STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505181	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redmond Care and Rehabilitation Center	7900 Willows Road Northeast Redmond, WA 98052

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on interview and record review, the facility failed to ensure allegation of abuse was reported to the State Agency for 1 of 3 residents (Resident 237), reviewed for abuse allegations. This failure placed the resident at risk for potential unidentified abuse and lack of protection from abuse. Findings included . Review of the facility's policy titled, Abuse Prevention & [and] Investigation, revised in July 2015, showed, It is the policy of the facility that all suspected, alleged, or actual cases of resident abuse, including injuries of unknown origin, shall be thoroughly and completely investigated and reported according to State and Federal regulations. Review of the Nursing Home Guidelines, The Purple Book, dated October 2015 (sixth edition), showed injuries of unknown source means any injury sustained by a resident where the source of the injury was not observed directly by staff, or the resident is not able to report/inform how the injury occurred. It further showed, Substantial injuries of unknown source, even if they do not appear to be due to abuse or neglect, must be reported to the Department; because the injuries may have resulted from failure to take preventative measures. Resident 237 admitted to the facility on [DATE] with diagnosis that included dementia (a cognition that affects thinking, memory, reasoning, personality, mood, and behavior). Review of the facility's January 2024 incident log dated 01/16/2024, showed Resident 237 had a left shoulder suspicious fx [fracture - a partial or complete break in a bone]. It further showed under the heading hotline notified (yes/no) was N [not notified]. Review of the facility's investigation report dated 01/19/2024, showed Resident 237 was found lying on their back by the entry door of their room with left temporal (head) bleeding and complained of left shoulder/back pain on 01/16/2024. Resident 237 was sent to the emergency room and returned to the facility the same day with an x-ray result concerning for fracture in the scapula (shoulder blade). It further showed that Resident 237 was unable to say what she was trying to do. Additionally, the investigation report showed that Staff R, Licensed Practical Nurse, reported that Resident 237 was unable to recall what had happened. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505181	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redmond Care and Rehabilitation Center	7900 Willows Road Northeast Redmond, WA 98052

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing progress notes dated 01/17/2024, showed Resident 237 returned from the hospital with a diagnosis of a closed fracture of the left upper arm, facial laceration, and injury of the head. On 06/06/2024 at 2:53 PM, Staff R stated that Resident 237 was not able to state what had happened on 01/16/2024. In an interview and joint record review on 06/10/2024 at 9:46 AM, Staff K, Assistant Director of Nursing, stated their policy for reporting of unobserved falls with substantial injury depended on if they ruled out abuse or neglect. Staff K stated it was not usually called in to the State Agency because they knew what had happened and ruled out abuse. Joint record review of the January 2024 incident reporting log showed that Resident 237's incident dated 01/16/2024 under the heading hotline notified (yes/no) was an N. Staff K stated N meant that it was not reported to the State Agency. Staff K stated Resident 237 stated they had a fall but was unable to give the details of what had happened. On 06/10/2024 at 10:58 AM, Staff A, Administrator, stated that they followed the Purple Book for guidelines for abuse reporting. Staff A stated if a resident had a serious unknown substantial injury, they would report it to the State Agency within the required timeframes. Reference: (WAC) 388-97-0640 (5)(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505181	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redmond Care and Rehabilitation Center	7900 Willows Road Northeast Redmond, WA 98052

