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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>505195 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                     | (X3) DATE SURVEY COMPLETED<br><br>03/22/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>North Auburn Rehab & Health Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2830 I Street Northeast<br>Auburn, WA 98002 |  |

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46471</p> <p>Based on observation, interview, and record review, the facility failed to ensure a person-centered comprehensive Care Plan (CP) was developed and implemented for 3 of 21 residents (Residents 30, 226, &amp; 71) whose CPs were reviewed for individualized care. The facility failed to implement CP interventions (Resident 30) and develop a discharge CP regarding discharge disposition, needs, and/or barriers (Residents 226 &amp; 71). These failures placed residents at risk for inconsistent and unmet care needs, anxiety regarding discharge, and a decreased quality of life.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility policy titled, Care Planning Process, revised 05/19/2023, the CP was driven not only by identified resident issues and/or conditions, but also by a resident's unique characteristics, strengths, and needs. The policy showed the facility would personalize the CP and add additional focuses, goals, and interventions as indicated regarding the resident's care.</p> <p>Review of the facility policy titled, Discharge Management, revised 05/18/2023, showed the Interdisciplinary Team (IDT) would communicate resident goals and status on the plan of care through care conferences, 1:1 meetings, and as needed at the request of the resident.</p> <p>&lt;Resident 30&gt;</p> <p>According to the 02/29/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 30 had clear speech and had medical conditions including memory impairment, anxiety, and mood disorder. The MDS showed Resident 30 exhibited wandering behavior that occurred daily.</p> <p>Observations on 03/17/2024 at 8:31 AM and on 03/19/2024 at 8:18 AM, Resident 30 was observed wandering along the hallways and in areas including the main dining room and therapy rehabilitation gym.</p> <p>A 03/09/2024 facility investigation report showed Resident 30 was found to have bruises of unknown origin on their lower, inner thighs and was sent to the hospital for evaluation and treatment. The report showed the facility ruled out abuse/neglect and indicated the bruising was probably from Resident 30 using the stationary bicycle inside the therapy gym. The report showed new interventions were put in place including instructions about Resident 30's daily cares.</p> <p>(continued on next page)</p> |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Review of Resident 30's 11/22/2023 Activities of Daily Living CP showed a nursing intervention put in place after the facility investigation on 03/09/2024 to only assign female staff to Resident 30.</p> <p>In an observation and interview on 03/21/2024 at 12:25 PM, Staff NN (Certified Nursing Assistant - CNA), a male nursing aide, was observed in Resident 30's room. Staff NN stated they were the staff assigned for Resident 30. Staff NN stated they did not know only female staff were to be assigned to take care of Resident 30. Staff NN stated they worked as an on-call staff (employee who did not have a regular position and covered available work shifts) and was given their assigned resident set for the day when they came to work that morning by staffing.</p> <p>In a joint interview on 03/21/2024 at 12:28 PM with Staff C (Assistant Director of Nursing) and Staff L (Chief Nursing Officer), Staff L stated it was important to ensure CP interventions were implemented and followed for resident safety. Staff L stated a male CNA should not be assigned to Resident 30 as instructed in the resident's CP, .absolutely not acceptable and you can quote me on that.</p> <p>&lt;Resident 226&gt;</p> <p>According to 02/22/2024 Admission MDS, Resident 226 had clear speech, understood others during communication, and had medical conditions including systemic infection, pulmonary disease, and muscle weakness. The MDS showed Resident 226 and their family participated in the assessment and goal setting and that Resident 226 expected to discharge back to the community. The MDS showed the Return to Community Referral Care Area Assessment was triggered and a decision was made by the IDT to develop a CP.</p> <p>Review of the facility census showed Resident 226 admitted to the facility on [DATE] under their skilled care benefits.