

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47836</b></p> <p>Based on observation, interview, and record review the facility failed to obtain resident consent for vaccinations for 3 of 5 sampled residents (Residents 35, 7, &amp; 24) and 1 supplemental resident (Resident 28) reviewed for vaccinations, obtain resident consent prior to administration of psychotropic medication for 2 of 5 residents (Resident 7 &amp; 24) reviewed for unnecessary medications, and obtain consent prior to utilization of safety devices for 4 of 6 residents (Resident 7, 24, 28, &amp; 35) reviewed for accident hazards. This failure placed residents at risk for loss of autonomy, entrapment, injury, and loss of the opportunity for alternative treatment options.</p> <p>Findings included .</p> <p>&lt;Policy&gt;</p> <p>According to a facility policy titled, Vaccinations for Residents P&amp;P, revised 12/2022, did not discuss obtaining consent prior to vaccine administration and showed inquiries concerning the policy should be referred to the Staff A (Administrator) or Staff P (Infection Preventionist).</p> <p>According to a facility policy titled, Psychoactive Medication Management, revised 08/2024, the facility would review the psychoactive medication with the resident and/or representative when it was prescribed. The policy did not instruct staff to obtain consent per regulation for psychotropic medications prior to implementing and/or changing.</p> <p>According to a facility policy titled, Safety Device Application, revised 04/07/2023, the facility would review safety devices with the resident and/or representative.</p> <p>&lt;Vaccinations&gt;</p> <p>&lt;Resident 35&gt;</p> <p>Review of Resident 35's health records showed the resident received the Covid 19 (respiratory virus) and Flu vaccination on 10/03/2024. Resident 35's health records did not show consent was obtained for the 2024/2025 season Covid 19 or Flu vaccine prior to administration. Resident 35's health records showed the facility documented the resident received pneumonia vaccines historically on 11/19/2014 and 11/22/2021. Resident 35's health records did not show documentation to support the historical pneumonia vaccine administration.</p> <p>(continued on next page)</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>&lt;Resident 7&gt;</p> <p>Review of Resident 7's health records showed the resident received the Covid 19 and Flu vaccination on 10/03/2024. Resident 7's health records did not show consent was obtained for the 2024/2025 season Covid 19 or Flu vaccine prior to administration. Resident 7's health records showed the resident received pneumonia vaccines on 02/27/2020 and 11/04/2018. Resident 7's health records did not show consent was obtained prior to pneumonia vaccine administration.</p> <p>&lt;Resident 24&gt;</p> <p>Review of Resident 24's health records showed the resident received the Covid 19 and Flu vaccination on 11/15/2024. Resident 24's health records did not show consent was obtained for the 2024/2025 season Covid 19 or Flu vaccine prior to administration. Resident 24's health records showed the resident received pneumonia vaccines on 02/27/2020 and 11/06/2018. Resident 24's health records did not show consent was obtained prior to pneumonia vaccine administration.</p> <p>&lt;Resident 28&gt;</p> <p>Review of Resident 28's health records showed the resident was offered and declined the Covid 19 vaccination on 03/17/2025. Resident 28's Covid 19 consent form showed Resident 28's name typed in, not signed, and a box marked for offered and refused. Resident 28's health records showed the facility documented the resident historically received pneumonia vaccines on 05/30/2019 and 03/08/2018 and the flu vaccine on 02/24/2025. Resident 28's health records did not show documentation to support the historical pneumonia vaccines or flu vaccine administration.</p> <p>In an interview on 04/21/2025 at 9:39 AM Staff P stated they expected staff to obtain residents or resident representatives signed consents for vaccinations or a witness signature if a resident or representative was unable to sign. Staff P stated when a resident stated they received a vaccination historically, the expectation was to obtain a copy of the residents immunization report and scan into the residents health records to show confirmed documentation of the vaccination being administered. Staff P stated Resident 35, 7, 24, and 28 did not have a signed consent for their immunizations but should. Staff P stated Residents 35 and 28's health records did not include documentation from the department of health supporting the historical immunization administration.</p> <p>&lt;Psychotropic Medications&gt;</p> <p>&lt;Resident 7&gt;</p> <p>According to a 11/08/2024 Annual Minimum Data Set (MDS - an assessment tool) Resident 7 readmitted to the facility on [DATE]. The MDS showed Resident 7 had diagnoses of, but not limited to, depression, traumatic brain injury (sudden injury that causes damage to the brain), and psychotic disorder (severe mental illness characterized by a disconnection from reality), seizure disorder (a neurological disease.) The MDS showed Resident 7 received antipsychotic, antidepressant, and anticonvulsant medications during the assessment period.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 7's health records showed a physician ordered dose change for an antipsychotic medication on 04/18/2025 and an antidepressant medication dose change on 02/25/2025. Resident 7's records showed consent was not obtained for the antipsychotic or antidepressant medication dose changes.</p> <p>&lt;Resident 24&gt;</p> <p>According to a 01/05/2025 Annual MDS Resident 24 readmitted to the facility on [DATE]. The MDS showed Resident 24 had diagnoses of, but not limited to, depression, non-Alzheimer's dementia, and schizophrenia. The MDS showed Resident 24 received antipsychotic and antidepressant medications during the assessment period.</p> <p>Review of Resident 24's health records showed physician order dose changes for an antipsychotic medication on 03/21/2023 and an antidepressant medication dose change on 02/25/2025. Resident 24's records showed consent was not obtained at time of dosage changes for the antipsychotic or antidepressant medications. Resident 24's records showed a Psychopharmacological Medication Informed Consent form dated 04/18/2023 for the antipsychotic medication dosage change with .son via email typed in the box name of person receiving informed consent. The form was completed 26 days after Resident 24 received an increased dose of antipsychotic medication.</p> <p>In an interview on 04/18/2025 at 9:20 AM Staff O (Resident Care Manager) stated they were unable to provide a copy of an email notification to Resident 24's son and Resident 7's guardian for the antipsychotic and antidepressant medication dose changes.</p> <p>In an interview on 04/18/2025 at 12:05 PM Staff E (Assistant Director of Nursing) stated consent was not obtained for Resident 7's and 24's dosage changes for their antipsychotic or antidepressant medications. Staff E stated they expected staff to obtain signed consent from the resident or resident representative prior to administration. Staff E stated they expected staff to obtain a signature from the resident or resident representative on the informed consent form and if staff received verbal consent over the phone, they expected staff to have another staff member sign the form as a witness.</p> <p>&lt;Safety Devices&gt;</p> <p>&lt;Resident 7&gt;</p> <p>Observation on 04/15/2025 at 9:56 AM showed bilateral bed rails and a bolstered air mattress (a mattress filled with air that includes bolsters on either side) to Resident 7's bed. Observation at this time showed a tilt in space wheelchair for Resident 7.</p> <p>Review of Resident 7's health records showed a 01/02/2019 physician order for the tilt in space wheelchair (a wheelchair that reclines back), a 08/28/2024 physician order for the bolstered air mattress, and a 06/10/2022 physician order for the bilateral bed rails. Review of Resident 7's health records showed no evidence of consent for the bilateral bed rails, bolstered air mattress, or tilt in space wheelchair from the resident or their guardian.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 4/18/2025 at 9:20 AM Staff O stated they were unable to provide email notifications for Resident 7's bilateral bed rails or bolstered air mattress. Staff O showed a quarterly update email notification on 03/25/2025 for the tilt in space wheelchair but the notification did not include whether the guardian consented or not. Staff O stated the form they used as a consent form did not include documentation of consent but should.