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 Note: The nursing home is disputing this citation.	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on interview and record review, the facility failed to ensure 1 of 6 residents (Resident 1), reviewed for the Preadmission Screening and Resident Review (PASRR - a federally required screening of all individuals who has an Intellectual Disability (ID) or Related Condition and/or a Serious Mental Illness (SMI) prior to admission to a Medicaid-certified nursing facility or a significant change of condition). Resident 1 had a positive Level I PASRR (a screening to determine if a resident may have a SMI/ID related condition and if a Level II PASRR is required), and a Level II PASRR (an in-depth evaluation to determine whether the resident requires specialized rehabilitation services) was not completed or followed up on after referral. This failure placed the resident at risk for unmet care needs, unmet mental health needs, and a decreased quality of life. Findings included . Review of the facility's policy titled, PASRR, revised in September 2018, showed, A PASRR shall be completed on every resident upon admission. Based upon the assessment, the facility will ensure proper referral to appropriate state agencies for the provision of specialized services to residents with mental illness. Resident 1 readmitted to the facility on [DATE]. Review of Resident 1's Level I PASRR, dated 05/16/2023, showed the resident had diagnoses of depression (mood disorder), anxiety (a feeling of fear and worry), and psychotic disorder (serious mental illness that affects the mind), and a Level II PASRR evaluation referral was required for their SMI. In an interview and joint record review on 06/06/2024 at 9:42 AM, Staff J, Social Services Director, stated they referred residents for Level II PASRR when there were SMI indicators. A joint record review of Resident 1's Level I PASRR, showed that Resident 1 needed a Level II PASRR evaluation and Resident 1's electronic health record showed no documentation that Resident 1 had been referred for Level II PASRR evaluation. Staff J stated there was no evidence that a referral had been made. Staff J further stated that Resident 1 did not receive Level II services. On 06/10/2024 at 2:21 PM, Staff A, Administrator, stated that if a resident had a Level II PASRR evaluation required checked on their Level I PASRR that the resident should be appropriately referred. Staff A further stated there should be documentation that a referral had been sent. Reference: (WAC) 388-97-1915 (2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505181	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redmond Care and Rehabilitation Center	7900 Willows Road Northeast Redmond, WA 98052

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** 46912 Based on observation, interview, and record review, the facility failed to implement care plans for 2 of 18 residents (Residents 5 & 42), reviewed for comprehensive care plans. The failure to implement care plans for restorative care (to maintain a person's highest level of physical, mental, and psychosocial function to prevent decline that impact quality of life) and communication/sensory placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility's policy titled, Restorative Care, revised in May 2016, showed, Restorative Care will be provided to each resident according to his/her individual needs and desires as determined by assessment and interdisciplinary care planning. RESIDENT 5 Resident 5 admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set (an assessment tool) dated 04/11/2024, showed Resident 5 had Range of Motion (ROM - the amount of movement a joint or body part can make in a specific direction) impairment on both sides of their upper and lower extremities. Review of the activities of daily living care plan printed on 06/04/2024, showed an intervention for Resident 5, AROM [Active Range of Motion - moving joints entirely by the individual performing the exercise] of shoulders, elbows, hips, knees, and ankles .will be performed in order to maintain strength and ROM for 15 mins [minutes] at least 3x [times]/week. Review of the facility provided document titled, Restorative Nursing showed the following documentation of the days Resident 5's received AROM in May 2024: - 05/06/2024 to 05/12/2024: Two days - 05/13/2024 to 05/19/2024: One day - 05/20/2024 to 05/26/2024: Two days - 05/27/2024 to 05/31/2024: Zero days In an interview and joint record review on 06/05/2024 at 12:01 PM with Staff I, Certified Nursing Assistant, stated they worked as a restorative aide, and they provided restorative exercises for Resident 5 on Mondays, Wednesdays, and Fridays and that they documented in the Electronic Health Record (EHR). Joint record review of Resident 5's EHR, showed the last time the exercises were documented was on 05/24/2024. Staff I stated, I probably didn't document when I did the exercises. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505181	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redmond Care and Rehabilitation Center	7900 Willows Road Northeast Redmond, WA 98052