</p> <p>A 02/20/2024 social services note showed Resident 226's primary discharge plan was to return home.</p> <p>On 03/17/2024 at 1:31 PM, Resident 226 stated they were not involved in discussion of their care. Staff 226 stated they would like to know the status of their care in the facility because they were told their skilled care benefits ended. Resident 226 stated they did not feel safe and/or was ready to go home.</p> <p>Review of Resident 226's CP did not show a discharge CP was developed or initiated for the resident.</p> <p>In an interview on 03/21/2024 at 10:07 AM, Staff O (Social Services Director) stated Resident 226's initial discharge plan to go home had changed and the resident would be staying in the facility instead. Staff O stated they had communicated the change with Resident 226 but had not documented the new discharge plan in the resident's medical records. Staff O confirmed Resident 226's CP did not have a discharge CP in place and stated a discharge CP should have, but was not developed.</p> <p>&lt;Resident 71&gt;</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of the 02/29/2024 Admission MDS showed Resident 71 had clear speech, their memory was intact, understood others during communication, and had medical conditions including respiratory and systemic infections. The MDS showed Resident 71 and their significant other participated in the assessment and goal setting and that Resident 71 expected to discharge back to the community.</p> <p>Review of the facility census showed Resident 71 admitted to the facility on [DATE] under their skilled care benefits.</p> <p>On 03/17/2024 at 12:04 PM, Resident 71 stated they admitted to the facility due to generalized weakness after having a bad lung infection. Resident 71 stated they did not see social services staff or have a CP meeting regarding their care. Resident 71 stated they felt they were getting better but were not aware of their discharge plan.</p> <p>Review of Resident 71's progress notes from 02/22/2024 until 03/20/2024 did not show any documentation from social services that discussed the resident's discharge plan.</p> <p>Review of Resident 71's CP did not show a discharge CP was developed or initiated for the resident.</p> <p>In an interview on 03/21/2024 at 9:57 AM, Staff O stated a discharge CP was important to develop and implement to ensure the residents remained informed of their care and to decrease the resident's anxiety. Staff O stated the discharge plan should be written in the CP and accessible to the entire IDT for consistency of information. Staff O stated a discharge CP should have, but was not developed for Resident 71.</p> <p>REFERENCE: WAC 388-97-1020(1), (2)(a)(b).</p> |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>46479</p> <p>Based on observation, interview, and record review, the facility failed to have sufficient nursing staff to provide timely assistance with toileting and call light response in accordance with established clinical standards as evidenced by information provided from 8 (Resident 52, 3, 228, 276, 60, 178, 44, &amp; 277 ) resident interviews, information provided by 2 (Resident 22 &amp; 7) Resident Council residents, review of facility grievance forms for Residents 10, 8, 60, &amp; 48, call light reports for Resident 277, 276, &amp; 56, and staff interviews provided by Staff KK (Certified Nursing Assistant - CNA), Staff MM (Registered Nurse), and Staff N (Licensed Practical Nurse). The facility had insufficient staff to ensure Restorative Nursing Programs (RNPs) were provided to Residents 7, 55, &amp; 44. These failures placed residents at risk for unmet care needs and other negative health outcomes.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>Review of the Resident Call System facility policy dated 09/2022 showed when a resident utilized the call light system, staff should respond to the resident's needs in a reasonable amount of time.</p> <p>&lt;Resident Interviews&gt;</p> <p>&lt;Resident 52&gt;</p> <p>In an interview on 03/17/2024 at 8:10 AM, Resident 52 stated they had to wait for two and a half hours on a regular basis to get assistance and the wait time usually occurred after 3:00 AM on a given day. Resident 52 stated they used the bed pan or bedside commode on their own when they did not get help.</p> <p>&lt;Resident 3&gt;</p> <p>In an interview on 03/17/2024 at 10:10 AM, Resident 3 stated staff did not come when the resident called. Resident 3 stated it usually took an hour or so for staff to answer the call light. Resident 3 said I usually take myself to the bathroom to keep from wetting myself.