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	01/13/2025

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 0561

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45117

Based on observation, interview, and record review, the facility failed to ensure each resident's right to choose important aspects of their life, including frequency of showers and meal preferences for 2 of 3 residents (Residents 87 and 22) reviewed for choices. This failure disallowed Resident 87 the opportunity to increase their weekly showers and Resident 22 the right to dietary preferences.

Findings included .

Review of an undated policy titled, Resident Rights, showed the resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choice.

<Resident 87>

Review of the medical record showed the resident admitted to the facility on [DATE] with diagnoses to include bi-polar disorder (a mental illness that causes extreme mood swings, along with changes in energy, sleep, thinking and behavior), and personality disorder (long-term patterns or behaviors and inner experiences that differ significantly from what is expected). The 11/20/2024 comprehensive assessment showed Resident 87 required supervision or touching assistance for activities of daily living [(ADLs) the basic tasks you do every day to take care of yourself including showers/bathing] and had a moderately impaired cognition.

During an interview on 01/06/2025 at 1:46 PM, when asked about his choices regarding his shower schedule, Resident 87 stated they could only get one shower per week scheduled. Resident 87 stated it was a big change for them to only bathe once a week and they would like two showers a week at least. Resident 87 stated they had voiced this to staff, but they (the staff) have yet to accommodate them. Resident 87 stated they were able to wash themselves in the sink, but it was not the same as a shower.

Review of the resident's shower records for November 2024, December 2024 and January 2025 showed Resident 87 received one shower per week on Thursday's.

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 01/13/2025 at 11:12 AM Staff B, Director of Nursing, stated the process for showering/bathing was for all residents to be placed on a once weekly schedule unless they requested them more frequently. Staff B stated staff were to inform the shower aides if any residents were to request more frequent bathing/showers and the correct process was not followed for Resident 87. <Resident 22> Review of the medical record showed Resident 22 was admitted to the facility with diagnoses including diabetes mellitus (a group of diseases that result in too much sugar in the blood), heart failure, and liver disease. The 10/09/2024 comprehensive assessment showed Resident 22 required supervision/moderate assistance of one staff member for activities of daily living (ADLs)and was independent with eating. The assessment also showed Resident 22 had an intact cognition. During an interview on 01/06/2025 at 2:42 PM Resident 22 stated there were limits on the amount of food they could have at a meal that was printed on the back of the menu. They stated for breakfast they could only have one piece of toast, one hashbrown, and one small bowl of cereal. Resident 22 stated if they were still hungry after a meal, they were out of luck. Record review of the Menu for [facility name], dated 01/12/2025 through 01/18/2025, showed no more than 3 drinks per meal, Toast, Hashbrown Patty (limit 2 patties), Pepperoni Pizza (Limit 1), Bowl of Chili (Limit 2), Hotdog w/Bun, [NAME] (ketchup), May (mayonnaise), Mus (mustard), Relish (Limit 2), Cheeseburger w/Fixin's (Limit 1). The menu also showed Only 1 entree per meal order and only 2 sides, no more then 3 items per meal. Review of Resident 22's meal intake record dated 12/16/2024 through 01/14/2025, showed there were 90 meal opportunities. Resident 22 consumed 75%-100% of their meal for 84 of the 90 opportunities. During an interview on 01/13/2025 at 9:33 AM, Staff B stated it was not the process to limit a resident's food. They stated if a resident requested an additional meals, they should have them. Reference: WAC 388-97-0900(1)(3) 48368

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48368 Based on observation, interview, and record review, the facility failed to maintain confidentiality of medical conditions through posting of signs in a Resident's room for 1 of 7 residents (Resident 84) reviewed for resident's rights. Posting a sign that identified a medical condition, prevented protection of residents' right to privacy of a medical condition. Findings included . Review of the resident's medical records showed they admitted on [DATE] with diagnoses to include schizophrenia (a serious mental illness that affects a person's thoughts, feelings, and behaviors). The 11/29/2024 comprehensive assessment showed Resident 84 ' s cognition was severely impaired. An observation on 01/06/25 at 2:31 PM, showed a laminated sign with bold black lettering on the wall above Resident 84's bed that stated, I have schizophrenia, I come in and out of reality (not from drugs), I'm also blind feed me half meals, I love my room cool and love tons of water. During an interview on 01/09/2025 at 1:23 PM, Staff I, Registered Nurse, stated resident rooms should not have signs displayed that contained private personal health history information. Reference WAC: 388-97-0380 (1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 46722 Based on observation and interview, the facility failed to ensure a sanitary and homelike environment for 1 of 1 shower room reviewed for environment. This failure placed residents at risk for not having a comfortable and homelike experience during showers. Findings included . Review of the undated policy titled, Resident Rights, showed the resident had the right to a safe, clean, comfortable and homelike environment, including treatment and support for safe daily living. <Shower Room> An observation and interview on 01/09/2025 at 8:50 AM, showed the shower room had a staff desk, desk chair, and cabinet across from the entrance door, against the adjacent wall. The top of the desk had a laptop and computer tablet, a clipboard of resident names for bathing/showering, tape dispenser, and a pen. The cabinet top contained a notebook, a personal large pink jug, half full of clear fluid, and a black shaker cup. The top shelf of the cabinet had a pink cell phone, an Apple watch, a personal large silver drink tumbler, a small red and white gift bag, and an open box of tissues. The wall above the desk had an electrical outlet where the laptop, computer tablet, and a cellphone charger were plugged into. To the left of the entrance door was a shower stall area. The area had a ledge in the shower area that had a large pink drink tumbler and a clear Dutch Bro's (brand of coffee) cup that was half full of a brown and white liquid and a pink straw. The area to the right of the desk contained the resident bathtub with a lift, five types of resident shower chairs, a chair with torn, shredded leather-type fabric on the armrests. The tile against the top of the bathtub below the faucet was bulging out from the wall, that left a one-inch gap between tiles, exposing the wall behind the tiles. The tile surrounding the bathtub handles had a two-inch area of broken tile with sharp edges. The bathtub faucet handles and spout were covered in a white, crusty film. Staff G, Nursing Assistant, stated the desk area was for the bathing staff to use for resident documentation. Staff G obtained the cell phone from the top of the cabinet shelf and took a drink from the tumbler. An observation on 01/13/2025 at 10:06 AM, showed Staff G exited the shower room with a resident after their shower. The shower room showed the desk, desk chair, and cabinet on the adjacent wall. The cabinet top showed a large pink jug, a large silver drink tumbler, and a clear shaker cup half full of tan liquid and a light green lid. The top of the cabinet had pink cell phone, an Apple watch, a small red and white gift bag, and an open box of tissues. The shower stall to the left of the shower room entrance had a large pink drink tumbler with a straw and an open container of germicidal surface wipes. During an interview on 01/13/2025 at 12:45 PM, Staff B, Director of Nursing, stated there should not be any food or drink in the shower room. Staff B stated the desk was in the shower room for the nursing assistants to document. Staff B stated the nursing assistants could document at the nursing station. Staff B stated they had not realized the desk in the resident shower room was not homelike. Reference WAC: 388-97-0880(1)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642 Based on interview and record review, the facility failed to issue a written notice of bed hold (holding or reserving a resident's bed while the resident was absent from the facility) at the time of hospital transfer for 2 of 4 residents (Residents 27 and 58), reviewed for hospitalization . This failure placed residents at risk for lack of knowledge regarding their right to hold their bed and monetary charges associated with the bed hold while in the hospital. Findings included . Review of the undated facility policy titled Bed Hold Prior to Transfer, showed the facility would provide written information to the resident/resident representative prior to transferring to the hospital. The written information would include the duration of the bed-hold, reserve bed payment, and facility policies regarding bed-hold periods to include permitting residents to return to the facility. <Resident 27> Review of Resident 27's medical record showed the resident admitted to the facility on [DATE] with diagnoses including heart failure, respiratory failure, and diabetes [a disease in which the body does not control glucose (a type of sugar) in the blood]. The 12/16/2024 comprehensive assessment showed Resident 27 had an intact cognition and was able to make decisions regarding their care. Review of a progress note dated 05/14/2024 showed Resident 27 had experienced an eight-pound weight gain and wheezing. Resident 27 was assessed and sent to the hospital for evaluation. Additional record review found an electronic bed-hold notice; the notice did not contain reserve bed payment information as required. Review of a progress note dated 07/29/2024 showed Resident 27 had experienced a change in their level of consciousness (change in alertness and awareness), was lethargic (lack of energy), and had shortness of breath. The resident was assessed and was sent to the hospital for evaluation. Additional record review found no documentation Resident 27 had been provided a bed-hold notice as required. Review of a progress note dated 08/12/2024, showed Resident 27 began to shake, had low blood pressure, elevated heart rate, and a slight fever. The resident was assessed and sent to the hospital. Additional record review found no documentation that Resident 27 had been provided a bed-hold notice as required. <Resident 58> Review of the medical record showed Resident 58 admitted to the facility with diagnoses including diabetes, heart failure, and depression. The 12/16/2024 comprehensive assessment showed Resident 58 required partial assistance of one staff member for personal hygiene activities of daily living (ADLs) independent for mobility and eating and had an intact cognition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note dated 08/23/2024, showed Resident 58 was diaphoretic (excessive sweating related to an unknown health condition or medication), wheezing breath sounds, weak, and had abdominal pain. Resident 58 was transferred to the emergency department for evaluation. There was no documentation in the medical record that showed a notice of a bed-hold was issued. During an interview on 01/08/2025 at 9:55 AM, Resident 58's Representative, stated the resident did have a hospital stay for an acute illness in the month of August 2024, and they were not provided with a bed-hold notice. During an interview on 01/13/2025 at 11:53 AM, Staff B, Director of Nursing, stated bed holds were offered upon admission in the admission agreement. Staff B stated the facility had changed from paper to an electronic bed-hold form. Staff B stated the form needed more clarification to identify if the resident or representative agreed or acknowledged the bed-hold agreement. Reference: WAC 388-97-0120(4)(a)(b)(c) 46722