</p> <p>&lt;Resident 24&gt;</p> <p>Observation on 04/15/2025 at 10:52 AM showed bilateral bed rails to Resident 24's bed.</p> <p>Review of Resident 24's health records showed a 02/28/2023 physician order for the bilateral bed rails. Review of Resident 24's health records showed no evidence of consent for the bilateral bed rails from the resident.</p> <p>&lt;Resident 28&gt;</p> <p>Observation and interview on 04/14/2025 at 12:25 PM showed bilateral bed rails to Resident 28's bed. Resident 28 stated they did not use the bed rails because they did not want to depend on them. Resident 28 stated staff did not discuss the bed rail usage with them.</p> <p>Review of Resident 28's health records showed a 03/18/2025 physician order for the bilateral bed rails. Review of Resident 28's health records showed no evidence of consent for the bilateral bed rails from the resident or the resident representative</p> <p>&lt;Resident 35&gt;</p> <p>Observation on 04/15/2025 at 12:57 PM showed a bed rail to Resident 35's right side of bed.</p> <p>Review of Resident 35's health records showed a 03/25/2025 physician order for the right-side bed rail. Review of Resident 35's health records showed no evidence of consent for the bilateral bed rails from the resident or the resident representative. Resident 35's health records showed a 03/25/2025 safety device evaluation form for the right-side bed rail with resident typed in the information provided to box, no signature for consent. Resident 35's health records showed they had severe cognitive impairment and had a Power of Attorney (POA) for their healthcare decision making.</p> <p>In an interview on 04/17/2025 at 9:00 AM Staff O stated they expected staff to obtain consent prior to implementation of safety devices. Staff O stated they were informed by corporate that by providing a copy of the device safety assessment was obtaining consent from the resident or resident representative. Staff O stated the form does not include documentation whether the resident or resident representative consented to the bed rails or not so they were unable to provide consents for Residents 7, 24, 28, or 35's devices. Staff O stated they were unaware Resident 35 was unable to consent at the time and during this interview observed Resident 35 had a POA in place. Staff O stated Resident 35's POA was not notified of the bed rail and they did not obtain a signature from the resident consenting to the bed rail.</p> <p>REFERENCE: WAC 388-97-0260, -0200(2), -0300(3)(a).</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>20264</p> <p>Based on observation, interview and record review, the facility failed to have a system in place which ensured grievances were thoroughly investigated and resolved in response to residents' concerns for two (Residents 52 &amp; 17) of three residents reviewed for grievances. Failure to ensure accurate resident inventories detracted from staff's ability to thoroughly investigate reported complaints of missing items and failure to follow up with residents about the grievances placed residents at risk of feeling frustration and diminished quality of life.</p> <p>Findings included .</p> <p>&lt;Policy&gt;</p> <p>According to the 02/2024 Grievances Policy, employee responsibilities in the grievance process included: (1) initiating the Resident Grievance Report for all concerns brought forth by residents, and (2) immediately providing the completed report to the Grievance Officer or designee. The policy showed the Grievance Officer or designee would follow-up with the resident/resident representative about the grievance to ascertain satisfaction with the resolution of the reported concern.</p> <p>&lt;Resident 52&gt;</p> <p>According to the 02/24/2025 Quarterly Minimum Data Set (MDS- an assessment tool) Resident 52 was cognitively intact and able to understand and be understood in conversation.</p> <p>In an interview on 04/14/2025 at 2:27 PM Resident 52 indicated they had multiple missing personal items including an Amazon Tablet stating, I reported it to the administrator, two or three administrators ago.</p> <p>Review of the grievance log showed on 11/22/2024 the resident reported missing an Amazon tablet. According to the grievance form dated 11/22/2024 staff documented the concern was resolved because, Resident was not certain (they) had an Amazon Tablet. Tablet not on the inventory. Review of the resident's record and grievance documents showed no indication staff attempted to determine if the resident ever had the Amazon Tablet or if the inventory was correct.</p> <p>In an interview on 04/18/2025 at 8:17 AM Staff E (Assistant Director of Nursing) indicated that resident inventories are done on the day of admission and kept in a 3-ring binder at the nurse's station. Review of the binder at the nurses' station showed no inventory for Resident 52. Staff E at this time confirmed the absence of an inventory and stated it should be in the book. Staff E contacted Staff G (Social Service Director - SSD) who provided multiple pieces of paper, undated, with no resident name or identifiers but included a partial list of personal items.</p> <p>Observation on 04/18/2025 at 8:28 AM showed Resident 52 had multiple items in their possession including an Amazon Fire Tablet, a cellular phone, three pairs of glasses and a cane. Review of the undated personal inventory for Resident 52 showed that these items were not on the inventory list.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/18/2025 at 8:31 AM Staff E confirmed Resident 52's inventory should, but did not, include the resident's name, room number and date and the identified electronics, glasses and cane. Staff E stated if a resident reported missing items, staff should not rely solely on the inventory sheets as they were not always correct.</p> <p>&lt;Resident 17&gt;</p> <p>According to the 01/31/2025 Quarterly MDS Resident 17 was assessed as cognitively intact and able to understand and be understood in conversation.</p> <p>In an interview on 04/14/2025 at 10:58 AM Resident 17 stated they had a missing iPhone, which the facility would not replace stating, I had to buy an android, I couldn't afford an iPhone. I really liked that phone. The resident at this time indicated she would prefer an iPhone. Observation at that time showed Resident 17 had an android cell phone.</p> <p>According to the grievance log Resident 17 reported the phone was missing on 01/20/2025. According to the grievance notes facility staff documented SSD followed up with admin and (they) notified SSD to see if resident (family) would like for phone to be replaced and (they) declined stating,I already purchased another phone for (the resident).</p> <p>In an interview on 04/21/2025 at 8:30 AM Staff G reviewed the grievance form and confirmed staff did not follow up with Resident 17 regarding the missing phone.</p> <p>REFERENCE: WAC 388-97-0460.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264</b></p> <p>Based on observation, interview, and record review the facility failed to accurately assess 5 (Resident 30, 36, 61, 62, &amp; 69) of 20 residents' Minimum Data Sets (MDS - an assessment tool) reviewed. Failure to ensure accurate assessments regarding cognitive patterns (Resident 36) language (Resident 61), oral status (Resident 61), vision status (Resident 30), behaviors (Resident 36), dental status (Resident 62), and discharge status (Resident 69) placed residents at risk for unidentified and/or unmet needs.</p> <p>Findings included .</p> <p>&lt;Resident 30&gt;</p> <p>According to the 09/13/2024 Admission, the 12/14/2024 Quarterly, and the 03/05/2025 Significant Change MDSs, staff assessed Resident 30 with adequate vision and no corrective lenses.</p> <p>Observations on 04/14/2025 at 1:20 PM revealed a pair of glasses on Resident 30's overbed table. Resident 30 stated they required eyeglasses, and their current prescription was old.</p> <p>In an interview on 04/17/2025 at 8:29 AM Staff B (Director of Nursing) stated the MDS was coded incorrectly and should reflect the resident's altered vision and use of glasses.</p> <p>According to the 03/05/2025 Significant Change MDS, staff assessed the resident with three pressure ulcers but no vascular ulcers (sores on the skin caused by impaired blood circulation, either in arteries or veins). According to a 03/05/2025 contracted wound company's progress note, Resident 30 was treated for a Chronic Ulcer that was not reflected on the 03/05/2025 MDS.