assessment showed Resident 1's cognition was intact and they were independent for transfers and walking. Review of Resident 1's 12/04/2024 incident investigation showed Resident 1 left the facility at around 8:00 AM unsupervised and without the staff's knowledge, nor did the resident sign out. The investigation showed the facility began a search process of the facility, the grounds, and the immediate area. The investigation showed Local Law Enforcement (LLE) were notified and the Resident Representative (RR) for Resident 1 was called but did not answer. The investigation showed on 12/04/2024 at 8:49 PM, Resident 1 returned to the facility, transported by the city bus, and stated they went to the nearby city to take care of some business. The investigation showed the resident verbalized they had not consumed drugs while out of the facility, but had smoked tobacco, after first removing their nicotine patch (a medication used to administer nicotine through the skin, when trying to quit smoking). The investigation showed the Resident discharged from the facility on 12/5/2024 against medical advice (AMA, when someone leaves/discharges from a facility against the medical advice of a physician due to unsafe health risks). The investigation showed no witness statements of staff or other residents for when the resident was last seen, no timeline of events or a documented timeline for notifications to the provider, LLE, or the RR. There were no outcome resolutions as to how the resident left the facility unnoticed by staff or how long they had been gone before staff noticed. Additionally, the investigation showed there were no interventions formulated to prevent further elopement. Review of Resident 1's 11/22/2024 Care Plan (CP) showed no CP updates had been made to reflect the resident's risk/actual elopement with interventions to prevent further elopement. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/17/2024 at 1:30 PM, Staff C, Resident Care Manager (RCM), and Staff D, RCM, stated they were the staff that had dealt with the missing resident incident on 12/04/2024. Staff C stated Staff A, AD, and Staff B, DNS, were both out of town at the time of the incident. Staff C stated they did not think to interview staff or other residents and still was not sure how the resident left unnoticed. Staff C stated they provided education to Resident 1 later that evening when they returned to the facility, but nothing that was put in writing. Staff C stated they did not make the notifications to the RR or to LLE, nor did they document the notification to the provider. During an interview on 12/17/2024 at 3:00 PM, Staff A, AD, along with Staff B, DNS, stated they had made the calls to the RR and to LLE but did not document the calls or the time they were made. Staff A stated they had talked with Resident 1 when they returned later that evening and made a verbal agreement with Resident 1 that they would not leave the facility again without notifying the staff and signing out. Staff A stated they did not report that to other staff or document that agreement in the CP. Staff B stated they did not interview other staff or other residents to determine when Resident 1 left the facility or how long they had been gone. Staff B stated the next day, 12/05/2024, they went to talk with Resident 1 regarding the elopement on 12/4/2024 and they were not in their room. Staff B stated Resident one had went missing again and was later located at the bus stop in the main part of the town. Staff B stated at that time Resident 1 decided to discharge from the facility against the medical advice of a doctor. Staff B stated they did not treat the 2nd elopement as an elopement because the resident discharged so therefore, they did not investigate the incident. Additionally, Staff B stated witness statements should always be obtained during an investigation. WAC Reference: 388-97-0640 (6)(a)(b)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview, and record review, the facility failed to ensure residents received substance use disorder (SUD, a medical condition that is defined by the inability to control the use of a particular substance or substances despite harmful consequences) assessments and interventions for 3 of 3 residents (Residents 1, 2, and 3) reviewed for elopement (when a resident leaves the premises without authorization or necessary supervision to do so). Additionally, the facility failed to timely implement all aspects of their elopement process when Resident 1 eloped from the facility twice. These failed practices placed residents at risk for unidentified risk factors and preventable accidents. Findings included . Review of a policy titled, Safety for Residents with Substance Use Disorder, dated 2024, showed residents would be assessed for risks, including the potential to leave the facility without notification, and use of illegal/prescription drugs to include a Care Plan (CP) with increased monitoring and supervision. Review of a policy titled, Elopements and Wandering Residents, dated 2023, showed residents would be assessed for risks, implement interventions, and monitored for effectiveness, modify those interventions when needed, and educate relevant