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to ensure a Preadmission Screening and Resident Review [(PASARR) a process to determine if a potential nursing home resident had mental health/intellectual disability needs which required further assessment/treatment] assessment accurately reflected residents' mental health conditions for 3 of 6 residents (Resident 51, 55, and 84) reviewed for unnecessary medications. Additionally, the facility failed to ensure a PASARR was completed prior to admission for 1 of 6 residents (Resident 9) reviewed for PASARR screening on admissions. These failures placed residents at risk for inappropriate nursing home placement and/or not receiving timely and necessary services to meet their mental health needs. Findings included . Record review of an undated policy titled, Resident Assessment - Coordination with PASARR Program, showed the Social Services Director (SSD) was responsible to ensure all applicants to the facility were screened for serious mental disorders or intellectual disabilities prior to admission and care and services were provided in the appropriate setting. <Resident 51> Review of the medical record showed Resident 51 was readmitted to the facility on [DATE] with diagnoses including vascular dementia without behavioral disturbance (a condition where someone with vascular dementia experiences significant changes in their behavior, such as agitation, aggression, apathy, depression, mood swings, or other unusual actions, alongside cognitive impairments like memory loss and difficulty thinking clearly, all caused by damage to brain blood vessels affecting their brain function) , psychotic disturbance, mood disturbance, and anxiety (cognitive impairment without behavior issues like agitation, hallucinations, mood swings, or anxiety), bipolar disorder (a mental illness that causes extreme shifts in mood, energy, activity levels, and concentration), and adjustment disorder with anxiety and depressed mood (a reaction to a stressful event that involves both anxious and depressed feelings). The 11/11/2024 comprehensive assessment showed Resident 51 was independent with activities of daily living (ADLs). The assessment also showed Resident 51 was cognitively intact. Record review of Resident 51's medical record showed a PASARR Level I form, dated 06/10/2024, showed Resident 51 had no serious mental illness indicators, no evidence of serious functional limitation during the past six months related to a serious mental illness, and had not had psychiatric treatment greater than outpatient care or experienced a significant disruption to the normal living situation. The PASARR Level I form showed no Level II screening was indicated for Resident 51, despite their mental health diagnoses of vascular dementia, bipolar disorder, and adjustment disorders. During a concurrent observation and interview on 01/08/2025 at 12:15 PM, Staff D, SSD, reviewed Resident 51's current PASARR Level I form and stated the form was incorrect as Resident 51 had a diagnosis of bipolar disorder. Staff D stated Resident 51 had returned from a hospital stay and would not have expected the hospital to complete a new PASARR Level I. Staff D stated they had missed this when they returned from the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER: Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 55> Review of Resident 55's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include major depressive disorder (a serious mental health condition that can cause a person to feel a persistent low mood and lose interests in activities they usually enjoy). The 12/29/2024 comprehensive assessment showed Resident 55's cognition was severely impaired. The assessment also showed Resident 55 experienced delusions (misconceptions or beliefs that are firmly held, contrary to reality). Review of Resident 55's 07/16/2024 PASARR Level I assessment showed, Resident 55 was identified to have a mood disorder - depressive or bipolar. Further review showed a PASARR Level II (further assessment to determine if the resident requires extra support beyond standard nursing home care due to their specific needs) evaluation was not indicated. <Resident 84 > Review of the medical record showed Resident 84 admitted to the facility on [DATE] with diagnoses to include schizophrenia (a serious mental illness that affects a person's thoughts, feelings, and behaviors) and major depressive disorder. The 11/29/2024 comprehensive assessment showed Resident 84's cognition was severely impaired. The assessment also showed the resident felt down and depressed and had feelings of being tired or little energy. Review of Resident 84's 09/03/2024 PASARR Level I assessment showed Resident 84 was identified to have a schizophrenic disorder and a mood disorder - depressive or bipolar. Further review showed a PASARR Level II evaluation was not indicated. During an interview on 01/09/2025 at 4:04 PM Staff D stated they were aware of the new PASARR requirements that required them to do a referral for a Level II PASARR evaluation if any diagnosis were marked yes on the Level I PASARR assessment. Staff D stated Residents 55 and 84 should had been reviewed and sent for a PASARR Level II evaluation and they did not follow the correct process. <Resident 9> Review of the medical record showed Resident 9 was admitted to the facility on [DATE] with diagnoses including vascular dementia with behavioral disturbances, major depressive disorder, and an anxiety disorder. The 11/06/2024 comprehensive assessment showed Resident 9 was dependent on one to two staff for ADLs. The assessment also showed Resident 9 had a moderately impaired cognition. Record review of Resident 9's medical record showed there was no PASARR Level I form completed for their admission to the facility on [DATE]. During an interview on 01/08/2025 at 12:17 PM, Staff E stated the process for a PASARR Level I screening for new admissions included receiving the completed form from the discharging facility. Staff E stated they reviewed the PASARR Level I form prior to the resident admitting to the facility to ensure diagnoses related to serious mental disorders were listed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 01/13/2025 at 11:46 AM, Staff F, Admissions Coordinator, was seated at their desk while reviewing Resident 9's medical record. Staff F stated they had a received a PASARR Level I screening for Resident 9 but was unable to locate it in the medical record. During an interview on 01/13/2025 at 12:09 PM, Staff A, Administrator, stated PASARR screenings needed to be completed timely and accurately, upon admission and as needed. Reference WAC: 388-97-1915(1)(2)(a-c) 48368

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER: Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to develop a baseline care plan, within 48 hours of admission, that documented resident-specific goals and treatment plans for 3 of 4 residents (Residents 48, 196, and 9) reviewed for baseline care plan. Failure to develop a baseline care plan placed the residents at risk of not receiving continuity of care and resident centered care needs. Findings included . Review of an undated policy titled Baseline Care Plan, showed the facility would develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality of care. The baseline care plan would be developed within 48 hours of a resident's admission and it was to include the minimum healthcare information necessary to properly care for the resident, including initial goals based on admission orders, physician orders, dietary orders, therapy services, social services, and Preadmission Screening and Resident Review [(PASARR) a process to determine if a potential nursing home resident had mental health/intellectual disability needs which required further assessment/treatment] recommendations, if applicable. <Resident 48> Review of the medical record showed Resident 48 was admitted to the facility with diagnoses including vertebral fractures (a break in the bones of the spine), kidney and respiratory failure, and muscle weakness. The 12/22/2024 comprehensive assessment showed Resident 48 required maximum/dependent assistance from one to two staff members for activities of daily living (ADLs). The assessment also showed Resident 48 was cognitively intact. Review of Resident 48's baseline care plan dated 12/30/2024, showed no documentation of the PASARR recommendations, behavioral health goals, or interventions until 12/23/2024, five days after Resident 48's admission to the facility. <Resident 196> Review of the medical record showed Resident 196 was admitted to the facility on [DATE] with diagnoses including heart failure and adult failure to thrive (a syndrome in older adults characterized by unexplained weight loss, decreased appetite, poor nutrition, inactivity, often accompanied by depression, cognitive impairment, and functional decline). The 01/07/2025 comprehensive assessment showed Resident 196 was cognitively intact. Review of Resident 196's baseline care plan revised 01/08/2025, showed no documentation that the baseline care plan contained PASARR recommendations or Social Services goals or interventions until 01/07/2025, four days after Resident 196's admission to the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview on 01/13/2025 at 12:52 PM, with Staff J, Registered Nurse (RN), and Staff I, RN, Staff J stated Staff K, Minimum Data Set [(MDS) a standardized assessment tool that measures health status in nursing home residents] Nurse, was responsible for creating the baseline care plan. Staff J stated once the baseline care plan was created, they would print it, along with the physician orders, and deliver them to the resident. Staff I, RN, stated the baseline care plans were completed on admission and given to the resident within 48 hours of their admission to the facility. <Resident 9> Review of the medical record showed Resident 9 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (a group of diseases that result in too much sugar in the blood) and vascular dementia with behavioral disturbances (a condition where damage to the brain blood vessels causes significant changes in a person's behavior such as agitation, aggression, apathy, depression, and cognitive impairments like memory loss and difficulty thinking clearly). The 11/06/2024 comprehensive assessment showed Resident 9 was dependent on one to two staff members for ADLs. The assessment also showed Resident 9 had a moderately impaired cognition. Record review of Resident 9's care plan dated 11/12/2024, showed focus areas, goals, and interventions from their previous admissions to the facility, dated back to 01/22/2024. There were no focus areas, goals, or interventions dated after 10/31/2024 (their current admission) until 11/05/2024, five days after their admission to the facility. During an interview on 01/13/2025 at 11:52 AM, Staff K stated Resident 9 was a readmit to the facility, which caused the previous care plan to pull forward in the electronic medical record. They stated they reviewed the resident's information upon admission and verified that the information was accurate. They stated the resident was considered a new admission according to the MDS, but the electronic medical record automatically pulled the previous information into their new admission record. Staff K stated each department reviewed the care plan for accuracy, including falls, skin, pain, ADLs, nutrition, and activities. During an interview on 01/13/2025 at 12:42 PM, Staff I stated the previous care plan had not been closed out in the EMR when Resident 9 previously discharged . Staff I stated, that should have been done and a new baseline care plan should have been created. Reference: WAC 388-97-1020(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025

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 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45642

Based on observation, interview, and record review the facility failed to develop and implement comprehensive Care Plans (CPs) for one of seven residents (Resident 27) whose CPs were reviewed. The failure to develop and/or implement comprehensive CP interventions left residents at risk for unmet care needs and other negative health outcomes.