</p> <p>In an interview on 04/21/2025 at 9:05 AM Staff D (Corporate Nurse) confirmed staff should, but did not, correctly code the wound in question.</p> <p>&lt;Resident 36&gt;</p> <p>According to the 03/12/2025 Quarterly MDS staff were able to interview Resident 36 for activity preferences, but did not complete the Cognitive Patterns interview with the resident because the resident was rarely/never understood. Staff coded this MDS to indicate Resident 36 demonstrated delusions (a false belief or judgment about external reality despite evidence to the contrary) during the assessment period.</p> <p>Observations on 04/16/2025 at 7:36 AM showed Resident 36 lying in bed conversing with a family member at the bedside. The resident was able to participate in conversation, answering questions when asked. Observations on 04/14/2025 at 9:02 AM, 10:31 AM, and 12:19 PM, 04/16/2025 at 5:35 AM, 7:36 AM, and 11:20 AM, and on 4/17/2025 at 9:33 AM and 2:48 PM, revealed no indication the resident demonstrated delusional behavior.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 04/16/2025 at 7:47 AM Staff G (Social Service Director) stated I don't know why the Social Worker coded (the resident) as not interviewable, that's wrong, (the resident) is interviewable. Staff F stated the MDS was coded incorrectly as there was no indication Resident 36 demonstrated delusional behavior during the assessment period.</p> <p>&lt;Resident 61&gt;</p> <p>Resident 61 admitted to the facility on [DATE] and according to the 01/02/2025 Admission MDS had diagnoses including a brain injury which caused the loss of muscle function and aphasia (a disorder that affected a person's ability to communicate). According to the dental section of the MDS, staff were unable to examine Resident 61's dental status.</p> <p>Observation on 04/18/2025 at 10:44 AM showed Resident 61 lying in bed. At this time, Staff B did a cursory oral exam and stated, I would say the MDS was wrong, I cannot think of a reason staff would document unable to examine on the MDS.</p> <p>According to Section B of the 01/02/2025 Admission MDS, Resident 61 had no speech and was rarely/never understood. Review of Section F showed staff indicated Resident 61 was able to be interviewed for preferences for activities and Section Q showed the resident, but no family, participated in the assessment.</p> <p>In an interview on 04/21/2025 at 8:42 AM Staff D was unable to answer how staff were able to interview the resident regarding activity preferences, but not mental status.</p> <p>The 01/02/2025 Admission MDS indicated Resident 61's primary language was Samoan but staff documented unable to determine the need or want for an interpreter.</p> <p>In an interview on 04/21/2025 at 8:09 AM Staff G stated they contacted the resident's family and confirmed that while the resident communicated in both Samoan and English, Samoan was the primary and preferred language. Staff E confirmed the resident involved family members and the facility should indicate the resident would benefit from an interpreter.</p> <p>45941</p> <p>&lt;Resident 62&gt;</p> <p>Review of a 01/03/2025 Admission MDS showed Resident 62 had no natural teeth and no loose natural teeth.</p> <p>Review of a 01/02/2025 admission evaluation showed Resident 62 had two teeth and no dentures.</p> <p>Review of a 12/31/2024 Oral/dental Care Plan (CP) showed Resident 62 had two natural teeth and instructed staff to report to the dietitian for any chewing issues.</p> <p>Review of a 04/01/2025 Oral/dental health related to broken natural teeth CP instructed staff to coordinate arrangements for dental care.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview on 04/14/2025 at 10:50 AM showed Resident 62 had only two natural upper teeth and no lower teeth or dentures. Resident 62 stated they had only two teeth left, and they were very loose. Resident 62 stated they had a hard time chewing some of the foods.</p> <p>In an interview on 04/18/2025 at 10:04 AM Staff N (MDS Specialist) confirmed Resident 62's MDS showed they had no natural or broken teeth. Staff N stated the MDS was inaccurate. Staff N stated it was important for the MDS to be accurate to plan residents' care appropriately.</p> <p>46479</p> <p>&lt;Resident 69&gt;</p> <p>According to Resident 69's 02/24/2025 Discharge MDS, Resident 69 discharged from the facility on 02/24/2025 to a short-term general hospital.</p> <p>Review of a 02/24/2025 Resident Discharge Summary/Instructions evaluation form showed Resident 69 discharged to their private home.</p> <p>In an interview on 04/16/2025 at 11:39 AM, Staff N reviewed Resident 69's 02/24/2025 MDS and discharge summary. Staff N confirmed the MDS was coded incorrectly.</p> <p>REFERENCE: WAC 388-97-1000 (1)(b).</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264</b></p> <p>Based on interview and record review, the facility failed to ensure the completion of a required Pre-Admission Screening and Resident Review (PASRR) Level 2 evaluation (a person-centered evaluation that is completed for anyone identified as having or suspected of having a Serious Mental Illness (SMI), intellectual disability, developmental disability, or related condition) prior to admission for 3 of 5 sampled residents (Residents 17, 52, &amp; 62), and 2 supplemental residents (30 &amp; 36) reviewed for PASRRs. These failures placed the residents at risk for unmet mental health care needs.</p> <p>Findings included .</p> <p>&lt;Resident 17&gt;</p> <p>Resident 17 admitted to the facility on [DATE] and according to the 07/31/2024 Admission Minimum Data Set (MDS-an assessment tool) had diagnoses which included anxiety disorder and depression.</p> <p>Review of Resident 17's health records showed a 07/17/2024 Level I PASRR reflected SMIs and recommended a Level 2 PASRR. Resident 17's records showed a second Level I PASRR was completed by the facility on 12/05/2024 and also indicated Resident 17 required a Level 2 PASRR.</p> <p>Review of Resident 17's records showed no indication facility staff attempted to coordinate a Level 2 PASRR until staff documented on 04/08/2025, SS (Social Services) sent an email to the WA PASRR (office who performs the Level 2 PASRR) regarding any updates on an evaluation for the resident's updated PASRR. Currently pending an evaluation at this time. SS to follow up with any updates.</p> <p>In an interview on 04/16/2025 at 7:51 AM, Staff G (Social Services Director) confirmed there was a delay in seeking Level 2 PASRRs. When asked why there were significant delays in referring residents for Level 2 evaluations, Staff G indicated they got behind because they had no assistant.</p> <p>&lt;Resident 52&gt;</p> <p>Resident 52 admitted to the facility on [DATE] and according to the 02/22/2024 Admission MDS had diagnoses which included anxiety disorder and depression.</p> <p>Review of Resident 52's health records showed a Level 1 PASRR dated 02/12/2024 accurately reflected the resident's anxiety and depressive disorders but indicated Resident 52 did not require a Level 2 evaluation. Resident 52's records showed a PASRR level I completed by the facility on 12/05/2024 indicated the resident required a Level 2 evaluation.</p> <p>Review of Resident 52's progress notes showed no efforts to obtain a Level 2 evaluation until progress notes on 04/08/2025 showed, SS sent an email to the WA PASRR regarding any updates on an evaluation for the resident's updated PASRR. Currently pending an evaluation at this time. SS to follow up with any updates. Staff documented on 04/17/2025, On 4/14/25, SS received email from WAPASRR ., stating that they need supporting documents .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Staff G, in an interview on 04/16/2025 at 7:51 AM, confirmed there was a systemic delay in coordinating Level 2 PASRRs stating, I should have contacted them earlier.</p> <p>&lt;Resident 62&gt;</p> <p>According to the 01/03/2025 Admission MDS, Resident 62 admitted to the facility on [DATE] and had diagnosis of depression. Resident 62 received antidepressant medication seven of seven days during the assessment period.</p> <p>Review of the 12/31/2024 Level I PASRR showed Resident 62 had SMI depression and required a level II PASRR.</p> <p>Review of Resident 62's records showed no indication the facility staff attempted to coordinate a Level II PASRR until Staff G documented on 04/08/2025 they sent an email to WA PASRR authority regarding updates on an evaluation for PASRR Level II.