staff on the changes. The policy showed when a resident went missing, staff were to search the facility and the grounds and if not located in either area, the Administrator (AD) would notify Local Law Enforcement (LLE) and the Director of Nursing Services (DNS) would notify the provider and the Resident's Representative (RR). <Resident 1> Review of the resident's medical record showed they admitted on [DATE] with diagnoses of an infection to their right lower extremity with intravenous (delivered in the vein) antibiotics, a stimulant dependence (a chemical or substance that affects one's behavior, mind, and body), opioid (pain relieving medicines) dependence (the chronic use of opioids that causes clinically significant distress or impairment), and psychoactive (a drug affecting the mind) substance abuse (a need for a psychoactive substance for its positive effects or to avoid the negative effects of not having it). The 11/27/2024 comprehensive assessment showed Resident 1's cognition was intact and was independent for transfers, bed mobility, and walking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's 12/04/2024 incident investigation, showed Resident 1 left the facility at around 8:00 AM, unsupervised and without the staff's knowledge, nor did the resident sign out. The investigation showed the facility began a search process of the facility, the grounds, and the immediate area. The investigation showed LLE were notified and the RR for Resident 1 was called but did not answer. The investigation showed on 12/04/2024 at 8:49 PM, Resident 1 returned to the facility and stated they had gone to the nearby city (Wenatchee) to take care of some business. The investigation showed the resident verbalized they had not consumed drugs while out of the facility but had smoked tobacco. The investigation showed the Resident discharged from the facility on 12/05/2024 against medical advice (AMA, when someone leaves/discharges from a facility against the medical advice of a physician due to unsafe health risks). The investigation showed the resident had a history of drug use and was previously homeless. Review of Resident 1's 11/21/2024 Elopement Risk assessment, showed Resident 1 was assessed to be a four, which equaled they were a high risk for elopement. Review of a nursing progress note dated 11/21/2024 at 4:58 PM, showed Resident 1 admitted to the facility with a Peripheral Inserted Central Catheter (PICC, a long thin tube that's inserted through a vein in your arm and passed through the larger veins near your heart) to their left upper extremity with two ports for access. Review of the 11/22/2024 CP showed Resident 1 had a CP focus for alcohol and drug dependency with an intervention to assess the resident's coping skills and facilitate coping strategies to prevent substance use. The CP showed no coping skills or coping strategies had been assessed, nor did the CP show Resident 1 was at high risk for elopement. The CP showed no safety interventions had been implemented to prevent elopement nor was there increased monitoring or supervision. The CP showed no CP focus or interventions for the use of the PICC line regarding the dangers and ease of drug use while the PICC line was accessible. <Resident 2> Review of the resident's medical record showed they admitted to the facility with diagnoses to include an infection to their right lower extremity and a SUD. The 12/05/2024 comprehensive assessment showed Resident 2's cognition was intact, they were independent for bed mobility and walking, and they received intravenous medications. During an observation on 12/17/2024 at 11:16 AM, Resident 2 was observed standing at the doorway entrance of their room, with their coat on, looking at their cellular phone as if they needed help. Resident 2 stated they were trying to unlock their phone but were unable to. At that time, Resident 3, in a wheelchair, propelled up to Resident 2 and asked them what they needed. Resident 2 asked Resident 3 where there was an exit door located. Resident 3 pointed to the end of hallway 100 and gave Resident 2 directions to access the exit door. At the end of the 100 hallway there was an exit door to the left and an empty room to the right. Resident 2 then went back into their room. Review of a nursing progress note dated 11/29/2024 at 3:27 PM, showed Resident 2 admitted with a PICC line to their right upper extremity. Review of Resident 2's 11/29/2024 Elopement Risk assessment showed the resident was at a three which equals a moderate risk for elopement. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's 12/08/2024 CP showed an alcohol/drug dependency focus but no coping skills or strategies had been assessed or resident specific interventions implemented. The CP showed no elopement risk CP. <Resident 3> Review of the resident's medical record showed they admitted with diagnoses to include removal of their left great toe with infection, and a SUD. The 11/29/2024 comprehensive assessment showed Resident 3's cognition was intact and was independent for bed mobility and wheelchair use. Review of Resident 3's 11/23/2024 Elopement Risk assessment showed the resident was at a three, which equals a moderate risk for elopement. Review of Resident 3's 11/25/2024 CP showed no alcohol/drug dependency coping skills or strategies had been assessed or resident specific interventions implemented. The CP showed no elopement risk care plan. During an interview on 12/17/2024 at 1:25 PM, Staff E, Social Services, stated they formulated the CPs for residents if they had alcohol/drug dependency. Staff E stated they did not assess residents for their SUD because this was a newer issue to them and Staff E had no training on how to deal with SUD residents. Staff E stated Resident 1 was allowed to leave the facility independently and unsupervised, even though the resident had a SUD and a PICC line, and that decision was a collaborative decision of the whole team. During an interview on 12/17/2024 at 1:30 PM, Staff C, Resident Case Manager (RCM), and Staff D, RCM, with Staff E present, stated Resident 1 had left the faciity on [DATE] sometime after they completed their antibiotic treatment at 8:30 AM, when they were last seen. Staff C stated it was normal for Resident 1 to go out on walks, unsupervised, but would return a short time later and that Resident 1 would always sign out. Staff C stated after they searched the facility, the grounds, and the two local towns and Resident 1 could not be located, they notified the AD and the DNS. The AD then notified LLE and Resident 1's RR. Staff C stated they had not been successful in locating Resident 1, who then returned to the facility at approximately 8:50 PM. Staff C stated Resident 1 had denied drug use while they were out of the facility but had appeared symptomatic, as if they had, so the medical provider ordered a urine drug screen. Staff C stated, the following morning, after Resident 1 received their antibiotic treatment, they left the facility again without staff knowledge and unsupervised. Staff C stated they, along with the DNS, began a search of the local area and found Resident 1 in town at the bus stop. Staff C stated Resident 1 agreed to go back to the facility and discuss options, and at that time, the resident decided they wanted to discharge from the facility AMA. Staff C stated they received an order to remove the PICC line from Resident 1 prior to them discharging. Staff C stated Resident 1 had stated to them on admission they loved doing drugs and had no intentions of quitting and was only at the facility to treat their infection. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/17/2024 at 2:03 PM, Staff A, AD, stated they reviewed the sign out sheets and Resident 1 did not sign out of the facility on 12/04/2024 or 12/05/2024 when they went missing from the facility. Staff A stated they were not notified of Resident 1 missing until 12:00 PM, after staff had searched the facility, the grounds, and the two local town areas [[NAME] and Wenatchee [NAME] (which was 12 miles from the facility), at approximately 11:00 AM]. Staff A stated they called LLE at 1:43 PM, and Resident 1's emergency contact at 2:12 PM (nearly three hours after notification was received that Resident 1 was missing and it had been verified the resident was not in the facility or on the grounds, and more than five hours after Resident 1 was last seen by staff). Review of the November and December 2024 sign in/out sheets showed Resident 1 signed themselves out on 11/22/2024 at 10:50 AM, with an estimated return time of 11:20 AM, but did not return until 1:18 PM, and 12/3/2024 at 8:19 AM and again at 1:30 PM, both showed no return time or estimated return time. During an interview on 12/17/2024 at 2:51 PM, the Contracted Medical Director (CMD), stated they were not aware Resident 1 was allowed unsupervised access outside of the facility, with a PICC line in place and accessible. The CMD stated Resident 1 should have only been allowed to go to and from medical appointments. The CMD stated if the resident did not agree with that and they were able to come and go as they pleased, then they should have been discharged without the PICC line for safety. During an interview on 12/17/2024 at 3:00 PM, Staff B, DNS, along with Staff A, stated they had gone to speak with Resident 1 on 12/05/2024 in the morning, regarding their elopement on 12/04/2024, and that was when Resident 1 was noted to be gone again. Staff B stated they, along with the RCM, searched the local town area and found Resident 1 at the bus stop. Staff A stated they had made a verbal agreement with Resident 1 on 12/04/2024 when they returned to the facility, that the resident would notify staff if they were going to leave and sign out. Staff A stated that agreement had not been care planned, it was just between Staff A and Resident 1. Staff B stated they would expect a high-risk elopement resident to be care planned with interventions and if they had SUD and/or a PICC line that the provider should have been notified and an appropriate order for the resident to leave the facility unsupervised should have been obtained. Staff B stated they would have expected the care plan interventions to be followed and resident's that had a SUD should have been assessed and care planned interventions put into place now that it was brought to our attention. WAC Reference: 388-97-1060(3)(g)