Findings included .

<Resident 27>

Review of Resident 27's medical record showed the resident was admitted to the facility on [DATE]. The resident had medically complex diagnoses including a heart condition that could cause fluid in the lungs. The comprehensive assessment dated [DATE], showed Resident 27's cognition was intact and able to make decisions regarding their care.

During a concurrent observation and interview on 1/08/2025 at 2:24 PM, Resident 27 stated he had not worn their pulmonary vest in a long time and staff had not asked them about it nor documenting the use of their inhaler.

Review of the medical record showed an 11/18/2024 physician's order directing staff to assist Resident 27 with a pulmonary vest to be worn for 30 minutes, document all refusals, two times a day nursing monitoring and to be worn during a nebulizer (a machine that turns medication into a fine mist to be breathed directly into the lungs through a face mask) breathing treatment twice a day.

Review of Resident 27's November 2024, Medication Administration Record (MAR), showed the resident had refused wearing the pulmonary vest and medication twenty-three times on the day shift and eighteen times on the evening shift. Further review of the resident's medical record did not show documentation of on the refusal of care, a risk and benefits assessment, nor a notification to physician of refusal.

Review of Resident 27's December 2024 MAR showed the resident had refused wearing the pulmonary vest and medication twenty-three times on the dayshift and eighteen times on the evening shift. Further review of the resident's medical record did not show documentation of on the refusal of care, a risks and benefits assessment, nor a notification to physician of refusal.

Review of the 12/18/2024 comprehensive CP showed the facility had not developed a CP addressing Resident 27's pulmonary vest or the resident refusal of cares. There were no goals developed, and there were no directions for staff for application of the vest or direction if the resident were to refuse the care.

During an interview on 01/09/2025 at 3:35 PM, Staff P, Medication Assistant, stated Resident 27 had worn the pulmonary vest in the past, that the resident did not wear the pulmonary vest

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/10/2025 at 8:18 AM, Staff C, Licensed Practical Nurse, stated Resident 27 had worn the pulmonary vest when it was first ordered. Staff C stated that Resident 27 would make their own decisions when it came to their care. During an interview on 01/13/2025 at 11:58 AM, Staff B, Director of Nursing, stated nursing staff were expected to follow the physician orders. Staff B stated that the refusal of cares should be part of the care plan to assist in meeting the residents needs. Reference: WAC 388-97-1020(1)(2)(a)(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on observation, interview, and record review, the facility failed to develop and implement a process of monitoring daily fluid intake for residents with a physician's order for daily fluid restriction for 1 of 2 residents (Resident 196) reviewed for quality of care. Additionally, the facility failed to identify and provide needed care and services for 1 of 2 residents (Resident 4) reviewed for positioning. These failures placed the residents at risk for health complications and poor clinical outcomes. Findings included . Review of an undated policy titled, Fluid Restriction, showed the nurse would obtain and verify the physician's order for a fluid restriction that included the breakdown of the amount of fluid per 24 hours, to be divided between the food and nutrition department and the nursing department. The fluid intake would be recorded on the medication record. Water would not be provided at the bedside unless calculated into the daily total fluid restriction. <Fluid Restriction> <Resident 196> Review of the medical record showed Resident 196 was admitted to the facility on [DATE] with diagnoses including biventricular heart failure (a condition that occurs when both the left and right sides of the heart are affected by heart failure with symptoms of shortness of breath, swelling, and weight gain), generalized edema (a condition where fluid builds up in the body's tissues), and chronic ulcers of the lower legs. The 01/07/2025 comprehensive assessment showed Resident 196 had an intact cognition. A concurrent observation and interview on 01/06/2025 at 11:43 AM, showed Resident 196 sitting in their bed with their legs outstretched in front of them. There was a brown covered cup, capable of holding 280 milliliters [(mL) a liquid measurement] of fluid, with a straw on the over the bed table, next to Resident 196's bed. There was a sign taped to the wall at the foot of Resident 196's bed that showed they were on a fluid restriction of 2000 mL of fluid in 24 hours, that included 1200 mL of fluid from dietary sources and the remaining 800 mL from the nursing department. Resident 196 stated they were on a fluid restriction. They stated the nursing staff brought them cold water at least three times daily and whenever they wanted and pointed to the brown covered cup. During an observation on 01/10/2025 at 8:16 AM, Resident 196 was sitting on the edge of the bed eating breakfast. There was a half glass of water (120 mL), a cup of coffee (240 mL), and a brown cup with a lid containing water (280 mL) on the over the bed table. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/10/2025 at 8:25 AM, Staff L, Licensed Practical Nurse (LPN), stated the half glass of water on Resident 196's over the bed table contained 120 mL of water. They stated when a resident was on a fluid restriction, the kitchen was given their daily limitations for fluids and nursing had theirs. Staff L stated the total fluid intake was passed on both in charting and verbal report to the oncoming shift. They stated the nursing assistants (NAs) did not chart fluid intake, it all goes through the nurses. During a combined interview on 01/09/2025 at 1:21 PM, Staff M, NA, stated residents on a fluid restriction had a sign posted on their door. They stated they would ask the residents how much they drank during the day and reported that amount to the nurse. Staff M stated they also recorded that amount in the task record in the computer. Staff N, NA, stated there were no residents on the 100 hall (where Resident 196 resided) that were on a fluid restriction, despite Resident 196 having a fluid restriction. Staff M stated there had been a resident that had a fluid restriction and had verified with the Registered Nurses that it had been removed. Staff M stated were not aware of any other residents on the 100 hall that had a fluid restriction. Review of the medication administration record for January 2025, showed Resident 196 had a physician order for a 2000 mL fluid restriction, dietary 1200 mL, nursing 800 mL, two times a day for nurse monitoring. Record review of a NA daily task record titled, Nutrition - Fluid at Meals, dated 01/14/2025 through 01/12/2025, showed three of 20 yes responses to the question Is resident on a fluid restriction, the remaining 17 responses were no, despite Resident 196's fluid restriction. Review of the medical record showed the NA task record had three areas for documentation of daily fluid intake labeled Amount of fluid taken, Amount of Additional Fluids taken, and How much free fluids did resident take this shift? Review of the medical record showed total fluid intake from the licensed nurses and NAs was: 01/04/2025 total: 2350 mL, 1550 mL over the nursing fluid allotment (the amount of something given to a person). 01/05/2025 total: 3440 mL, 2640 mL over the nursing fluid allotment. 01/06/2025 total: 2340 mL, 1540 mL over the nursing fluid allotment. 01/07/2025 total: 1300 mL, 500 mL over the nursing fluid allotment. 01/08/2025 total: 2940 mL, 2140 mL over the nursing fluid allotment. 01/09/2025 total: 2300 mL, 1500 mL over the nursing fluid allotment. 01/10/2025 total: 1820 mL, 1020 mL over the nursing fluid allotment. During an interview on 01/13/2025 at 9:00 AM, Staff O, Anonymous Licensed Nurse, stated there was no process in place for accounting for the total amount of fluid intake for the residents on a fluid restriction. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025

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 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During an interview on 01/13/2025 at 9:35 AM, Staff B, Director of Nursing, stated the process for monitoring fluid restriction included placing a sign on the resident's door and in their room with the amount of their daily fluid restriction. There would be a physician order stating what the restriction was and the amounts of the restriction. Dietary sent out their allotted amounts with the meal trays and nursing calculated the fluid intake given by nursing. The NAs were required to talk to the nurse prior to giving any fluids. At the end of each shift, an order would populate in the electronic medical record to document the total shift intake. Staff B stated they were unaware that Resident 196 was on a fluid restriction. Staff B stated they did not know how the dietary intake was included in the fluid monitoring and that Resident 196's fluid intake had not been monitored appropriately.

<Positioning>

<Resident 4>

Review of the medical record showed Resident 4 was admitted to the facility on [DATE] with diagnoses including osteoporosis (a disease that causes bones to become weak and brittle), spastic hemiplegia (the loss of the ability to move and/or coordinate a side of the body that causes muscles on the affected side to become stiff and difficult to control), traumatic brain injury (an injury to the brain by an external force), and dysphagia (difficulty swallowing food and/or drink). The 10/16/2024 comprehensive assessment showed Resident 4 required moderate/dependent assistance of one to two staff members for ADLs, setup assistance for eating, independent for manual wheelchair (w/c) and had a moderately impaired cognition.

Review of Resident 4's care plan, last reviewed on 10/19/2024, showed no interventions for positioning during eating or wheelchair use.

Review of Resident 4's medical record showed no nursing assessments for Resident 4's positioning for w/c mobility or during meals.

An observation on 01/06/2025 at 11:59 AM, showed Resident 4 being pushed in a w/c, completely hunched forward, head and face down towards the floor, with their chin at the level of their knees. The w/c did not have attached footrests, and, as Resident 4 was pushed in the w/c, their right foot was dragging and was caught underneath the w/c. This caused the staff member to pause and ask Resident 4 to lift their feet for the transfer to the dining room.

An observation on 01/06/2025 at 12:00 PM, showed Resident 4 in their w/c at a dining table in the main dining room. Resident 4 was completely hunched over, head and face towards the floor and below the level of the dining table. Staff Q, Helping Hands, was seated to the right of Resident 4. Staff Q loaded a fork with food from Resident 4's lunch plate and provided the fork to them. Resident 4 attempted to place food into their mouth as food dropped from the fork and their mouth. Resident 4 had an abundance of saliva and nasal drainage as they attempted to eat their meal. Resident 4 continually wiped their face, nose, and clothing with paper towels and tissues during the meal period.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

An observation and interview on 01/06/2025 at 3:22 PM, showed Resident 4 in their w/c in their room attempting to propel themselves. Resident 4 was completely hunched over, head and face towards the floor, grunting and gurgling, as saliva and nasal drainage leaked from their mouth and nose. Resident 4 had a handful of tissues in their hand, attempting to clean up the drainage. Resident 4 stated they were ok but their back hurt.