</p> <p>In an interview on 04/16/2025 at 11:02 AM, Staff G stated there was a delay in following up Level II PASRR. Staff G stated they should follow up with PASRR evaluator within 30 days from PASRR I updated, but they did not.</p> <p>&lt;Resident 30&gt;</p> <p>Resident 30 admitted to the facility on [DATE] and according to the 09/13/2024 Admission MDS had diagnoses which included anxiety disorder and depression.</p> <p>According to the Level I PASRR dated 09/04/2024, Resident 30 had no SMIs. Facility staff completed a second Level I PASRR on 12/05/2024 which reflected Resident 30 had anxiety disorder and mood disorder and recommended a Level II PASRR.</p> <p>In an interview on 04/16/2025 at 7:24 AM, Staff G stated the Level II request was sent to the evaluator on 02/06/2025; but it should have been sent prior to that. Staff G indicated there should be follow up after a few weeks if no response was received from the agency performing the Level II PASRRs.</p> <p>Staff G confirmed at this time there was a delay in coordinating a Level II PASRR for Resident 30.</p> <p>&lt;Resident 36 &gt;</p> <p>Resident 36 admitted to the facility on [DATE] and according to the 12/10/2024 Admission MDS had diagnoses which included depression and bipolar disorder.</p> <p>According to the 12/04/2024 PASRR level I, Resident 36 had SMI but did not trigger for a Level 2 PASRR. Facility staff completed a second Level I on 12/09/2024 which reflected the resident required a Level II evaluation.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 04/16/2025 at 7:24 AM, Staff G stated the request for coordinating a Level II evaluation for Resident 36 was not faxed until 02/07/2025, two months after it was determined a Level II was required. There was no further follow up for coordination until a progress note on 04/08/2025 when SS staff reached out to the agency responsible for Level II evaluations.</p> <p>In an interview on 04/16/2025 at 11:28 AM Staff G stated, We should have contacted the PASRR folk earlier . every few weeks.</p> <p>REFERENCE: WAC 388-97-1915(4).</p> <p>45941</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264</b></p> <p>Based on interview and record review, the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR) assessments were accurately completed prior to or upon admission to the facility for 3 of 5 (Residents 52, 24 &amp; 35) and 1 supplemental resident (Resident 30) reviewed for PASRR's . This failure placed residents at risk for inappropriate placement and/or not receiving timely and necessary services to meet their mental health care needs.</p> <p>Findings included .</p> <p>&lt;Resident 52&gt;</p> <p>Resident 52 admitted to the facility on [DATE] and according to the 02/22/2024 Admission Minimum Data Set (MDS- an assessment tool) had diagnoses which included Anxiety Disorder (a mental health disorder with an excessive, irrational dread of everyday situations) and Depression (mental health disorder characterized by persistent feelings of sadness and/or lack of interest in daily activities).</p> <p>The Level 1 PASRR dated 02/12/2024 accurately reflected the resident's anxiety and depressive disorders but indicated the resident did not require a Level II evaluation.</p> <p>Review of a 12/05/2024 PASRR I Resident 52 had Serious Mental Illness (SMI) and required a Level II PASRR.</p> <p>In an interview on 04/16/2025 at 7:54 AM, Staff G (Social Service Director) indicated the PASRR rules changed in July 2024 and the 12/05/2024 PASRR requesting a Level II was late and should have been completed in July of 2024.</p> <p>&lt;Resident 30&gt;</p> <p>Resident 30 admitted to the facility on [DATE] and according to the 09/13/2024 Admission MDS Resident 30 had diagnoses which included anxiety disorder and depression.</p> <p>According to the Level I PASRR dated 09/04/2024, Resident 30 had no SMI's. Facility staff completed a second Level I PASRR on 12/05/2024 which reflected Resident 30's anxiety and mood disorder</p> <p>In an interview on 04/16/2025 at 7:24 AM, Staff G confirmed Resident 30's admission PASRR was incorrect. Staff G explained incorrect PASRRs should be corrected within the first 72 hours of admission. When asked why it took three months to correct the PASRR Staff G stated, It should have been done but we got behind and we did an audit in December.</p> <p>In an interview on 04/16/2025 at 8:20 AM when asked why PASRRs were not corrected timely, Staff G replied, It fell through the roof (like through the cracks) I didn't have a stable assistant.</p> <p>47836</p> <p>&lt;Resident 24&gt;</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>According to a 10/07/2024 Quarterly MDS Resident 24 had diagnoses of, but not limited to, Depression and Schizophrenia (mental health disorder often characterized by hallucinations, delusions, and/or disorganized thoughts).</p> <p>Review of Resident 24's health records showed a 12/05/2024 PASSR I which indicated a PASSR II referral was made. Resident 24's records did not include a PASRR II.</p> <p>In an interview on 04/18/2025 at 8:55 AM Staff G stated they communicated with the state PASRR coordinator since questions came up during survey about PASRR's and the coordinator had informed them they had not received a PASRR II referral for Resident 24. Staff G stated they were responsible to follow up on PASRR's within 3 weeks after a referral was made but they did not follow up on Resident 24's because they were running behind.</p> <p>&lt;Resident 35&gt;</p> <p>According to a 06/29/2024 Admission MDS Resident 35 had diagnoses of, but not limited to, Depression and Anxiety Disorder.</p> <p>Review of Resident 35's health records showed a 06/22/2024 PASSR I with no SMI's documented and no level II referral necessary. Resident 35's records showed a 12/18/2024 updated PASRR I that included SMI's, documented a level II PASRR was indicated, and the PASRR II referral was made.</p> <p>In an interview on 04/18/2025 at 8:55 AM Staff G stated they were expected to review the PASRR I's after the resident admitted to the facility to ensure they were correct. Staff G stated Resident 35's PASRR I review was missed. Staff G stated they completed an updated PASRR I on 12/18/2024 to reflect the SMI's and that a PASRR II referral was indicated. Staff G stated they communicated with the state PASRR coordinator since questions came up during survey about PASRR's and the coordinator had informed them they had not received a PASRR II referral for Resident 35. Staff G stated they were responsible to follow up on PASRR's within 3 weeks after a referral was made but they did not follow up on Resident 35's because they were running behind.</p> <p>REFERENCE: WAC 388-97-1915(1)(2)(a-c).</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264</b></p> <p>Based on observation, record review, and interview the facility failed to ensure Care Plans (CP) were updated and/or revised as needed to reflect person-centered care for 4 (Residents 17, 61, 36 &amp; 62) of 20 sample residents whose CPs were reviewed, and failed to provide CP meetings for 4 (Residents 62, 23, 66, &amp; 28) of 7 sample residents reviewed for CP meetings. The failure to update and/or revise CPs or provide CP meetings left residents at risk for unmet care needs, inappropriate care, and other negative health outcomes.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>Review of the facility's Care Planning Process policy revised 05/2023 showed the comprehensive CP was an interdisciplinary tool that must have measurable objectives with time frames and described the services to be provided to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The CP must be reviewed and revised at a minimum on admission, quarterly, and with a significant change in condition.</p> <p>Review of the facility's Care Conferences policy revised 05/2023 showed the facility would ensure the resident/resident representative were part of the interdisciplinary team and participate in the development and ongoing review of the plan of care. The facility would schedule care conferences for residents upon admission, quarterly, with significant changes in condition, and per residents/representatives request and document the outcome of the care conference meeting and attendees in resident's record.