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	On 06/05/2024 at 2:12 PM, Staff O, Director of Rehabilitation, stated their expectation was that staff should be doing the ROM exercises [as stated] in the care plan. In an interview and joint record review on 06/06/2024 at 1:28 PM, Staff K, Assistant Director of Nursing, stated they expected Staff I to make sure she's doing the program in the care plan and documenting that it was done. Joint record review of the facility provided document titled, Restorative Nursing, did not show that Resident 5 had received AROM three times a week as was written in the care plan. Joint record review of Resident 5's care plan showed Resident 5 should have AROM exercises three times a week. Staff K stated that the care plan had been followed 50 percent of the time and that it did not meet their expectation. Staff K further stated that the care plan/program should be followed. 48899 Resident 42 admitted to the facility on [DATE]. Review of Resident 42's communication care plan initiated on 05/17/2023, showed Resident 42 was at risk for a communication problem r/t [related to] hearing deficit with interventions that included referral to audiology (testing and management of hearing and balance problems) for hearing consult as ordered and social services to follow up with hearing aids. Review of the nursing progress note dated 05/17/2023 to 06/07/2024, showed no documentation that the facility implemented Resident 42's communication care plan to referral to audiology and social services to follow up with hearing aids. On 06/04/2024 at 8:23 AM, Resident 42 stated that they were supposed to have hearing checkup at least annually. Resident 42 further stated that the facility did not arrange that for me and I have been telling them, but they did not listen. Sometimes I have hearing difficultly, and I am supposed to have hearing aid but did not get nothing. No body helped me with the appointment for about a year. Joint record review and interview on 06/07/2024 at 12:49 PM with Staff F, Licensed Practical Nurse Supervisor, showed no documentation that Resident 42's communication care plan was implemented. Staff F stated that there should have been a follow up on Resident 42's hearing needs. In an interview and joint record review on 06/07/2024 at 12:57 PM with Staff P, Social Services Director, stated that they did not help Resident 42 with their audiology appointment. Joint record review of the nursing progress notes from 05/17/2023 to 06/07/2024 with Staff P, showed no documentation that social services followed up with Resident 42 regarding their hearing aids. Staff P stated that they should have followed up with Resident 42's hearing concerns and implemented their care plan. On 06/10/2024 at 2:57 PM, Staff K stated that staff should have implemented the care plan. Reference: (WAC) 388-97-1020 (3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505181	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redmond Care and Rehabilitation Center	7900 Willows Road Northeast Redmond, WA 98052

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48899 Based on interview and record review, the facility failed to follow up on hearing services for 1 of 2 residents (Resident 42), reviewed for communication and sensory. This failure placed the resident at risk for ineffective communication, unmet care needs, and a diminished quality of life. Findings included . Review of the facility's policy titled, Resident Rights, revised in 11/23/2016, showed residents have rights to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the center. Review of the facility's policy titled, Hearing Impaired Resident, revised in February 2018, showed staff will assist the resident or representative with locating available resources, scheduling appointments, and arranging transportation to obtain needed services. Resident 42 admitted to the facility on [DATE]. Review of Resident 42's communication care plan initiated on 05/17/2023, showed that Resident 42 was at risk for a communication problem r/t [related to] hearing deficit with interventions that included referral to audiology (testing and management of hearing and balance problems) for hearing consult as ordered and social services to follow up with hearing aids. Review of the nursing progress notes dated 04/23/2024, showed that Resident 42 reported difficulty hearing and that the Nurse Practitioner was notified of Resident 42's concern. It further showed that Resident 42 declined the assessment by the Nursing Practitioner and that they would follow up as indicated. Review of the nursing progress notes dated 04/23/2024 to 06/07/2024 showed no documentation that the facility staff followed up on Resident 42's difficulty hearing. On 06/04/2024 at 8:23 AM, Resident 42 stated that they were supposed to have hearing checkup at least annually. Resident 42 further stated that the facility did not arrange that for me and I have been telling them, but they did not listen. Sometimes I have hearing difficultly, and I am supposed to have hearing aid but did not get nothing. No body helped me with the appointment for about a year. In an interview and joint record review on 06/07/2024 at 12:01 PM with Staff F, Licensed Practical Nurse Supervisor, stated that when Resident 42 reported difficulty hearing, the Nurse Practitioner was notified to assess, or order oil drop to soften the resident's ear a little bit. Staff F stated that if it was not effective the Nurse Practitioner would place an order for audiology. A joint record review of the nursing progress notes from 04/23/2024 to 06/07/2024, showed Resident 42's hearing assessment was not completed. Staff F stated the assessment was not completed and the audiology referral was not made. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505181	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redmond Care and Rehabilitation Center	7900 Willows Road Northeast Redmond, WA 98052