</p> <p>&lt;Resident 228&gt;</p> <p>In an interview on 03/17/2024 at 11:39 AM, Resident 228 stated staff were respectful but the facility was understaffed. Resident 228 stated Sundays were especially bad and it sometimes took staff several hours to answer Resident 228's call light.</p> <p>&lt;Resident 276&gt;</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>In an interview on 03/17/2024 at 12:06 PM, Resident 276 stated they had to lie in their soiled undergarments all night. Resident 276 stated a male staff person answered their call light after Resident 276 waited for more than one hour. The male staff person told Resident 276 the staff member needed to get another staff member help to provide care to Resident 276. Resident 276 stated the staff member never came back.</p> <p>&lt;Resident 60&gt;</p> <p>In an interview on 03/17/2024 at 1:33 PM, Resident 60 stated I do not think they have enough staff .my call light does not get answered on time, I have to sit in my [bowel movement].</p> <p>&lt;Resident 178&gt;</p> <p>In an interview on 03/18/2024 at 9:14 AM, Resident 178 stated they had to wait a long time at night when they needed to be changed. Resident 178 stated sometimes staff come sooner but most of the time, there were not enough staff.</p> <p>&lt;Resident 44&gt;</p> <p>In an interview on 03/18/2024 at 9:39 AM, Resident 44 stated the facility did not have enough staff. Resident 44 stated they usually waited 30 to 40 minutes to get the call light answered if they needed to be cleaned for a bowel movement.</p> <p>&lt;Resident 277&gt;</p> <p>In an interview on 03/18/2024 at 1:21 PM, Resident 277 stated staff were sometimes pretty slow to answer the call light. Resident 277 stated at 3:30 AM, they had to [urinate] in the bed because staff did not answer the call light in time. Resident 277 stated day time call light response was slow but nighttime was worse.</p> <p>&lt;Resident Council Interviews&gt;</p> <p>&lt;Resident 22&gt;</p> <p>During a resident council meeting on 03/21/2024 at 11:00 AM, Resident 22 stated [staff] could be faster with call lights, it's like [staff] don't care. Resident 22 stated they called the front desk on occasion when their call light was not answered. Resident 22 stated they waited over an hour for the staff to assist the resident to lie down.</p> <p>&lt;Resident 7&gt;</p> <p>During the resident council meeting on 03/21/2024 at 11:12 AM, Resident 7 stated staff take too long to answer their call light. Resident 7 stated If I scream, then they come.</p> <p>&lt;Grievance Forms&gt;</p> <p>&lt;Resident 10&gt;</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>A 01/24/2024 grievance form showed Resident 10 stated call lights were not answered timely at night.</p> <p>&lt;Resident 8&gt;</p> <p>A 01/24/2024 grievance form showed Resident 8 stated there were not enough staff, nurse's aides needed more training on the evening and night shift.</p> <p>&lt;Resident 60&gt;</p> <p>A 02/01/2024 grievance form showed Resident 60 stated nurse's assistants do not answer call lights timely. This form showed Resident 60 stated yesterday it took [staff] 40 minutes to get my light, I was almost late for dialysis [outpatient appointment to filter waste from blood].</p> <p>&lt;Resident 48&gt;</p> <p>A 02/21/2024 grievance form filed by Resident 48's spouse showed Resident 48 had their call light on for an hour around 4:00 PM. After waiting an hour, Resident 48 called their spouse who called the facility and was put on a 20-minute hold. Resident 48's spouse called the facility again, staff answered and told Resident 48's spouse they would send staff in to assist Resident 48. Resident 48 called their spouse after an additional 20 minutes passed without receiving assistance.</p> <p>&lt;Call Light Report&gt;</p> <p>&lt;Resident 277&gt;</p> <p>Review of the facility's call light report showed on 03/15/2024 at 2:31 AM, Resident 277 turned on their call light. This report showed the call light was answered at 2:49 AM, 18 minutes later.</p> <p>Review of the call light report showed on 03/15/2024 at 8:32 AM, Resident 277 turned on their call light. At 8:57 AM, the call light was answered, nearly 25 minutes later.</p> <p>Review of the call light report showed on 03/15/2024 at 7:47 PM, Resident 277 turned their call light on. At 8:09 PM, the call light was answered, 20 minutes later.</p> <p>Review of the call light report showed on 03/19/2024 at 10:41 PM, Resident 277 turned their call light on. At 11:04 PM, Resident 277's call light was answered, 23 minutes later.