</p> <p>&lt;Failure to Review/Revise CPs&gt;</p> <p>&lt;Resident 17&gt;</p> <p>Resident 17 admitted to the facility on [DATE] and according to the most recent Quarterly Minimum Data Set (MDS- an assessment tool) dated 01/31/2025 was assessed with a brain injury which caused the loss of muscle function and required partial to moderate assistance with rolling from lying on the back to left and right side. This MDS also reflected the resident experienced a weight loss and was on a prescribed weight-loss program.</p> <p>Observations on 04/14/2025 12:01 PM showed loose rails/enabler bars on both the left side and right side of the bed. Review of the Safety Device - bed mobility bar/rail CP documents dated 07/26/2024, staff were directed to evaluate safety device use monthly and as needed. A second intervention directed staff to, Evaluate safety device quarterly.</p> <p>In an interview on 04/16/2025 at 12:06 PM Staff C (Corporate Nurse) stated nursing evaluates the rails quarterly, not monthly, and the CP should be clarified.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Therapeutic nutritional risk CP dated 08/01/2024 identified a goal of, No significant changes r/t (related to) inadequate oral intake, although gradual weight loss as able may be beneficial. Resident's goal weight is 175 lbs. Interventions included, Monitor weight per protocol. The CP did not define acceptable parameters of a gradual weight loss or how much weight could be lost safely in a certain period of time. The CP did not direct staff when to weigh the resident.</p> <p>Progress notes dated 04/11/2025 identified Resident 17 had a 14.2 pound (or 6.2%) weight loss in one month.</p> <p>In an interview on 04/17/25 at 1:39 PM when asked how staff knew when to weigh a resident, Staff C (Corporate Nurse) stated, It should be on the CP. In an interview on 04/17/2025 at 1:54 PM Staff D (Clinical Nursing Officer) stated, There should be a measurable goal for safe wt loss, for example 1-2 pounds per week. Staff D confirmed this information should be included in the CP.</p> <p>&lt;Resident 61&gt;</p> <p>Resident 61 admitted to the facility on [DATE] and according to the 04/04/2025 Quarterly MDS was assessed with multiple complex diagnoses, including aphasia (a disorder that affects a person's ability to communicate), that the resident's preferred language was one other than English and was dependent on tube feeding (a method of delivering nutrients through a tube into the stomach of individuals who cannot or will not eat or drink enough food to meet their nutritional needs).</p> <p>Review of Resident 61's CP showed no indication of alteration in communication related to the resident's preferred language nor were there interventions to improve communication related to a potential language barrier. Failure to ensure clear means of communication in a language the resident prefers and detracts from the resident to understand their healthcare status and the care being provided.</p> <p>According to the Nutrition risk CP dated 04/02/2025, interventions directed staff to Monitor/document circumstances surrounding mealtimes/refusals to eat. Attempt to determine pattern or cause. Where possible alter or remove the cause. A Potential for pain CP dated 12/26/2024 directed staff to Observe during eating for indications of dental, mouth and/or facial pain. A 04/01/2025 Bladder Incontinence CP directs staff to monitor and report change in eating pattern.</p> <p>A separate CP for Inadequate oral intake related to NPO (nothing by mouth) . dated 02/04/2025 was in direct conflict with CPs which indicated the resident could eat. The Inadequate oral intake CP also specified the resident received a brand of nutritional supplement tube feeding not specifically formulated to residents with diabetes at 65 cc (cubic centimeters) an hour for 20 hours a day. Review of the April 2025 MARs showed staff were instructed to administer a specific nutritional supplement for diabetics at 75 cc an hour.</p> <p>In an interview on 04/17/2025 at 9:24 AM Staff C confirmed staff should, but did not update the CP to reflect the tube feeding type and rate. Staff C also confirmed the CP was not individualized as it directed staff to monitor issues related to eating when the resident took nothing by mouth.</p> <p>&lt;Resident 36&gt;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 36 admitted to the facility on [DATE] and according to the 12/10/2024 Admission MDS had diagnoses that included bipolar disorder (a mental illness characterized by extreme shifts in mood, energy, and activity levels, ranging from periods of abnormally elevated mood and energy to periods of depression), demonstrated no indicators of psychosis which required the use of antipsychotic medication daily and utilized an indwelling urinary catheter.</p> <p>Review of MARs for April 2025 showed Resident 36 received an antipsychotic medication for Bipolar disorder with Psychotic Features. Review of Target Behaviors showed staff were monitoring for Angry Outbursts and Verbal Aggression.</p> <p>According to a Psychiatric Practitioner note dated 02/06/2025 staff were directed to, Continue to monitor for any increase in frequency or severity of auditory hallucinations .</p> <p>Review of the Uses antipsychotic medication (related to) Bipolar Disorder dated 12/09/2024 indicated that target behaviors included mood swings and angry outbursts.</p> <p>In an interview on 04/18/2025 at 9:16 AM Staff C confirmed the CP should, but did not, include the psychotic behavior (hallucinations) which required the antipsychotic medication and questioned the inclusion of the mood swings on the CP as they were not monitored.</p> <p>According to Resident 36's Alteration in Urinary elimination CP dated 12/06/25 the resident had a diagnosis of neurogenic bladder (a condition where nerve damage disrupts communication between the brain and bladder, leading to a loss of bladder control). In an interview on 04/18/25 at 9:23 AM Staff C confirmed the CP should indicate obstructive uropathy (a condition where a blockage in the urinary tract prevents the normal flow of urine from the kidneys to the bladder and then out of the body) not neurogenic bladder.</p> <p>45941</p> <p>&lt;Resident 62&gt;</p> <p>According to the 01/03/2025 Admission MDS, Resident 62 admitted to the facility on [DATE] and had diagnosis of complex medical conditions including one side of body weakness. This assessment showed Resident 62 required one person assistance with transferring and toileting.</p> <p>Review of a revised 01/08/2025 Activities of Daily Living (ADL) Care Plan (CP) showed Resident 62 required a mechanical Hoyer lift machine with two-person assistance for transfers and one person assistance with toileting.</p> <p>Observation on 04/14/2025 at 10:57 AM showed Resident 62 transferred independently from bed, on 04/15/2025 at 11:01 AM, and at 2:32 PM, and on 04/16/2025 at 10:55 AM, showed Resident 62 was walking in hallway with a walker.</p> <p>In an interview on 04/16/2025 at 11:00 AM, Staff M (Certified Nursing Assistant) stated Resident 62 did not need help with transfers, they transferred themselves and walked in their room and in hallways independently with their walker.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 04/18/2025 at 8:44 AM, Staff C (Corporate Resource Nurse) stated the facility updated resident's care plans with change in condition and change in medications and staff had to follow the care plans to provide safe care to residents. Staff C stated Resident 62 was independently transferring and ambulating everywhere with a walker. Staff C reviewed Resident 62's care plans and stated care plans were not updated according to Resident 62's status. Staff C stated care plans should, but were not, revised and updated.</p> <p>&lt;CP Meetings&gt;</p> <p>&lt;Resident 62&gt;</p> <p>According to the 01/03/2025 Admission MDS, Resident 62 admitted to the facility on [DATE], had clear speech, and no memory impairment. The assessment showed Resident 62 had complex medical conditions including hemiplegia (a condition characterized by paralysis or weakness on one side of the body) and depression.</p> <p>In an interview on 04/14/2025 at 10:48 AM, Resident 62 stated they did not have a CP meeting since they were admitted to the facility.</p> <p>Review of Resident 62's record did not show documentation Resident 62 had a CP meeting since their admission.</p> <p>In an interview on 04/18/2025 at 8:28 AM, Staff G (Social Service Director) reviewed Resident 62's record and confirmed there was no documentation regarding a CP meeting. Staff G stated the facility staff should have a CP meeting with Resident 62 and their representative, but they did not.