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In another joint record review and interview on 06/07/2024 at 12:49 PM with Staff F, showed Resident 42 had recommendations (orders) from their speech and hearing consultant visit dated 03/02/2023 and that the recommendations (orders) were not implemented. Staff F stated that for Resident 42's hearing consultant's recommendations, there should have been a follow up. Joint record review and interview on 06/07/2024 at 12:57 PM with Staff P, Social Services Director, showed the nursing progress notes dated 03/24/2023 to 06/07/2024 did not show documentation that the facility followed up with Resident 42's hearing aids. Staff P stated that they did not help Resident 42 with their audiology appointment and that they should have followed up on it. On 06/07/2024 at 1:00 PM, Staff Q, Nurse Practitioner, stated that I tried to evaluate him after he reported his hearing difficulty, but he refused. I did not do another attempt to evaluate until today. Staff Q further stated Resident 42 agreed for evaluation and that an audiology referral was done today. On 06/10/2024 at 2:57 PM, Staff K, Assistant Director of Nursing, stated that the facility's process was that when there was a report/concerns from residents about hearing issue we notify the Nurse Practitioner to make sure they assessed them. Also, if residents need referral, we have to make sure that was done. Staff K further stated that if residents had a recommendation from hearing consultants, the facility should follow up. On 06/11/2024 at 8:51 AM, Staff A, Administrator, stated when residents had concerns with hearing the facility tries to resolve it ASAP [as soon as possible]. Reference: (WAC) 388-97-1060(3)(a).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505181	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redmond Care and Rehabilitation Center	7900 Willows Road Northeast Redmond, WA 98052

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49619 Based on observation, interview, and record review, the facility failed to maintain an environment free of accident hazards for 1 of 3 residents (Resident 76), reviewed for accident hazards. The failure to monitor and assess a sliding door as an exit, and to ensure a fence/gate that led to a parking lot and street was secured/locked, placed the resident at risk for elopement [form of unsupervised wandering that leads to a resident leaving the facility], injury, and a diminished quality of life. Findings included . Review of the facility's policy titled, Elopement/Unsafe Wandering, revised in January 2022, showed, This facility is committed to promoting resident autonomy [ability to make own decisions] by providing an environment that remains as free of accident hazards as possible. The policy further showed the facility would provide a safe environment for all residents through appropriate assessment and interventions to prevent accidents related to unsafe wandering or elopement. Resident 76 admitted to the facility on [DATE]. Review of Resident 76's admission Minimum Data Set (MDS- an assessment tool), dated 05/09/2024, showed the resident had impaired cognition. Review of Resident 76's Restraint/Enabling Device/Safety Device Evaluation, dated 05/29/2024, showed the resident was evaluated to be, forgetful follows visitors/family exit doors, and that the device recommended was a wanderguard (a system in which a resident at risk for elopement /wanderer wears a bracelet, sensors that monitor doors, and alarm in real time), that alerted staff when the resident was by an exit door. Review of Resident 76's Elopement/Wandering Evaluation dated 06/01/2024, showed the resident was at high risk for elopement, was ambulatory with an assistive device (mobility aid), and had intermittent (sudden) confusion. Further review of the evaluation showed Resident 76's wandering was, aimless w/[with] potential to go outside, active exit seeking behavior. Review of Resident 76's elopement risk/wanderer care plan initiated on 06/04/2024, showed the resident had, Impaired safety awareness, Resident wanders aimlessly, following visitors going out the door. Review of Resident 76's physician order printed on 06/06/2024, showed an order for Wanderguard to (R [right] ankle): check for placement and function, initiated on 05/29/2024. Observation on 06/05/2024 at 12:55 PM, showed Resident 76 was walking independently using a walker in front of the facility parking lot with a visitor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505181	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redmond Care and Rehabilitation Center	7900 Willows Road Northeast Redmond, WA 98052