During an interview on 01/06/2025 at 6:24 PM, Resident 4's Representative (RR), stated Resident 4 became w/c bound when they had an accident from a fall from a horse when they were young. The RR stated therapy had not continued to work with Resident 4 after they completed their initial therapy when they admitted to the facility. The RR stated they believed Resident 4 should be more upright in their w/c for eating and mobility, as they have had falls from the w/c and were concerned for their swallowing risks.

An observation on 01/07/2025 at 8:31 AM, showed Resident 4 in their bed eating breakfast by themselves. The head of the bed was inclined, allowing Resident 4 to sit up, face forward, and was able to make eye contact. The bedside tray table was across Resident 4's lap area with a divided plate, cup of oatmeal, cup of orange juice, with lid and straw, and cup of milk with lid and straw. Their food was 75% eaten and drinks were 50% full. Resident 4 had a napkin laid across their chest and stomach area and there was no visible food spillage on them. Resident 4 was not grunting or gurgling, nor did they have saliva or nasal drainage.

An observation on 01/08/2025 at 12:05 PM, showed Resident 4 in their w/c at the dining table in the main dining room. They were completely hunched over, head and face towards the floor, and head below the level of the dining table. Resident 4 was grunting and gurgling with saliva and nasal drainage during the meal. Resident 4 attempted to place food onto a fork as they did not have any assistance from a staff member. Resident 4 pulled the tablecloth towards them to bring their lunch plate closer to them. Resident 4 attempted to scoop food onto the fork but would drop the food onto their clothing or floor. They wiped their clothing and dropped napkins on the floor and leaned further to pick the napkins up off the floor. Once again, Resident 4 pulled the tablecloth towards them and when doing so, their forehead and hair touched their food on their plate.

An observation and interview on 01/08/2025 at 4:10 PM, showed Resident 4 in their w/c in the East hallway by their room and nursing medication cart. Resident 4 was completely hunched over, head and face towards the floor, grunting, gurgling and breathing loudly. Resident 4's had saliva and nasal drainage and continually wiped their face with tissues. Resident 4 requested their medication from Staff Z, Registered Nurse. Staff Z prepared Resident 4's medication and placed them onto a spoon to administer to them. Staff Z got down onto their knees and attempted to provide the medication to Resident 4. Staff Z stated they needed to add pudding to the spoon to prevent the medications from falling off the spoon. Staff Z asked Resident 4 to try and sit up in their w/c. Resident 4 did not respond or sit up. Staff Z then got down onto their knees, leaned down, and administered the medications from the spoon into Resident 4's mouth. Staff Z stated Resident 4's position for taking medications was not best for swallowing.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 01/09/2025 at 9:12 AM, Resident 4 was in their bed eating breakfast. Resident 4's head of bed was inclined that allowed them to sit upright, face forward, and able to make eye contact. Resident 4 had a napkin across their chest and stomach and no visible food spillage. Resident 4 was not having saliva or nasal drainage during the meal and interview. Resident 4 stated they had tried a tilt-in-space w/c before, and did not like it because they could not put their feet on the ground to propel them around. Resident 4 stated they hunched over in the current w/c as that would enable them to use their feet to move around. Resident 4 stated they did have a fall from their w/c in the main dining room when they were hunched over and reached to pick up items they had dropped on the floor. Resident 4 stated they did experience a small cut to their forehead that needed staples. Resident 4 stated they would be willing to try something to help their positioning be more upright when they ate and used their w/c. Resident 4 also stated they would like to be able to continue to use their feet to move around in their w/c. During an interview on 01/09/2025 at 10:54 AM, Staff DD, Director of Rehab, stated Resident 4 was recently referred to physical and occupational therapy for re-evaluation of their needs for toileting and transfers. Staff DD stated they had made a recommendation for a room move, as Resident 4 needed more space in their room. Staff DD stated when Resident 4 was in therapy after their arrival to the facility, they had trialed a harness to keep them upright in their w/c. Staff DD stated Resident 4 was able to use the clip attachment to put on and remove the harness, however , Resident 4 would continue to drop items onto the floor. Staff DD stated when their therapy was completed, they refused to wear the harness any longer. Staff DD stated they had not tried other wheelchairs that would help Resident 4 be secure in the w/c or anything else for upright positioning. During an interview on 01/13/2025 at 10:01 AM, Staff M, NA, stated Resident 4 had been in their current position for eating and w/c use since they had arrived at the facility. Staff M stated they had not been educated or received any positioning instructions for Resident 4. During an interview on 01/13/2025 at 12:24 PM, Staff B stated Resident 4 did have a fall from their w/c in the dining room when they had reached for a tissue they dropped on the floor. Staff B stated Resident 4's positioning during eating and when using their w/c was a risk factor for a potential bad outcome and they had been worried about this for some time. Staff B also stated the nursing assistants did not have directions on how to position Resident 4 during their meals or in their w/c. Reference: WAC 388-97-1060(1)(2)(b)(3)(g) 46722

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 45117 Based on observation, interview, and record review, the facility failed to develop and implement an effective pain management program for 1 of 3 residents (Resident 51) reviewed for pain management. This failed practice placed the residents at risk for unmanaged pain and emotional distress. Findings included . Review of an undated policy titled, Pain Management, showed the facility must ensure a pain management program was provided to residents that was consistent with professional standards of practice, in accordance with the comprehensive, person-centered care plan, and the resident's goals and preferences. Pharmacological interventions would follow a systemic approach for selecting medications to treat pain. The facility would consider administering medication around the clock instead of as needed (PRN) or combining longer acting medications with PRN medications for breakthrough pain. Opioids (prescription pain medications like oxycodone) would be prescribed and dosed in accordance with current professional standards of practice and manufacturers' guidelines to optimize their effectiveness and minimize their adverse consequences. Facility staff would notify the provider if the resident's pain was not controlled by the current treatment regimen. Review of the medical record showed Resident 51 was admitted to the facility with diagnoses including neck pain, chronic pain syndrome (a combination of chronic pain and psychological stress that can cause physical illness), lumbar stenosis with neurogenic claudication (a condition that occurs when the spinal canal narrows in the lower back, compressing the spinal nerves causing pain, numbness and weakness in the lower back and legs), and osteoarthritis [(OA) a chronic disease that causes the breakdown of cartilage and bone in the joints, resulting in pain, stiffness, and swelling] of the knee. The 11/11/2024 comprehensive assessment showed Resident 51 was independent with activities of daily living and was cognitively intact. The assessment also showed Resident 51 was receiving scheduled pain medication, PRN medications, and non-medication interventions for pain. An observation and interview on 01/06/2025 at 10:49 AM, showed Resident 51 sitting on the edge of their bed with the over the bed table next to them. They stated, with tears in their eyes, that they had pain in both knees, left hip, and back, and no one believes me. Resident 51 rubbed both knees and stated they were told their knees were bone on bone (the advanced stage of OA when the cartilage in a joint has worn away, causing bone to rub against the bone) and that was causing the pain. Resident 51 stated they received oxycodone every four hours for pain with Tylenol in between the oxycodone doses. Resident 51 rated their current pain level at a seven out of 10 on the pain scale (a tool used to measure the intensity of a patient's pain, with zero representing no pain and 10 representing the worst pain). During an interview on 01/09/2025 at 9:06 AM, Resident 51 stated their left hip and knees hurt. They stated it had been a long time since they had seen a provider. Record review of pain assessments dated 07/30/2024, 08/23/2024, and 11/11/2024 showed Resident 51 had occasional pain, with interventions of distraction, positioning, and rest. The assessments showed pain appears to be fairly well controlled with current plan of care, despite Resident 51 verbalizing and showing non-verbal signs of pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER: Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a physician progress note dated 11/20/2024, showed Resident 51 reported left knee pain and would be interested in a steroid injection (an anti-inflammatory medicine used to treat a range of conditions such as joint pain and arthritis). An order was placed to refer to ortho (the medical specialty that focuses on injuries and diseases of the body's musculoskeletal system) for consideration of steroid injection for Resident 51's knee pain. The progress note also showed Resident 51 was last evaluated by neurosurgery (a medical specialty that involved diagnosing and treating disorders of the nervous system), physiatry (a branch of medicine dedicated to the diagnosis, prevention, and treatment of all types of conditions related to the brain, nerves, bones, and muscles), and orthopedic in 2021-2022 (greater than two years ago) for their chronic pain syndrome and lumbar stenosis with neurogenic claudication. Review of provider notes from an outside orthopedic provider, dated 12/11/2024, showed Resident 51 was seen for pain in both knees. The provider's assessment showed bilateral (both) knee OA, left worse than right. The plan for Resident 51 included the use of Tylenol or nonsteroidal anti-inflammatory drugs (a class of medications used to reduce pain, inflammation, and fever), ice and heat, bracing, and the role of injection therapy and physical therapy. The provider note showed Cortisone (steroid) injections could be considered at some point. Review of the December 2024 medication administration record (MAR) showed Resident 51 had a physician order for Tylenol 650 milligram [(mg) a unit of measure] every four hours PRN pain. Resident 51 received 36 doses of Tylenol and had consistently rated their pain level at a seven or eight out of 10 on the pain scale. The MAR also showed an order for oxycodone 5 mg every four hours PRN pain. Resident 51 received 49 doses and had rated their pain level at a six to eight out of 10 on the pain scale. There was an additional order for oxycodone 10 mg every four hours PRN pain. Resident 51 received 46 doses of 10 mg oxycodone and had rated their pain level at six to nine out of 10 on the pain scale. Record review of Resident 51's care plan dated 11/25/2024, showed interventions for pain management had not been updated since 06/22/2022 and did not show non-pharmacological (a healthcare intervention that doesn't primarily used medication) interventions for pain management. During an interview on 01/13/2025 at 8:55 AM, Staff R, Registered Nurse (RN), stated when Resident 51 rated their pain level at an eight to 10, they administered 10 mg of oxycodone, and for a pain level of six to seven, they administered five mg of oxycodone. They stated Resident 51 would ask for a 10 mg dose, but if they appeared drowsy, they would only administer the five mg dose. Staff R stated, I don't think there are parameters (guidelines) for determining which dose to give. Staff R stated, I just give what I know they need. During an interview on 01/13/2025 at 9:49 AM, Staff B, Directing of Nursing, stated when administering pain medications, the nurses should start at the lowest dose and work their way up. Usually for a lower pain scale, the nurse would give a lower dose. Staff B stated there should be a process in place to ensure there were parameters for medication administration and for converting PRN medications to a scheduled medication. Staff B stated when a resident returned from an outside appointment, the facility provider reviewed the notes and wrote orders based on what was recommended. They stated, unless they send back orders, we don't do anything. (continued on next page)