</p> <p>46479</p> <p>&lt;Resident 23&gt;</p> <p>According to the 05/09/2024 Admission MDS, Resident 23 admitted to the facility on [DATE] and had diagnoses including kidney failure requiring dialysis (procedure that filtered waste from the blood), an autoimmune disease affecting the brain and spinal cord, and depression. The MDS showed Resident 23 was cognitively impaired, had clear speech, was sometimes understood, and could sometimes understand others.</p> <p>In an interview on 04/14/2025 at 10:32 AM, Resident 23 stated they were not aware of having any care conferences.</p> <p>Review of Resident 23's records on 04/21/2025 at 8:10 AM showed the resident did not have documentation of a care conference until 11/11/2024, over six months after they admitted to the facility. In an interview at that time, Staff G stated residents were supposed to have a care conference with the first 72 hours after admission and quarterly thereafter. Staff G confirmed Resident 23 did not have an admission or quarterly care conference until 11/11/2024.</p> <p>&lt;Resident 66&gt;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>According to the 03/21/2025 Admission MDS, Resident 66 had clear speech, was usually understood and could usually understand others. The MDS showed Resident 66 had diagnoses including an amputation, wound infection, and diabetes (inability to regulate blood sugar levels).</p> <p>In an interview on 04/14/2025 at 8:48 AM, Resident 66 stated they did not have a care conference since their admission to the facility.</p> <p>Review of Resident 66's records on 04/21/2025 at 8:07 AM showed no documentation the resident was offered or provided a care conference. In an interview at that time, Staff G confirmed the resident did not have a care conference as required.</p> <p>47836</p> <p>&lt;Resident 28&gt;</p> <p>According to a 02/28/2025 Admission MDS Resident 28 admitted to the facility on [DATE]. The MDS showed Resident 28 had no memory impairment.</p> <p>Review of Resident 28's health records showed a 03/14/2025 initial care conference evaluation. The evaluation showed only the daughter was in attendance.</p> <p>In an interview on 04/18/2025 at 8:55 AM Staff G stated expectations for offering/conducting care conferences were within 72 hours after admission to the facility, quarterly, and as needed. Staff G stated social services, rehab director, nurse manager, dietary, and activities attend resident care conferences. Staff G stated only the daughter and Staff G attended Resident 28's care conference on 03/14/2025. Staff G stated there was no documentation in Resident 28's health records as to why they were not invited to their own care conference and could not recall any reason for this. Staff G stated Resident 28 and other interdisciplinary team members did not, but should have, participated in Resident 28's care conference.</p> <p>REFERENCE: WAC 388-97-1020(2)(c-d)(f), (4)(b).</p> <p>REFER TO: F692-Nutrition/Hydration Status Maintenance.</p> <p>F700- Bedrails</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264</b></p> <p>Based on observation, interview, and record review the facility failed to ensure services provided met professional standards of practice for 7 of 20 (Residents 36, 54, 30, 17, 7, 64, &amp; 52) residents reviewed. Nursing staff failed to: follow or clarify physicians orders when indicated, document for only those tasks completed, monitor residents for significant medication dose changes, follow up on appointment recommendations from outside providers, and to monitor residents for side effects for the treatment received at appointments in outside clinics. These failures placed residents at risk for medication errors, delay in treatment, adverse outcomes, and diminished quality of care.</p> <p>Findings included .</p> <p>&lt;Failure to Follow/Clarify Physician Orders&gt;</p> <p>&lt;Resident 52&gt;</p> <p>Resident 52 admitted to the facility on [DATE] and according to the most recent Quarterly Minimum Data Set (MDS-an assessment tool) received regularly scheduled and as needed pain medication.</p> <p>Review of March 2025 Medication Administration Records (MARs) showed a Physician's Order for a pain patch Apply to bilateral (both) knees topically one time a day for Pain Do not exceed 3 patches for up to 12 hours (hr) with 24 hr period. Wash hands after handling and remove per schedule. The order directed staff to apply the patches at 9:00 AM and remove them at 5:59 AM next morning. According to the MAR, staff applied the patches for 15 hours per day rather than the 12 hours as directed.</p> <p>A second order directed staff to apply a pain patch to Bilateral shoulders topically one time a day for (joint disease). Do not exceed 3 patches for up to 12 hrs with 24 hr period. Wash hands after handling and remove per schedule. This order similarly directed staff to apply the patches at 9:00 AM and remove them at 5:59 AM. According to the MAR, staff applied the patches for 15 hours per day rather than the 12 hours as directed.</p> <p>After reviewing the MAR, in an interview on 04/16/2025 at 10:56 AM Staff C (Nurse Consultant) stated, The patch should only be on for 12 hours, the nurse should have clarified the order since the time code indicated a time of greater than 12 hours. Staff C also confirmed that the nurses, by following the physicians orders would exceed the do not exceed 3 patches directive and should have clarified the order.</p> <p>Observation of the resident on 04/15/2025 at 12:07 PM showed the resident had an undated white patch applied to the right shoulder. Observations on 04/16/2025 at 10:26 AM showed the resident had an undated white patch applied to the right shoulder.</p> <p>During observations of the resident on 04/16/2025 at 10:56 AM, Staff C stated the nurse who applied the patch to the right shoulder should have, but did not, initial and dated it upon application.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Examination of the resident's left shoulder revealed no pain patch. The resident stated at this time My left shoulder is fine, it's my neck that hurts. Further examination showed staff applied a pain patch to the resident's neck without a physician order to do so. In an interview on 04/16/2024 at 10:56 AM Staff C stated, No, there shouldn't be a patch on the neck, there is no order. Nurses should not apply medicated patches without physician's orders.</p> <p>Examination of the resident's knees showed pain patches to each knee dated 04/14/2025. In an interview on 04/16/2025 at 10:56 AM Staff C stated, The patches should be dated for today (04/16/2025).</p> <p>Review of the April 2025 MARs showed nursing staff documented the 04/14/25 knee pain patches were removed and that new patches were applied and removed on 04/15/2025. In an interview on 04/16/2025 at 10:56 AM, Staff C confirmed Resident 52 did not get medications as ordered and that nursing staff signed for tasks that were not performed.</p> <p>Additionally, according to April 2025 MAR staff were instructed to obtain weights on 04/01/2025 but documented, NA, rather than a weight.</p> <p>In an interview on 04/16/2025 at 10:44 AM, Staff C stated, We don't force residents, but the nurses should reattempt the weight and document a progress notes as to why they couldn't get the weight, then reattempt it later.</p> <p>&lt;Concomitant Medications&gt;</p> <p>Review of March and April 2025 MARs showed Resident 52 had as needed orders for as needed muscle relaxant and as needed pain medication at the same time on 03/06,15, 24, 29 and 30/2025 and on 04/05/2025 and 04/09/2025.</p> <p>In an interview on 04/16/2025 at 10:39 AM. Staff C stated that nursing staff should give the muscle relaxant medications first to relieve the muscle spasms which might be causing the pain, then the pain medication if it was still needed. Staff C stated the medications should not be given together unless the order directs to do so.</p> <p>&lt;Resident 17&gt;</p> <p>Resident 17 admitted to the facility on [DATE] and according to the Admission MDS dated [DATE] had diagnoses which included anxiety disorder which required the use of antianxiety medication.</p> <p>Record review showed Resident 17's antianxiety medication dose was doubled on 09/16/2024. Resident 17's records showed a 09/16/2024 progress note, Patient received new order antianxiety medication TID (three times a day) for Anxiety. There was no alert charting to monitor Resident 17 for any changes or effects of the significant increase in dosage.