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/06/2024 at 3:21 PM, showed Resident 76 was in their room with a visitor. Their room had a sliding glass door wide open with the sliding screen door in place. Further observation showed the sliding door had no wanderguard trigger alarm box (part of the wanderguard alarm system that is placed on door/exit). Observation outside of Resident 76's room sliding door on 06/06/2024 at 3:54 PM, showed a grassy area with an uneven cement blocks pathway, and led towards the fenced gate that was wide open. Further observation showed the unsecured gate led to a parking lot towards a busy road. Joint observation and interview on 06/06/2024 at 4:43 PM with Staff L, Licensed Practical Nurse, showed Resident 76 had a wanderguard on their right ankle. Resident 76's visitor had left for the day. Resident 76's room glass sliding door was wide open and the screen sliding door was in place. Further joint observation showed Staff L walked through the sliding door with a wanderguard bracelet and no alarm was heard and that there was no [NAME] trigger alarm in the resident's room. Staff L stated that normally they would have one [trigger alarm] on the sliding door but they did not see one. Joint observation outside of Resident 76's room sliding door on 06/06/2024 at 4:46 PM with Staff L, showed a cement blocks pathway that was uneven. Staff L stated it could place the resident at risk for falls, and the gate was open to the parking lot/street, and could be potential for harm, or a very bad injury. In an interview and joint record review on 06/10/2024 at 10:03 AM, Staff B, Director of Nursing, stated that the wanderguard was important because it alerted staff that the resident was by an exit door and the alarm would trigger. Staff B stated that it would prevent elopement and injury as a consequence. Staff B further stated that Resident 76 was ambulatory, forgetful, and when family came to visit them, Resident 76 would follow them to the door. Staff B stated that Resident 76 was confused and that they scored high risk for elopement. Joint record review of Resident 76's admission MDS dated [DATE], showed resident had a brief interview for mental status (tool used to assess cognitive status) score of 0 (zero - indicating severely impaired cognition). Staff B stated that Resident 76 had impaired cognition. In another joint record review and interview on 06/10/2024 at 10:17 AM with Staff B, showed a physician order for a wanderguard was initiated on 05/29/2024. Staff B stated that was when the resident was determined to be at risk for elopement because they were seen by the exit door following a visitor. Joint observation and interview on 06/10/2024 at 12:20 PM with Staff D, Maintenance Director, showed there was no trigger alarm for Resident 76's previous room (room [ROOM NUMBER]-C). Staff D stated there was no alarm on the sliding door and that on 06/06/2024, they had been asked to place an alarm on and that they had been asked to block the doors. Another joint observation and interview on 06/10/2024 at 12:25 PM with Staff D, showed the outside environment of Resident 76's previous room had a cement block pathway that was uneven. Staff D stated that the gate was probably left opened [on 06/06/2024] and that it was supposed to stay closed. Staff D further stated this placed the resident at risk for a fall or injury. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505181	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redmond Care and Rehabilitation Center	7900 Willows Road Northeast Redmond, WA 98052