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	01/13/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/13/2025 at 10:57 AM, the Medical Director stated the orders should read oxycodone five mg for a pain level of four to six, and oxycodone 10 mg for a pain level of seven to 10. The provider stated they would add the parameters, so the orders were clear for the nurses to take care of the resident. During an interview on 01/13/2025 at 1:12 PM, Staff J, RN, stated they would not follow up on steroid injections for Resident 51's knees until (they) complain again, then we will readdress. Staff J stated the oxycodone orders needed to have parameters. Reference: WAC 388-97-0160(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 45642 Based on observation, interview, and record review, the facility failed to ensure the nursing staff posting was posted daily and/or reflected the actual nursing staff hours worked during 4 of 5 days of the survey period. This failed practice prevented residents, family members and visitors from knowing the facility's actual number of available nursing staff. Findings included . Observation on 01/06/2025 at 9:40 AM, showed the nursing staff posting across from the nurses' station was dated 01/03/2025 (three day's prior) and did not show actual nursing staff hours posted for the current day. Observations on 01/07/2025 at 10:09 AM, 01/08/2025 at 8:59 AM, and 01/09/2025 at 8:29 AM showed the nursing staff posting across from the nurses' station was dated 01/03/2025 and did not show any adjustments to nursing staff hours posted for the past four days. Observation on 01/10/2025 at 9:04 AM, and at 3:05 PM, sowed the nursing staff posting across from the nurses' station was dated 01/09/2025 (prior day's date) and did not show actual nursing staff hours posted for the current day. During an interview on 01/13/2025 at 10:45 AM, Staff H, Staffing Coordinator, stated the Staffing levels were based on the facility census. Staff H stated the nursing staff posting was posted daily as adjustments were made on the staff schedule. Staff H stated they filled out the posting forms for the weekend and placed postings in the med room so that nursing could put that out on the weekend. Staff H acknowledged the importance of the posting and stated they would have to revisit with nursing about the postings on the weekends. During an interview on 01/13/2025 at 11:57 AM, Staff B, Director of Nursing, stated they needed a better system. Staff H stated it was news to them that the nursing department was tasked with the daily staff posting for the weekend. During an interview on 01/13/2025 at 12:11 PM, Staff A, Administrator, stated they were made aware of the inconsistency of the nursing staff daily postings. Staff A stated they would be assigning the task to a dedicated staff member to ensure the daily nursing staff posting was done. Reference: WAC 388-97-0020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER: Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 46722 Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than five percent. Two medication errors were identified for 2 of 10 residents (Residents 345 and 8) observed during 26 medication administration opportunities that resulted in an error rate of 7.69%. Errors in medication administration had the potential to place residents at risk for not receiving the full therapeutic effect of the medication and possible adverse side effects. Findings included . Review of the undated policy titled, Insulin Pen, [a pre-filled disposable device containing (insulin - medication to control blood sugar in the blood)] showed when the insulin pen needle was inserted into the skin, the plunger (button) was to be depressed and held into the skin for six to 10 seconds and then removed from the skin. Review of the Instructions for use for an insulin pen by the U.S. Food and Drug Administration revised 07/2023 stated to insert the needle into the skin, press plunger all the way down, and continue to hold the plunger and slowly count to six prior to removing the needle. This step was to ensure the proper dosage of medication was administered. <Resident 8> Review of the medical record showed Resident 8 had diagnoses including diabetes (a group of diseases that results in too much sugar in the blood) and stroke. The 11/13/2024 comprehensive assessment showed Resident 8 required partial/moderate assistance of one staff member for activities of daily living (ADLs) and had an intact cognition. Review of Resident 8's physician orders, dated 07/07/2024, showed the resident's insulin order was to administer eight units (unit of measure) subcutaneously (under the skin) with an insulin pen twice daily. Resident 8 had an additional physician order dated 07/07/2024 to administer insulin on a sliding scale based on the resident's current blood glucose result. Resident 8's blood glucose was 255 milligrams/deciliter, [(mg/dl) a unit of measure]. The sliding scale showed based on a blood glucose of 251-300 mg/dl Resident 8 was to have four units of insulin. An observation on 01/09/2025 at 11:51 AM, showed Staff C, Licensed Practical Nurse, (LPN), administer 12 units of insulin with the insulin pen to Resident 8. Staff C held the needle into the resident's right upper arm for two seconds. <Resident 345> Review of the medical record showed Resident 345 had diagnoses including a kidney infection and diabetes. The 01/04/2025 comprehensive assessment showed Resident 345 supervision of a staff member for ADLs and had an intact cognition. Review of Resident 345's physician orders, dated 01/02/2025, showed the residents insulin order was to administer eight units subcutaneously with an insulin pen before meals and at bedtime. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview on 01/09/2025 at 12:03 PM, showed Staff C administer seven units of insulin with the insulin pen to Resident 345. Staff C held the needle into the resident's right upper arm for three seconds. Staff C stated to ensure the entire dose of insulin was administered was to hold the needle into the Resident's skin for a second or two. During an interview on 01/10/2025 at 3:10 PM, Staff B, Director of Nursing, stated the insulin pen needle was to be injected into the Resident's skin and press the plunger on the insulin pen until the insulin was emptied about a second or two. Reference WAC: 388-97-1060(3)(k)(ii)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46722 Based on observation, interview, and record review, the facility failed to ensure expired medications were removed from use for 2 of 4 medication carts (South and North) and 1 of 4 medication carts (East), and 1 of 2 wound carts were secured when unsupervised. Additionally, the facility failed to follow Centers for Disease Control (CDC) guidance for temperature monitoring of vaccines in 1 of 1 medication storage refrigerator located in the medication storage room. These failures placed the residents at risk for receiving expired medication and/or experiencing compromised or ineffective medications and vaccines and access to potentially harmful medications and negative health outcomes. Findings included . Review of the undated policy titled, Medication Storage, showed all medications and biological's would be stored and locked and under proper temperature control. The policy also showed the medication carts, when not under direct supervision, must be locked. Review of the CDC guidance titled, Vaccine Storage and Handling, dated 04/03/2024, showed to ensure safety of vaccines, the refrigerator must have a reliable temperature monitoring device with the recommended use of a recording device called a digital date logger (DDL-a device that records temperatures at least every 30 minutes). The guidance further showed when a DDL was not used, the facility should monitor and record the vaccine refrigerator temperature at a minimum of twice daily. <South Hall Medication Cart> During an observation and interview on 01/10/2025 at 1:10 PM, Staff C, Licensed Practical Nurse, stated the nurses were responsible for reviewing the medication carts for expired medications. The South Hall medication cart and the North Hall medication cart at the nurse's station contained the following expired medications: -Six bottles of Nystatin (anti-fungal) powder medication, expired on 09/06/2024, 11/05/2024, 11/24/2024, 12/09/2024, 12/16/2024, and 12/25/2024. -One tube of Nystatin cream, expired 11/05/2024. -One tube of Ketoconazole (anti-fungal) cream, expired 11/19/2024. -One tube of Ciclopirox (anti-fungal) cream, expired 11/19/2024. -One bottle of GI Cocktail (used for abdominal discomfort), expired on 12/04/2024. -Four containers of Nitroglycerin (used for severe chest pain), expired 07/11/2024, two containers expired on 12/24/2024 and 01/04/2025. -One Flonase Spray (anti-inflammatory spray for nasal allergy symptoms), expired 11/01/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Two Albuterol inhalers (medication to help open airway during breathing problems), expired 10/16/2024 and 12/09/2024. -Two tubes of wound gel (medication to promote wound healing), expired 04/2023 and 11/29/2024. <North Hall Medication Cart> -4 containers of Ondansetron (anti-nausea) medication, expired 11/30/2023, 09/18/2024, 10/22/2024, and 01/09/2025. -One Albuterol inhaler, expired on 12/23/2024. -One bottle of Chlorhexidine Gluconate (mouthwash to reduce bacteria in the mouth), expired on 09/13/2024. <Medication Room Refrigerator> During an observation and interview on 01/10/2025 at 2:53 PM, showed the medication refrigerator contained respiratory syncytial virus [(RSV) a contagious virus that causes infection in the respiratory tract] and influenza (a contagious viral infection) vaccines. The medication refrigerator temperature log showed temperature checks were done once a day. Staff C stated the night shift nursing staff were responsible for recording the temperatures once a day. During an interview on 01/10/2024 at 3:01 PM, Staff B, Director of Nursing, stated the medication refrigerator had the temperature recorded once a day by night shift nurses and was unsure if the medication refrigerator was required to be monitored and recorded more than once a day. <East Hall Medication Cart> An observation on 01/08/2025 at 10:50 AM, showed Staff Z, Registered Nurse, walk away from the unlocked East Hall medication cart and enter a resident's room. At 10:55 AM, Staff Z returned to the medication cart, prepared medications for a resident, then locked cart. An observation on 01/08/2025 at 4:10 PM, showed Staff Z walk away from the unlocked East Hall medication cart and obtained a used drink cup from a resident in the hallway. Staff Z proceeded down the hallway to the kitchen and returned the drink cup. <Wound Treatment Cart> An observation on 01/09/2025 at 11:24 AM, showed Staff C standing at the wound treatment cart, that contained vaccines, needles, wound creams, and medicated ointments. Staff C obtained a vaccine for a resident, gathered supplies, and walked away from the unlocked wound treatment cart. The wound treatment cart did not have a locking mechanism to secure the medications/vaccines. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/10/2025 at 3:10 PM, Staff B stated all medication carts were to be locked when not in use. Staff B stated they were aware that the wound treatment cart was unable to be locked. Staff B stated that cart should not contain any medications or vaccines and when the cart was used, the cart was to be turned toward the wall to prevent the drawers from being opened and accessed. Staff B stated when staff were required to administer a vaccine, they should obtain them one at a time and prepare them in the medication storage room. Staff B stated the nurses should not t place vaccines in the wound treatment cart. Reference WAC: 388-97-1300(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER: Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48368 Based on observation, interview and record review, the facility failed to 1) store Potentially Hazardous Food (PHF, food that requires time/temperature controlled to limit the growth of bacteria) and dry goods that did not have the proper labels and dates for food safety tracking for 1 of 1 kitchen reviewed, 2) adequately disinfected food preparation areas to prevent cross contamination (harmful spread of diseases) for 1 of 1 kitchen reviewed. These failures placed residents at an increased risk for food borne illnesses. Findings included . Review of the Washington State Retail Food Code [PHONE NUMBER]6(1)(2)(a,b)(3)(4), dated March 1, 2022 showed ready-to-eat or refrigerated, time/temperature control for food safety must be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than twenty-four hours, to indicate the date or day by which the food must be consumed on the premises. Prepared foods must have the date or day of preparation, with a procedure to discard the food on or before the last date or day the food can be consumed on the premises. Additionally, the concentration of the sanitizing solution must be accurately determined by using a test kit or other device, and the results of the testing must be logged. Review of facility's policy titled, Food Safety Requirements, dated 2023, showed to store food in a manner that helped prevent deterioration or contamination of the food, including growth of microorganisms. Staff were to label and date all foods when opened and the date when the food items must be used by. An observation on 01/06/2025 at 9:40 AM, showed the following items in the kitchen: <Refrigerator> One, eight-quart (unit of measure) container of green beans, no use by date. One, eight-quart container of peas, no use by date. One, eight-quart container with chicken noodle soup, no use by date. One, gallon (unit of measure) zip lock baggie with shredded American cheese, no use by date. One, 32-ounce (unit of measure) bag of carrots, no use by date. One, gallon of thickened cranberry juice, unlabeled, no use by date. One, gallon of health shake (meal replacement), unlabeled, no use by date. Three, sixteen ounce whipped topping bags, unlabeled, no use by date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Freezer #1> Two, ten-pound (lb-a unit of measure) ground beef roll with no date received or used by date. One, five-lb diced ham roll with no date received or used by date. <Freezer #2> 12 pieces of battered fish in two-gallon zip lock bags with white ice crystals on the fish appearing as freezer burn (caused by food not being securely wrapped in air-tight packaging) unlabeled, no