</p> <p>In an interview on 04/18/2025 at 9:41 AM Staff C stated Yes, there should be alert charting for doubling the antianxiety medication, but no there wasn't.</p> <p>Review of April 2025 MARs showed a physician order for (Medication used to treat heartburn) Give 1 tablet by mouth one time a day for GERD for 14 Days 30 minutes before other (medications). According to the MAR, this medication along with six other oral medications were scheduled for 0600.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 04/16/2025 at 10:39 AM. Staff C stated the nurse should have clarified the orders to ensure the heartburn medication was given on an empty stomach.</p> <p>&lt;Resident 36&gt;</p> <p>Resident 36 admitted to the facility on [DATE] and according to the 12/10/2024 Admission MDS had multiple medically complex diagnoses, including Vitamin D deficiency.</p> <p>Review of Resident 36's hospital discharge records showed orders for staff to administer Vitamin D supplement tablet once a week. Nursing staff transcribed this order for Resident 36 as daily and continued to administer it for nine days until 12/18/2024. Pharmacy review identified the vitamin D error for Resident 36.</p> <p>In an interview on 04/17/2025 at 1:07 PM Staff C acknowledged failure of the nurse to transcribe the physician orders correctly resulted in a medication error for Resident 36 and did not meet professional standards of practice.</p> <p>&lt;Resident 30&gt;</p> <p>Observation of medication pass on 04/14/2025 at 12:50 PM showed Staff J (Licensed Practical Nurse) obtain a blood sugar level of 230 from Resident 30, after the resident had started consuming their meal. Staff J then administered three units of an injectable medication based on the sliding scale order.</p> <p>In an interview on 04/16/2025 at 9:23 AM, Staff B (Director of Nursing) and Staff C confirmed the physician's order for blood sugar check and the injectable medication was scheduled at 11:30 AM, which was before lunch and obtaining blood sugars after Resident 30 initiated a meal placed the resident at risk for elevated blood sugars which would require higher doses of the injectable medication.</p> <p>45941</p> <p>&lt;Resident 54&gt;</p> <p>According to the 03/21/2025 Quarterly MDS, Resident 54 admitted to the facility on [DATE] and had diagnoses including rectal cancer, malnutrition, and chronic pain. The MDS showed Resident 54 was independent with daily activities and ambulation.</p> <p>In an interview on 04/14/2025 at 1:34 PM, Resident 54 was awake, sitting on the edge of their bed in their room, stating they were tired. Resident 54 stated they had cancer and had appointments with cancer doctors at least 4 days a week. Resident 54 stated they were going to be out of the facility for appointments on 04/15/2025, 04/16/2025, 04/17/2025, and 04/18/2025 and then had no appointments for two weeks.</p> <p>Observation on 04/17/2025 8:45 AM showed Resident 54 was walking in their room, stating their appointment was longer yesterday. Observation showed an Intravenous (IV) catheter on Resident 54's right chest, covered with a dressing. Resident 54 had a pump in their hand with tubing attached to their IV catheter and stated their cancer doctor provided them this pump for cancer medications.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 54's health record showed nursing progress notes on 04/15/2025 and 04/16/2025 indicating Resident 54 was out of the facility for appointments. No documentation showed Resident 54 came back from the appointments with any new medication orders or recommendations.</p> <p>Review of Resident 54's April 2025 physician orders showed no order for the IV catheter, dressing change, to monitor the IV site for any symptoms of infection, and to monitor the resident for any side effects of chemotherapy medications Resident 54 received at the cancer clinic during the appointments.</p> <p>In an interview on 04/17/2025 at 1:03 PM, Staff E (Assistant Director of Nursing) stated they were not aware Resident 54 had an IV catheter on their right chest area or a pump for medication. Staff E reviewed Resident 54's record and stated there was no order for an IV line or pump. Staff E stated staff should check with the resident for any new orders from oncologist when Resident 54 returned from appointments and document in their record, but they did not.</p> <p>46479</p> <p>&lt;Resident 64&gt;</p> <p>According to the 03/11/2025 Admission MDS, Resident 64 had unclear speech, was usually understood, and was able to understand others. The MDS showed Resident 64 had diagnoses including stroke, malnutrition, and a swallowing disorder due to the stroke. The assessment showed Resident 64 received nutrition via a tube surgically placed in their stomach.</p> <p>Review of Resident 64's 04/16/2025 order summary report showed the resident had a 03/04/2025 order directing staff the resident was to have nothing by mouth.</p> <p>Review of Resident 64's April 2025 MAR showed an order directing staff to offer the resident a snack at bedtime and document the percentage of the snack consumed by Resident 64. The MAR showed from 04/01/2025 to 04/17/2025, staff documented Resident 64 ate 100% of the snack offered on 11 of 17 opportunities. Staff documented not applicable on one occasion and a dash or 0 on 4 occasions.</p> <p>In an interview on 04/18/2025 at 10:21 AM, Resident 64 stated staff did not bring them or offer snacks at bedtime because they were unable to swallow.</p> <p>In an interview on 04/21/2025 at 10:20 AM, Staff E confirmed Resident 64 had a nothing by mouth order. Staff E stated staff should not be documenting tasks that were not done and staff should have clarified the order to provide Resident 64 with a snack at bedtime.</p> <p>47836</p> <p>&lt;Resident 7&gt;</p> <p>According to a 11/08/2024 Annual MDS Resident 7 experienced frequent 6/10 pain on a pain scale of 1-10 with 10 being the worst pain they've experienced. The MDS showed Resident 7 received scheduled pain medication during the assessment period.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 7's health records showed a 02/24/2025 physician order for an as needed pain medication without parameters.</p> <p>In an interview on 04/17/2025 at 9:24 AM Staff O (Resident Care Manager) stated Resident 7 had no pain level or maximum dose in 24 hours parameter in place for their as needed pain medication. Staff O stated Resident 7's pain medication should not exceed 3000 milligrams in 24 hours and the order should include this.</p> <p>REFERENCE: WAC 388-97-1620(2)(b)(ii).</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 20264</p> <p>Based on observation, interview, and record review the facility failed to provide assistance with Activities of Daily Living (ADLs) for 5 of 12 (Residents 61, 22, 62, 54, &amp; 31) who were assessed to be dependent on staff for ADLs. The failure to provide ADL assistance including bathing, oral care, and nail care as required, left residents at risk for poor hygiene, soiled long nails, diminished feelings of self-worth, and other negative health outcomes.</p> <p>Findings included .</p> <p>&lt;Resident 61&gt;</p> <p>Resident 61 admitted to the facility on [DATE] and according to the 04/04/2025 Quarterly Minimum Data Set (MDS - an assessment tool) was assessed with a brain injury which caused the loss of muscle function and aphasia (a disorder that affects a person's ability to communicate), and was dependent on tube feeding (a method of delivering nutrients to individuals who cannot or will not eat or drink enough food to meet their nutritional needs). This MDS assessed the resident as dependant on staff for all care, including personal hygiene.</p> <p>According to the resident's 01/22/2025 Care Plan (CP) for ADLs staff should provide oral care every shift with a toothette or glycerin sponge.</p> <p>Observations on 04/14/2025 at 12:13 PM revealed Resident 61 had long fingernails to both hands and dried debris along the left side of their mouth. A partial view of the resident's mouth showed yellow film/debris on their teeth and along the gum line. Similar observations were made on 04/16/2025 at 1:02 PM and 04/17/2025 at 1:22 PM.