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/10/2024 at 1:46 PM, Staff K, Assistant Director of Nursing, stated that a wanderguard and trigger alarm were important because it alerted the staff when a resident was trying to leave the building. Staff K stated that Resident 76 was ambulatory and that they were at risk for elopement. Staff K stated that Resident 76 had impaired cognition and that they tended to follow their visitor. Staff K stated that there was no alarm on Resident 76's sliding door and that the gate should have been closed. Staff K further stated that staff would not be alerted right away without a wanderguard trigger alarm. In an interview and joint record review on 06/11/2024 at 1:59 PM with Staff A, Administrator, stated that the trigger alarm notified staff when the resident was coming close to an exit and that it was audible. Joint record review of Resident 76's elopement/wandering evaluation dated 06/01/2024, showed the resident was at high risk for elopement. Staff A stated the assessment did not specify whether the resident was assessed for the ability to open their sliding door. Staff A further stated that the gate door was opened on 06/06/2024 and that they typically have it closed. In an interview on 06/12/2024 at 8:53 AM, Staff M, Occupational Therapist (OT), stated that Resident 76 had made a lot of progress in terms of Activities of Daily Living (ADLs - activities related to personal care) and that Resident 76 was currently at a supervision level for daily tasks. Staff M stated that this was mainly because Resident 76 was impulsive with their movements and was very quick to stand up and with turning. Staff M stated that Resident 76's daily tasks included dressing, going to the bathroom, getting in and out of bed, and transfers. Staff M stated that Resident 76 was able to ambulate independently in their room, familiar area, or short distances and that they were at risk for elopement. Staff M further stated that Resident 76 had no restrictions in their hands that affected them functionally, and was able to manipulate their utensils for meals or the toilet paper in the restroom and that in terms of dexterity (skill in performing tasks, especially with the hands) they had recently done a cognitive exam, consisting of putting strings into different holes, and that the resident had no problem with completing the tasks. Joint record review and interview on 06/12/2024 at 9:08 AM with Staff M, revealed Resident 76's OT notes dated 05/16/2024, showed, Cues for proper body mechanics and pacing due to impulsive mvmt [movement] and decreased safety awareness. Staff M stated the resident got up fast, and turned quickly, and had decreased safety awareness putting them at risk for falls. Joint record review and interview on 06/12/2024 at 10:04 AM with Staff N, Physical Therapist (PT), showed Resident 76's PT notes dated 06/02/2024, Resident 76 was able to ascend and descend steps, for a total of eight stairs using bilateral (both) handrails at supervision assist. Staff N stated that the stairs were approximately six to seven inches tall. At 10:07 AM, another joint record review of PT notes dated 06/06/2024, showed gait training had occurred in the hallway/gym/room and the resident used no assistive device for 200 feet (ft - a unit of measurement) and outdoor gait training on uneven surfaces for 500 ft at supervision assist. Staff N stated the resident was currently able to ambulate with no assistive device. Staff N further stated that on 06/06/2024, it was the first time they had evaluated the resident specifically for opening the glass sliding door. On 06/12/2024 at 10:51 AM, Staff A, stated that there was no specific documentation for Resident 76's ability to open the sliding door [prior to 06/06/2024]. Reference: (WAC) 388-97-1060 (3)(g)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505181	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redmond Care and Rehabilitation Center	7900 Willows Road Northeast Redmond, WA 98052

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on observation, interview, and record review, the facility failed to maintain, label/date, and properly store oxygen nasal cannula (flexible tubing that sits inside the nose and delivers oxygen) for 1 of 1 resident (Resident 47), reviewed for respiratory care. This failure placed the resident at risk for unmet care needs, respiratory infections, and related complications. Findings included . Resident 47 admitted to the facility on [DATE] with diagnosis that included chronic obstructive pulmonary disease (a condition that blocks airflow and makes it difficult to breathe). Review of Resident 47's physician orders showed the following: - Apply oxygen via nasal cannula three liters [a unit of measurement] per minute continuous to keep saturation (amount of oxygen in the blood) above 90 percent every shift dated 5/15/2024. - Change oxygen tubing and humidifier every Sunday on night shift dated 5/19/2024. Observation on 06/03/2024 at 11:14 AM, showed a portable oxygen tank on the back of Resident 47's wheelchair, the nasal cannula was laying on top of their wheelchair cushion unlabeled and was not stored in a bag. Resident 47 stated they had used it with therapy earlier in the day. At 2:03 PM, Resident 47's nasal cannula was laying on their wheelchair cushion unlabeled and was not stored in a bag. Observation on 06/04/2024 at 10:17 AM, showed on the back of Resident 47's wheelchair was a portable oxygen tank with the nasal cannula laying on top of their wheelchair cushion unlabeled and was not stored in a bag. Observation on 06/05/2024 at 8:21 AM, showed a portable oxygen tank and nasal cannula laying on top of Resident 47's wheelchair cushion with an unlabeled nasal cannula stored in a bag. Resident 47 stated they told staff to store the nasal cannula in a bag. In an interview and joint observation on 06/05/2024 at 9:03 AM, Staff G, Licensed Practical Nurse (LPN), stated they would change the nasal cannula weekly, label/date and store it in a bag when not in use. Joint observation showed Resident 47's portable oxygen tank and nasal cannula was laying on top of their wheelchair cushion with the unlabeled nasal cannula stored in a bag. Staff G stated that it should have been labeled. Staff G further stated that the nasal cannula should be stored in a bag when not in use. On 06/05/2024 at 2:31 PM, Staff F, LPN Supervisor, stated that the oxygen nasal cannula was labeled and changed weekly and stored in a bag when not in use. Staff F further stated that Resident 47's nasal cannula should have been labeled and stored in a bag when not in use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505181	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redmond Care and Rehabilitation Center	7900 Willows Road Northeast Redmond, WA 98052