</p> <p>&lt;Resident 276&gt;</p> <p>Review of the call light report showed on 03/17/2024 at 7:55 PM, Resident 276 turned on their call light. At 8:14 PM, Resident 276's call light was answered, 19 minutes later.</p> <p>Review of the call light report showed on 03/18/2024 at 10:22 PM, Resident 276 turned on their call light. At 10:40 PM, Resident 276's call light was answered, 18 minutes later.</p> <p>Review of the call light report showed on 03/20/2024 at 5:57 AM, Resident 276 turned on their call light. At 6:36 AM, Resident 276's call light was answered, 39 minutes later.</p> <p>(continued on next page)</p> |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>&lt;Resident 56&gt;</p> <p>In an observation and interview on 03/19/2024 at 5:09 AM, Resident 56 had their call light on. The call light monitoring system at the nurse's station showed Resident 56's call light was on for 44 minutes. In an interview at that time, Resident 56 stated they needed a bed pan. Resident 56 stated they turned their call light on around 4:00 AM. Resident 56 stated they eventually used their cell phone to call the nurse's station to get help. Resident 56 stated staff provided assistance about 15 minutes after the phone call. When Resident 56 was told their call light was on for 44 minutes, Resident 56 replied yes, that is pretty accurate.</p> <p>&lt;Staff Interviews&gt;</p> <p>&lt;Staff KK&gt;</p> <p>In an interview on 03/17/2024 at 8:10 AM, Staff KK stated staffing was up and down. Staff KK stated they used to work night shift but the night shift was always short-staffed so they decided to move to day shift.</p> <p>&lt;Staff MM&gt;</p> <p>In an interview on 03/20/2024 at 8:59 AM, Staff MM stated they were normally a night shift nurse. Staff MM stated they were asked to stay over for a couple of hours that morning after working the night shift because of a staffing conflict.</p> <p>&lt;Staff N&gt;</p> <p>In in interview on 03/20/2024 at 10:08 AM, Staff N was orienting a new nurse and stated they were responsible for residents on both Hall C and Hall D that day. Staff N stated there were days when there were four nurses and days when there were only three nurses and today is one of those days [where there were only three nurses].</p> <p>&lt;RNP&gt;</p> <p>&lt;Resident 7&gt;</p> <p>A 03/28/2023 Physician's Order (PO) directed staff to apply a splint to Resident 7's left hand each morning and remove the splint after eight hours.</p> <p>Observations on 03/18/2024 at 9:59 AM, 3/19/2024 at 10:14 AM, and 03/20/2024 at 9:51 AM showed Resident 7 without the splint to their left hand.</p> <p>&lt;Resident 55&gt;</p> <p>A 03/05/2024 PO directed staff to apply a splint to Resident 55's right hand daily.</p> <p>Observations on 03/18/2024 at 12:44 PM, 03/20/2024 at 12:26 PM, and on 03/21/2024 at 1:03 PM showed Resident 55 without the splint to their right hand.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>In an interview on 03/21/2024 at 1:47 PM, Staff J (CNA) stated it was the restorative aide's responsibility to apply the splint to Resident 55's right hand.</p> <p>&lt;Resident 44&gt;</p> <p>Review of an 08/31/2023 Self-Care Deficit care plan directed restorative staff to place a splint on Resident 44's left hand for three to six hours as tolerated, three to six times weekly.</p> <p>Observations on 03/17/2024 at 11:21 AM, 03/18/2024 at 9:34 AM, 03/19/2024 at 12:05 PM, and 03/21/2024 at 9:33 AM showed Resident 44 without a splint to their left hand.</p> <p>In an interview on 03/21/2024 at 9:49 AM, Resident 44 stated the restorative aide never splinted the resident's left hand.</p> <p>In an interview on 03/21/2024 at 2:57 PM Staff C (Assistant Director of Nursing) stated when staff called in, restorative aides would sometimes be pulled to work the floor instead of their restorative duties.</p> <p>In a joint interview on 03/21/2024 at 2:44 PM, Staff B (Director of Nursing) stated they expected call lights to be answered in a timely manner. Staff L (Chief Nursing Officer) stated a timely manner meant a call light should be answered within 15 minutes. Staff B acknowledged night shift had a trend toward long call light response times and they were aware of the grievances regarding long call light wait times. Staff B stated their expectation was that staff performed rounding on residents every two hours by checking if the resident needed toileting assistance, repositioning assistance, or if the resident had any pain, or other needs.</p> <p>Refer to: F688 Increase/prevent Decrease in Range of Motion/mobility.</p> <p>REFERENCE: WAC 388-97-1080(1).</p> |