open date or used by date. (60) Biscuits (dough) in a clear bag, unlabeled, no open or used by date. Four, four-packs of garlic bread in clear bags, unlabeled, no open or use by date. Six packs of garden vegetable soup, no date received or use by date. Two packs of cream of potato soup, no date received or use by date. Two packs of chicken noodle soup, no date received or use by date. <Freezer #3> One, five-lb bag of chicken breast, unlabeled, no open date or use by date. One, five-lb bag of pork sausage patties, unlabeled, no open date or use by date. One, five-lb bag of beef hot dogs, no received date or use by date. Three, four-lb bags of chili, no received date or use by date. Four beef steaks with white ice crystals on the steaks appearing as freezer burn, unlabeled, open date of 11/03, no use by date. One, ten-lb ham, pork roll no received date and no use by date. Ten cinnamon rolls (dough) in gallon zip lock bag, unlabeled, no open date and no use by date. During an interview on 01/06/2025 at 10:00 AM, Staff E, Dietary Department Director, stated the process for all foods was to be labeled, have an open/received date and a use by date that was dated for three days after the food item was opened. Staff E stated the items observed in the refrigerator and freezers should have been labeled, dated when opened/received with a used by date and the process was not being followed. <Disinfectant Buckets> (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the manufacturer's instructions for Disinfectant Multi Quat 146 (a chemical used to kill germs on surfaces) showed the parts per million (PPM- the concentration of the disinfectant solution in water) should be between 150 and 400 and the buckets should be tested every two to four hours or when the solution becomes dirty. During an observation and concurrent interview on 01/06/2025 at 10:17 AM, Staff E tested a bucket of Disinfect Multi-Quat 146 solution. Staff E stated the bucket of solutions were used to clean the counter tops. The test strip showed the solution had 100 PPM on the test strip and was outside of the normal concentration range of 150 to 400 PPM to prevent cross contamination. Staff E stated they did not have a process for testing the solution in the disinfectant buckets, and they change them about every four hours. Reference: WAC 388-97-1100(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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** 45117 Based on interview and record review, the facility failed to implement an effective Infection Control and Prevention Program (IPCP) including implementation of infection prevention measures to mitigate the spread of infection in the areas of hand hygiene for 1 of 1 staff (Staff Q) during dining service, cleaning of equipment for 8 of 8 staff (Staff W, Y, S, V, T, U, AA, and BB) during transfers with a mechanical lift, wound care for 1 of 1 staff (Staff C) while performing a dressing change, enhanced barrier precautions (a set of infection control measures that use gowns and gloves to reduce the spread of multidrug-resistant organisms) for 7 of 7 staff (Staff EE, L, CC, FF, GG, HH, and N) during high contact resident care, transmission-based precautions (additional infection control precautions used in healthcare to prevent the spread of disease) for 2 of 2 staff (Staff U, and AA) while in an isolation room, and food service for 4 of 4 meal carts (Main, North, East, and West) during meal service. These failures placed the residents and staff at risk for transmission of communicable disease and food borne illnesses. Findings included . Review of Centers for Disease Control and Prevention (CDC) guidance titled, Clinical Safety: Hand Hygiene for Healthcare Workers, dated 02/27/2024, showed hand hygiene protects both healthcare personnel and patients. Hand hygiene means cleaning your hands with soap and water or alcohol-based hand rub (ABHR). Hands should be cleaned immediately before touching a patient, before performing a task such as placing an indwelling device or handling medical devices, before moving from work on a soiled body site to a clean body site on the same resident, after touching a patient or their surroundings, after contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal. Review of the Association for Professionals in Infection Control and Epidemiology (APIC) guidance titled, Strategies to Mitigate Cross Contamination of Non-critical Medical Devices, dated 2021, showed non-invasive portable clinical items shared among patients may pose a threat of pathogen transmission. These items were typically not assigned to a specific patient and may be overlooked when establishing routine disinfection practices. Micro-organisms could live on surfaces for long periods of time, depending on the surface material, air temperature and humidity, and the presence of organic material. At a minimum, non-critical patient care devices are disinfected when visibly soiled and on a regular basis (between patients or once daily or weekly). Review of a policy titled, Clean Dressing Change, undated, showed the facility would provide wound care in a manner to decrease the potential for infection and/or cross contamination. Staff should set up a clean field on the over bed table with the needed supplies for the wound cleaning and dressing. If the table was soiled, it should be wiped clean. Place a disposable cloth or barrier on the table. Place only the supplies to be used for the wound on the clean field, one at a time. Establish an area for soiled products to be placed. Wash hands and put on clean gloves. Remove the existing dressing. Remove gloves, pulling inside out over the dressing, discard into the appropriate receptacle. Wash hands and put on clean gloves. Cleanse the wound and pat dry with gauze. Measure the wound or perform photo documentation. Wash hands and put on clean gloves. Apply topical ointments/creams and dress the wound as ordered. Discard the disposable items and gloves into the trash receptacle and wash hands. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the CDC guidance titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDRO), dated 04/02/2024, stated Enhanced Barrier Precautions (EBP) were an infection control intervention used to reduce the transmission of resistant organisms. EBPs require the use of a gown and gloves during high contact resident care activities. EBPs may be indicated for residents with wounds or indwelling medical devices, infection, or colonization (the process where a microorganism establishes itself on or within a host organism, growing and multiplying without causing any noticeable symptoms or immune response) with an MDRO. Review of the CDC guidance titled, Transmission-Based Precautions, dated 04/03/2024, showed TBPs are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission and include Contact Precautions (the use of PPE that includes a gown and gloves for all interactions that may involve contact with the patient or patient's environment, Droplet Precautions (PPE includes use of a mask and eye protection when entering the room, a gown, and gloves), and Airborne Precautions (PPE includes use of a respirator, face shield/goggles, gown, and gloves). Donning (putting on) PPE when entering the room and properly discarding before exiting the patient room was done to contain pathogens. Review of the CDC guidance titled, Single-Dose or Muli-Dose, undated, showed during the procedure, use aseptic (a set of practices that keep a sterile environment and prevent the spread of microorganisms), be sure to clean your hands immediately before handling any medication. Disinfect the medication vial by rubbing the diaphragm (rubber stopper) with alcohol. Draw up all medications in a clean medication preparation area. Review of an undated policy titled, Food Safety Requirements, showed foods and beverages would be distributed and served in a manner to prevent contamination and maintain food at the proper temperature. All foods would be covered when traveling a distance (down a hallway or to a different unit). <Hand Hygiene> An observation on 01/06/2025 at 11:47 AM, showed Staff Q passing out lunch trays in the dining room, ungloved. Staff Q used a spoon to take butter out of a container, placed the butter on the resident's mashed potatoes, and mixed them up. Staff Q walked to the garbage and threw away the butter container, wiped their hands on their shirt, and grabbed another butter container off of the tray cart, without performing hand hygiene. Staff Q walked over to the same resident, placed more butter on their mashed potatoes, and mixed them up. Staff Q was leaned over the table with both hands on the table. Staff Q grabbed a juice cup and a soiled lunch tray from the same table, walked to the soiled cart, and removed all the items off the soiled tray, one by one with no gloves on and left the dining room without performing hand hygiene. During an interview on 01/13/2025 at 11:12 AM, Staff B, Director of Nursing, stated all staff were required to adhere to CDC guidelines for hand hygiene. <Equipment> (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 01/09/2025 at 3:41 PM, Staff W, Nursing Assistant (NA), and Staff Y, NA, used a mechanical lift in room [ROOM NUMBER]. The resident equipment was removed from the room and placed in the hallway without sanitation. Staff W stated, we are going to use it again, when we are done, we put the equipment in the soiled utility room. Staff Y and Staff W entered room [ROOM NUMBER] with the un-sanitized mechanical lift and used the equipment for the resident in the first bed. The mechanical lift was then parked in the hallway with no sanitation after being used. Staff Y and Staff W then entered room [ROOM NUMBER] with the un-sanitized mechanical lift and used the mechanical lift to transfer a resident. Staff Y placed the equipment into the soiled utility room no sanitation after use. Staff Y stated they usually had a container of germicidal (something that kills germs such as bacteria's and viruses) wipes on the mechanical lift, and they would wipe down the equipment, but did not have the wipes at the time. During an observation on 01/09/2025 at 3:46 PM, Staff S, NA, and Staff V, NA, used a mechanical lift in room [ROOM NUMBER] to transfer a resident and then placed the equipment in into the soiled utility room. The mechanical lift was not sanitized after use. Staff S stated they would have used a germicidal wipe to clean the mechanical lift after use, I just forgot to do it. During an observation and concurrent interview on 01/10/2025 at 9:51 AM, Staff T, Helping Hands, entered a resident room with a mechanical lift. Staff U, NA, entered the room to assist with the transfer. Staff U removed the mechanical lift from the resident room after use and placed it into the soiled utility room without sanitizing it. Staff U stated they did not realize the sanitation had not been done, they assumed Staff T had done it. During an observation on 01/10/2025 at 8:42 AM, Staff AA, NA, exited a resident room with a mechanical lift. Staff AA pushed the mechanical lift into another resident room (under TBPs) without cleaning the lift between uses. During a second observation at 9:03 AM, Staff AA, after using the mechanical lift in the TBP room, used one disinfectant wipe and wiped the handle of the mechanical lift. Staff AA pushed the lift down the hall and into the soiled utility room and parked the lift in front of the sink. Observation of the soiled utility room at 9:12 AM, showed a countertop and sink area that ran the length of the wall on the right side of the room. The sink contained standing water with debris floating on the surface, three bed pans with feces on them, two soiled bedside commode buckets, and a trash can. There were four mechanical lifts parked in front of the countertop/sink, including the mechanical lift parked by Staff AA. During an interview on 01/10/2025 at 9:14 AM, Staff BB, NA, entered the soiled utility room and stated the soiled utility room was used to store things like trash, bedpans, and the mechanical lifts. Staff BB stated the process for using the lifts was to clean them when leaving the resident room, park them in the soiled utility room after use, and again prior to entering a resident room. During a concurrent observation and interview on 01/25/2025 at 9:21 AM, Staff J, Infection Preventionist (IP), entered the soiled utility room and stated the sink should not contain soiled bed pans. They stated staff were not following the process for cleaning the soiled bed pans which included the posted instructions above the sink if you are bringing soiled items in, please take the time to clean them and put them to dry, it is not sanitary leaving them in here dirty. Staff J stated equipment that was clean should not be stored in the soiled utility room but I'm not sure where else they could be stored. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/13/2025 at 10:14 AM, Staff B stated the night shift was responsible for cleaning the soiled supplies in the soiled utility room. They stated the mechanical lifts should not be stored in the soiled utility room. Staff B stated the process was not followed for cleaning of equipment and storage of the mechanical lifts. <Wound Care> During a concurrent observation and interview on 01/10/2025 at 3:11 PM, Staff C, Licensed Practical Nurse (LPN), stated they were ready to perform a dressing on a resident's left lower leg wound. Staff C put on gloves, without first performing hand hygiene, at the treatment cart parked in the hallway outside the resident room. They obtained a tube of ointment from the cart, squeezed a small amount into a medication cup, place the tube back into the medication cart and removed their gloves. Staff C gathered the remaining supplies from the cart, entered the resident room and obtained gloves from the sink area. They placed a tissue on the resident's bedside table on top of a notebook, next to a urinal containing residual fluid, cellphone, glass of water, chocolate milk, and a medication cup of high protein liquid supplement. Staff C placed the gloves and the stack of dressing supplies on the tissue barrier. Staff C, without performing hand hygiene, put on gloves and removed the soiled dressing. They placed the dressing in the trash, removed their gloves, and without performing hand hygiene, they put on clean gloves and proceeded to cleanse the wound with normal saline and gauze. They placed the soiled cleansing items in the trash, removed gloves, and, with performing hand hygiene, put on clean gloves. Staff C opened a gauze package and dried the wound surface, applied the ointment with cotton applicators, and placed a dressing over the wound. Staff C removed a roll of tape that was stuck to their shirt and taped the dressing to the left lower leg. At 3:22 PM, Staff C stated the resident they did not sanitize their hands before starting and between glove changes. They stated they had placed a barrier between the urinal and items on the bedside table, but it was probably not the best process to have the clean supplies next to a urinal. Staff C stated they did not wear a gown during wound care because the resident was not on EBPs. They stated EBPs were only required for chronic, unhealing wounds, indwelling catheters (a tube that is inserted into the bladder and left in place to drain urine) and maybe feeding tubes. <Enhanced Barrier Precautions> An observation on 01/09/2025 at 9:24 AM, showed Staff EE, Physical Therapist, working with a resident that had an indwelling catheter, in the therapy gym, without wearing PPE as required. During an observation on 01/09/2025 at 9:31 AM, Staff L, LPN and Staff CC, RN, performed a dressing change on a pressure ulcer. Neither Staff L nor Staff CC wore a gown during the dressing change as required. An observation on 01/09/2025 at 9:34 AM, showed EBP signage outside and above the resident's room [ROOM NUMBER]. Staff FF, NA, was changing bed linens in the room without wearing a gown. Staff FF removed the resident's soiled linens and rolled them into a ball on their bed. Staff FF gathered the soiled linens and held them against their clothing and placed the linens into a clear plastic bag. Staff FF exited the resident's room, took the soiled linen bag to the soiled utility room and placed it into the soiled linen bin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 01/10/2025 at 8:53 AM, showed Staff GG, RN, entered room [ROOM NUMBER] (designated as an EBP precautions room), don gloves (no gown), and lift the resident's gown to expose the leg strap that held the indwelling catheter tubing to their leg. Staff GG, attempted to loosen the leg strap and readjust for the resident's comfort. Staff GG stated to the resident they would have a nursing assistant return and assist the resident with their catheter leg strap. At 8:55 AM, Staff HH, NA, entered the resident's room, washed their hands, donned gloves and obtained a PPE gown from a plastic bin behind the resident's recliner and curtain. Staff HH proceeded to assist the resident to stand up and adjust their leg strap. The resident used the transfer pole for stability, stated they needed to use the bedside commode, and sat down in their wheelchair. Staff HH obtained the bedside commode and placed it near the resident. Staff HH removed their gown and gloves, closed the residents window blinds and donned new gloves, no required gown. Staff HH obtained a clear bag and placed inside the commode bucket, assisted the resident to stand, removed their brief, and sat them down onto the commode. Staff HH moved the resident's indwelling catheter bag from the wheelchair to the commode. Staff HH removed their gloves, provided the resident with a call light, washed their hands, and exited the room. An observation on 01/10/2025 at 9:03 AM, showed EBP signage outside and above the resident's room [ROOM NUMBER]. Staff HH, NA, assisted the resident into their room with their wheelchair. Staff HH washed their hands and donned gloves, no gown as required. Staff HH removed the resident's jacket and footrests from the wheelchair. Staff HH assisted the resident to stand with a transfer pole, grabbed the back of their pants, and pivoted the resident to sit onto their bed. Staff HH bent down and raised the resident's legs onto their bed. Staff HH removed the resident's shoes and placed their indwelling catheter bag onto the side of the bed frame, removed their gloves, and donned new gloves. Staff HH adjusted the head of the bed for the resident's comfort and covered them with a blanket. An observation on 01/13/2025 at 9:10 AM, showed Staff N, NA, enter room [ROOM NUMBER] to assist the resident to use the bedside commode. Staff N obtained washcloths and a clear plastic bag. Staff N donned gloves, no gown (as required), and turned on the warm water to moisten the washcloths. They rung them out the washcloths and placed them into the clear plastic bag. Staff N went to the resident's bedside and assisted them into a sitting position on the side of their bed. Staff N stated to the resident, their indwelling catheter bag was full of urine, and they would empty it prior to using the commode. Staff N obtained a urinal from the resident's bathroom and drained the urine from the catheter bag into the urinal. Staff N went into the resident's bathroom, poured the urine into the toilet, and flushed it. Staff N removed their gloves and donned a new pair without hand hygiene. Staff N returned to the resident and unhooked the resident's indwelling catheter bag from the bed and hooked it onto the commode. Staff N placed a gait belt around the resident's waist to assist them to a standing position, removed their brief, and pivoted them to sit on the commode. Staff N removed their gloves and washed their hands. Staff N donned new gloves, obtained the soiled urinal, exited the resident's room, and entered the soiled utility room. Staff N put the soiled urinal into the wash sink, filled with water and cleaner until sudsy, poured the water into the toilet, and rinsed the urinal with water. After the urinal was rinsed, Staff N removed one of their gloves, held the urinal in the ungloved hand, and placed it onto a drying table next to the wash sink. While still wearing one soiled glove, Staff N reorganized the room by moving two resident lifts from the center of the soiled utility room towards the back of the room. Staff N closed the soiled linen hamper lid, exited the room with resident's urinal, and placed it back in the resident's bathroom while wearing the one soiled glove. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER: Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/13/2025 at 9:03 AM, Staff EE stated they when they assisted residents with their physical therapy, they wore gloves. Staff EE stated when a resident was on precautions, they would not take the resident out of their room. Staff EE stated they had not seen many residents in the facility with precautions. Staff EE stated they were not well versed on all types of precautions. During an interview on 01/13/2025 at 10:09 AM, Staff B stated the process for EBPs included wearing gloves and gown when providing cares for any resident with a chronic wound, indwelling device (devices that are left inside the body for a period of time), feeding tube, or catheter. Staff B stated they received education from corporate staff regarding the use of EBPs and were taught that not all wounds required the use of a gown; only the wounds that were chronic. After observation of the EBP signage in use by the facility, Staff B stated they had been educated incorrectly and all residents with wounds required the use of EBPs. During an interview on 01/13/2025 at 10:14 AM, Staff II, NA, stated when residents were on EBP, they were to follow the sign instructions during close contact for any residents with indwelling catheters, wounds, or when they were in isolation for influenza, COVID-19 (an infectious disease-causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases, difficulty breathing, that could result in severe impairment or death) or any others. Staff II stated they only needed to wear gowns for indwelling catheter and/or personal cares. During an interview on 01/13/2025 at 10:21 AM, Staff N stated when a resident was on EBP, they were to follow the instructions on the sign when they performed personal care for a resident with an open wound or an indwelling catheter. Staff N reviewed the sign on resident room [ROOM NUMBER] and stated they should have worn a gown and followed the instructions when they provided personal cares. Staff N stated they did not follow the instructions. During an interview on 01/13/2025 at 12:40 PM, Staff J stated EBPs were only required for residents that had a feeding tube, catheter (a flexible tube that is inserted into the body to drain or deliver fluids), or a chronic wound (a wound that does not heal properly or within a normal time frame). Staff J stated they were not aware that all wounds required the use of EBPs. <Transmission Based Precautions> During an observation on 01/10/2025 at 8:40 AM, showed a resident room with a blue Contact Enteric Precautions (a type of infection control practice used to prevent the spread of infections transmitted through direct contact with fecal matter) sign on the wall next to the door. Perform hand hygiene before entering room or cubical and wash hands with soap and water for 15 seconds before leaving room. Gloves when entering room. Gown for direct patient care or whenever clothing may contact surfaces or equipment in the room. Families and guests: clean hands upon entering and wash hands with soap and water upon exiting room. Wear a gown and gloves while in the room and remove before exiting the room. Staff U, NA, entered the entrance to the resident room, without gown or gloves, pulled the curtain back, and took the residents meal tray from their bedside table. Staff U exited the room, placed the tray on the meal cart in the hallway, used ABHR, and entered another resident room, despite the PPE instructions on the resident room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER: Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 01/10/2025 at 8:42 AM, Staff AA, NA, entered the Contact Enteric Precautions room without wearing gown or gloves, and shut the door behind them. At 8:46 AM, after putting on gown and gloves, this surveyor observed Staff AA in the resident room, wearing gloves, tending to the resident in their bed, adjusting their clothing and bed linens. Staff AA was not wearing a gown as required. Staff AA removed their gloves, used ABHR, exited the room and closed the door. Staff AA re-entered the room at 8:49 AM wearing the required PPE (gown and gloves) and continued providing resident care, including placing a mechanical lift sling under the resident. At 8:51 AM, Staff U entered the resident wearing full PPE and assisted Staff AA with the mechanical lift to place the resident in their wheelchair. While wearing the same gloves, Staff AA obtained the residents hairbrush from the sink area and brushed the resident's hair. Staff U removed all bed linens from the bed and placed them into a bag. Staff AA removed their gown and gloves, washed their hands with soap and water for five seconds, and exited the resident room with the resident and pushed them down the hall. Staff U removed the linens from the resident's bed, placed them into a bag, removed their soiled PPE, and washed their hands for 25 seconds with soap and water. Staff AA put gloves on, picked up the bag and carried it to the soiled utility room. During an interview on 01/10/2025 at 9:36 AM, Staff AA stated they should have put on gown and gloves when entering the resident's room. They stated when done with cares, they should have taken off the gown and gloves and washed their hands with soap and water for at least 20 seconds. Staff AA stated they did not follow the process for PPE and handwashing. During an observation and interview on 01/10/2025 at 9:24 AM, Staff J reviewed the posted Contact Enteric Precautions and stated it was not the sign that they had posted. Staff J stated the sign they had posted had the correct precautions of wearing a gown and gloves when entering the room. They stated they did not know where the blue sign had come from, and it had incorrect information on it. <Medication Administration> An observation and interview on 01/09/2025 at 11:24 AM, showed Staff C, LPN, obtained a vial of a vaccine for a resident. Staff C stated they did not clean the tops (rubber stoppers) of new medications/vaccines as they had not been accessed and still had the flip caps on. Staff C did not disinfect the rubber stopper with alcohol prior to mixing the vaccine per CDC guidance. An observation on 01/09/2025 at 11:44 AM, showed Staff C prepared an insulin pen [a device that injects insulin (medication to control blood sugar) into the body] for a resident. Staff C removed the resident's insulin pen from the medication cart, obtained a new needle, and attached the needle to the previously used resident insulin pen without disinfecting the rubber seal as required. A second observation at 12:03 PM, showed Staff C prepare an insulin pen injection for another resident using that same practice. During an interview on 01/10/2025 at 3:10 PM, Staff B stated the process and expectation for safe injection practice, was to clean the top of the medication/vaccine vial with alcohol to ensure the dirt, dust, and biofilm (a thin, slimy bacteria on a surface) was removed prior accessing the vial or attaching a new needle to a reusable insulin pen to prevent the spread of germs. <Food Service> (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 01/06/2025 at 12:23 PM, a meal delivery cart was brought to the North Hall. The cart contained meal trays, each tray containing a covered entree, glasses of beverages that were uncovered, salads that were uncovered, and desserts that were uncovered. Staff OO, Activities Aide, opened the meal cart, removed a tray with the uncovered foods and drinks and delivered it to a resident room, leaving the cart door open and the cart unattended. There was a housekeeping cart containing mop water, cleaning solutions, and soiled clothes one doorway away from the open meal cart. Staff OO returned to the meal cart and continued to deliver the trays with uncovered foods/drinks to the remaining resident rooms, while leaving the cart door open. Staff OO stated they did not normally deliver meals to the resident rooms and should have closed the meal cart door. During observations on 01/08/2025 of the Main dining room cart at 11:39 AM, the [NAME] Hall cart at 11:55 AM, the East Hall cart at 12:04 PM, and the North Hall cart at 12:22 PM, showed the drinks and desserts (apple pie mousse) were not covered prior to leaving the kitchen. The carts traveled down the hallways into the different units. During an interview on 01/13/2025 at 10:56 AM, Staff E, Dietary Department Director, stated all drinks and desserts were covered by the insulated carts not individually. Reference: WAC 388-97-1320(1)(c)(2)(a)(5)(c)(e) 45642 46722 48368