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/05/2024 at 2:56 PM, Staff N, Physical Therapist, stated that they would use a new nasal cannula each time they saw the resident and would discard it after their therapy session. Staff F stated that the nasal cannula tubing should have been discarded after therapy was done with their session. On 06/06/2024 at 2:39 PM, Staff K, Assistant Director of Nursing, stated that therapy should have discarded the nasal cannula after their session with Resident 47. Staff K further stated that the nasal cannula should be stored in a bag when not in use. On 06/06/2024 at 3:17 PM, Staff O, Director of Rehabilitation, stated that their process was to use a new nasal cannula each time they worked with a resident and would discard the nasal cannula after their session. Staff O further stated Resident 47's nasal cannula should have been discarded after their therapy session. Reference: (WAC) 388-97-1060 (3)(j)(vi)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505181	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redmond Care and Rehabilitation Center	7900 Willows Road Northeast Redmond, WA 98052

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. 48899 Based on observation, interview, and record review, the facility failed to ensure foods stored were labeled/dated and discarded after the expiration date or use by date in accordance with professional standards for food safety for 1 of 3 freezers (Kitchen Walk-In Freezer) and 2 of 2 refrigerators (Kitchen Walk-In Refrigerator and Residents' Refrigerator), reviewed for food services. This failure placed the residents at risk for food borne illness (caused by the ingestion of contaminated food or beverages) and a diminished quality of life. Findings included . Review of the facility's policy titled, Food Safety, dated 2018, showed, The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded, the individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared, the discard day or date may not exceed the manufacturer's use-by-date. KITCHEN WALK IN FREEZER Joint observation and interview on 06/03/2024 at 8:44 AM with Staff H, Nutrition Service Manager, showed 10 bags of vegetable mix, three bags of carrots and 10 bags of broccoli with no delivery date and use by date. Staff H stated that the facility's policy was to put the delivered date and use by date on the day of the arrival. Staff H stated that vegetable mix, carrots, and broccoli were not labeled with delivery date and use by date and should have been. KITCHEN WALK IN REFRIGATOR Joint observation and interview on 06/03/2024 at 8:20 AM with Staff H, showed 20 packets of tartar sauce with use by date of 06/01/2024 and one package of roast beef with no use by date. Staff H stated that there should have been a use by date and proceeded to write the use by date of 06/20/2024 on the roast beef. Staff H further stated that tartar sauce should have been discarded on or after the use by date. RESIDENTS' REFRIGATOR Joint observation and interview on 06/10/2024 at 1:51 PM with Staff H, showed Resident 17's left over lunch dated 06/09/2024 was in the Residents' Refrigerator located in the room between the Social Services office and Evergreen Room (Conference Room). Staff H stated that the left-over foods could be kept for three days. Staff H further stated that the left-over food should have had a use by date on it and proceeded to write 06/12/2024 on Resident 17's food. On 06/11/2024 at 8:51 AM, Staff A, Administrator, stated that it was their expectation for the kitchen staff to maintain food safety per the State and Federal guidelines. Reference: (WAC) 388-97-1100 (3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505181	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redmond Care and Rehabilitation Center	7900 Willows Road Northeast Redmond, WA 98052

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 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Hire a qualified full-time social worker in a facility with more than 120 beds. 49619 Based on interview and record review, the facility failed to employ a qualified social worker that met the educational requirements and supervised social work experience for one year in a health care setting for 2 of 2 social workers (Staff J & P), reviewed for social worker qualifications. This failure placed the residents at risk for unmet social services care needs, and a diminished quality of life. Findings included . Review of the facility's document titled, Job Description Social Services Manager, dated November 2021, showed under section Education and/or Experience, an employee, Must have, as a minimum, a bachelor's [a type of undergraduate degree] degree in social work or a bachelor's degree in a human services field including but not limited to sociology [study of social life and change], special education, rehabilitation counseling [focused on helping people with disabilities], and psychology [study of mind and behavior]. The document further showed the employee, Must have, as a minimum, 1 [one] year of experience as a Social Worker, preferably in a hospital, long-term care facility, or other related health care facility. Review of the Facility Assessment, updated on 04/05/2024, showed the facility was licensed to provide care for 139 residents. STAFF J Review of the facility staff list showed Staff J, Social Services Director, was hired on 06/05/2023. Review of Staff J's resume showed they had an associate (academic qualification below a bachelor's degree) degree in communication. On 06/12/2024 at 10:15 AM, Staff J stated they had an associate degree in communication and that they did not have a bachelor's degree. STAFF P Review of the facility staff list showed Staff P, Social Services Director, was hired on 09/18/2023. Review of a copy of Staff P's bachelor's degree, dated 01/24/2018, showed Staff P had a degree in leisure [involving recreational occupation] and hospitality management [focus on aspects of business]. On 06/11/2024 at 10:08 AM, Staff P stated that there were two social workers for the building. Staff P stated that they had graduated with a bachelor's degree in leisure and hospitality management and that they had previously worked as a dental assistant. Staff P further stated that they had started to work as a social worker in the United States in September of 2023. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505181	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redmond Care and Rehabilitation Center	7900 Willows Road Northeast Redmond, WA 98052

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 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	On 06/11/2024 at 1:47 PM, Staff A, Administrator, stated that Staff P's bachelor's degree was not in any of the categories related to social work. On 06/12/2024 at 10:16 AM, Staff P stated that it had not been a year since they started working as a social worker for the facility and that their bachelor's degree was not in a human services field including, sociology, gerontology (study of the aging process), special education, rehabilitation counseling, or psychology. On 06/12/2024 at 11:05 AM, Staff A stated the facility had 139 certified beds. Staff A stated that Staff P started working in September 2023, and that they did not have a year experience. Staff A further stated that Staff J had the one year experience but did not have a bachelor's degree. Reference: (WAC) 388-97-0960 (2)(a)(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505181	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redmond Care and Rehabilitation Center	7900 Willows Road Northeast Redmond, WA 98052

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. 46912 Based on observation, interview, and record review, the facility failed to ensure hand hygiene practices were followed before and after resident care and during meal tray pass for 1 of 13 staff (Staff I) reviewed for infection control. This failure placed the residents, visitors, and staff at an increased risk for infection and related complications. Findings included . Review of the facility's policy titled, Hand Hygiene, revised on 02/21/2022, showed, Use an alcohol-based hand rub .or, alternatively, soap .and water for the following situations, before and after direct contact with residents and after contact with objects in the immediate vicinity of the resident. Observation on 06/03/2024 at 12:15 PM, showed Staff I, Certified Nursing Assistant, brought a meal tray into Resident 1's room, touched the fork and knife, and assisted in cutting Resident 1's food. Staff I then left Resident 1's room without performing hand hygiene and went to the kitchen, touched the kitchen door, and left the kitchen with a new fork. Staff I entered Resident 1's room and handed the new fork to Resident 1. Staff I did not perform hand hygiene prior to re-entering Resident 1's room. Staff I then helped Resident 5 (Resident 1's roommate) get their meal tray set up, touched items on the bedside table, and left Resident 5's room and did not perform hand hygiene. Staff I then entered Resident 46's room and touched their bedside table. On 06/03/2024 at 1:43 PM, Staff I stated they should perform hand hygiene after touching resident's items and going between residents. Staff I stated they should have performed hand hygiene when leaving the resident's room and entering the room. On 06/10/2024 at 10:04 AM, Staff S, Infection Preventionist, stated they expected staff to perform hand hygiene every time they help a resident and between resident rooms. On 06/12/2024 at 8:24 AM, Staff K, Assistant Director of Nursing, stated Staff I should have performed hand hygiene before coming out [of resident's rooms] and going in. Staff K further stated they expected Staff I to perform hand hygiene after leaving one resident's room and before going into the next resident's room. Reference: (WAC 388-97-1320 (1)(c)