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER Cashmere Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 45117 Based on interview and record review, the facility failed to ensure there was a designated Infection Preventionist (IP) who worked at least part-time at the facility and was responsible for the facility's Infection Control and Prevention Program (IPCP), including implementation of infection prevention measures to prevent the spread of communicable diseases. These failures placed the residents at risk for transmission of infectious disease and unmet care needs. Findings included . Review of the undated policy titled, Infection Preventionist, showed the infection preventionist was employed on site and at least part time. They were scheduled with enough time to properly assess, develop, implement, monitor, and manage the IPCP, address training requirements, and participate in required committees such as Quality Improvement and Performance Improvement (QAPI). Review of the Facility Assessment (FA), dated 09/20/2024, showed the need for an IP to develop and regularly update infection control protocols, personal protective equipment availability, and vaccination availability. The FA did not show the number of IP hours per week required for the needs of the resident and staff had been assessed. During an interview on 01/10/2025 at 9:19 AM, Staff J, IP, stated they had been in the IP role for under a year. They stated they spent approximately 15% of their working hours devoted to infection control and the rest of their time as a Resident Care Manager (a licensed nurse that is responsible for supervising, implementing, coordinating, and managing resident care). Staff J stated Staff B, Director of Nursing, shared some of the IP duties. Staff J stated they were able to keep up on antibiotic use but spent the majority of their time managing resident care. During an interview on 01/13/2025 at 10:14 AM, Staff B stated they did not perform any IP duties. They stated Staff J was the IP and that 15% of their time devoted to IP duties was not enough to cover the needs of the facility. Staff B stated Staff J probably needs more time to complete the IP duties. Refer to F880, Infection Control Reference: WAC 388-97-1320(1)(a)