</p> <p>During an observation on 04/18/2025 at 10:44 AM, Staff B (Director of Nursing) stated, (The resident) has really bad breath, the teeth look brown and do not look clean. Staff B confirmed it appeared no oral care was done stating, It does not look like oral care has been happening</p> <p>45941</p> <p>&lt;Resident 22&gt;</p> <p>According to the 03/13/2025 Quarterly MDS, Resident 22 had intact memory and had a diagnosis of depression and edema (swelling caused by fluid build up in body tissues) on both legs. The MDS showed Resident 22 was dependent on staff for showers, toileting hygiene, and lower body dressing. Resident 22 required one-person assistance with personal hygiene and transfers. The MDS showed Resident 22 did not refuse care during the assessment period.</p> <p>The 10/21/2024 revised ADL Self Care deficit CP showed Resident 22 was totally dependent on staff for bathing and Resident 22 preferred showers twice a week. The CP showed Resident 22 required extensive assistance from staff for personal hygiene.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observations on 04/14/2025 at 11:55 AM, 04/15/2025 at 9:21 AM, and 04/17/2025 at 12:08 PM, showed Resident 22's fingernails were long and dirty, their toenails were thick, and there was dry flaky skin on both feet. Their lower legs were wrapped with elastic bandages.</p> <p>In an interview on 04/14/2025 at 11:55 AM, Resident 22 stated they wanted to have showers twice a week, but staff provided only bed baths because of the bandages wrapped on Resident 22's legs. Resident 22 stated staff did not wash their feet for a few weeks.</p> <p>Review of the Certified Nursing Assistant (CNA) documentation from 03/25/2025 through 04/19/2025 showed Resident 22 received four bed baths in 30 days and no shower was provided. This documentation showed no nail care was documented as provided. There were no documented refusals of nail care assistance.</p> <p>In an interview on 04/17/2025 at 12:52 PM, Staff E (Assistant Director of Nursing) reviewed Resident 22's CP and stated Resident 22 should receive showers twice a week but staff provided bed baths. Staff E stated staff should remove Resident 22's bandages from their legs and provide showers but they did not. Staff E stated nail care was important for dependent residents. Staff E stated shower aides and nurses were educated to clip resident's nails weekly and as needed, but staff did not follow the instructions.</p> <p>&lt;Resident 62&gt;</p> <p>According to the 01/03/2025 Admission MDS, Resident 62 required one person assistance from staff with personal hygiene, toileting needs, and bathing. The MDS showed no refusal of care behaviors during the assessment period.</p> <p>The 01/08/2025 revised ADL Self Care deficit CP showed Resident 62 required extensive assistance from staff with personal hygiene needs.</p> <p>Observations on 04/14/2025 at 10:46 AM, 04/16/2025 at 7:38 AM, and on 04/17/2025 at 10:41 AM showed Resident 62 had long fingernails and had black debris under their nails. Resident 62 stated they need assistance from staff to clip their fingernails.</p> <p>In an interview on 04/17/2025 at 12:55 PM, Staff E stated staff should provide nail care to all residents weekly on their shower days and as needed. Staff E stated any refusals should be documented in resident's records and notify the supervisor.</p> <p>&lt;Resident 54&gt;</p> <p>According to the 03/21/2025 Quarterly MDS, Resident 54 admitted to the facility with rectal cancer and chronic pain, and required one person assistance from staff for bathing. The MDS showed no refusal of care during the assessment period.</p> <p>Observation on 04/14/2025 at 11:22 AM and 04/15/2025 at 12:40 PM showed Resident 54 had long, sharp, and broken fingernails and had black debris under their fingernails. Resident 54 stated they need help to cut their fingernails.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of April 2025 CNA documentation showed no nail care was documented to be provided. There were no documented refusals of nail care assistance.</p> <p>In an interview on 04/17/2025 at 1:00 PM, Staff E stated staff should provide nail care to all residents weekly on their shower days and as needed. Staff E stated any refusals should be documented in resident's records and notify the supervisor.</p> <p>46479</p> <p>&lt;Resident 31&gt;</p> <p>According to the 02/25/2025 Admission MDS, Resident 31 was cognitively impaired, had clear speech, was usually understood, and could usually understand others. The assessment showed Resident 31 required supervision or touching assistance with personal hygiene.</p> <p>Observation on 04/17/2025 at 11:27 AM showed Resident 31 lying in bed, with their right foot exposed. The toenails were long, extending past the toes. At that time, Staff X (CNA) observed and confirmed Resident 31's toenails were long. Staff X removed Resident 31's sock on the left foot revealing long toenails to the resident's left foot.</p> <p>Review of Resident 31's April 2025 CNA task documentation showed staff were to document every day shift if staff provided nail care to the resident. This documentation showed staff documented Y for yes-nail care was provided to the resident on 04/15/2025. This documentation did not specify if the nail care provided was to the resident's finger or toe nails.</p> <p>Review of Resident 31's 04/16/2025 physician orders and 03/31/2025 Activities of Daily Living CP showed no orders or directions to staff regarding what assistance the resident required for finger or toe nail care, or who was to provide the care and when.</p> <p>In an interview on 04/21/2025 at 9:28 AM, Staff E stated nail care should be done as needed. Staff E stated they expected CNAs to report to the nurse if they noted long toe nails on a resident. Staff E stated they expected nurses to note long toe nails on weekly skin checks and provide trimming as needed.</p> <p>REFERENCE: WAC 388-97-1060(2)(c).</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46479</b></p> <p>Based on observation, interview, and record review the facility failed to: ensure residents received follow up appointments as recommended for wound treatment for 1 (Resident 23) of 1 resident reviewed for referral follow up, ensure residents' skin was assessed, monitored, and treated as required for 2 (Resident 30 &amp; 52) of 5 residents reviewed for non-pressure skin, and ensure blood work was obtained for 1 (Resident 7) reviewed. These failures placed all residents at risk for delay in treatment, worsening of conditions, unmet care needs, and a decreased quality of life.</p> <p>Findings included .</p> <p>&lt;Resident 23&gt;</p> <p>Review of the 02/08/2025 Minimum Data Set (MDS - an assessment tool) showed Resident 23 had diagnoses including heart failure, end-stage kidney failure, and diabetes (inability to control their blood sugar levels). The MDS showed Resident 23 had a diabetic foot ulcer.</p> <p>Review of Resident 23's physician orders showed an 11/20/2024 order directing staff to refer the resident to infectious disease for a bone infection to their right, second toe.</p> <p>Review of an 11/22/2024 consulting wound provider progress notes showed Resident 23 was being treated for a diabetic foot ulcer. This note showed Resident 23 had a bone infection to the ulcer area. The wound provider referred Resident 23 for an infectious disease consult.</p> <p>Review of a 01/08/2025 staff progress note showed Resident 23 had an appointment with infectious disease scheduled for that day but the appointment was rescheduled to 01/22/2025.</p> <p>Observation on 04/14/2025 at 10:27 AM showed Resident 23 lying in bed. Resident 23 had a small, open, scabbed area to their second toe on their right foot.</p> <p>Review of Resident 23's comprehensive records on 04/18/2025 showed no further progress notes indicating Resident 23 went to their appointment with infectious disease on 01/22/2025 as scheduled. There were no scanned documents or appointment recommendations in the resident's record.</p> <p>In an interview on 04/18/2025 at 9:09 AM, Staff E (Assistant Director of Nursing) reviewed Resident 23's records and confirmed the resident did not attend their appointment on 01/22/2025. Staff E stated it was important for staff to ensure Resident 23 attended their infectious disease appointment to ensure the resident did not have an underlying infection.</p> <p>20264</p> <p>&lt;Resident 30&gt;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 30 admitted to the facility on [DATE] and according to the 03/05/2025 Significant Change MDS, the resident was cognitively intact and required care related to fractures and other multiple traumas. Resident 30 was assessed with multiple skin issues including pressure ulcers, functional limitations in range of motion to both lower extremities, and was dependant on staff for toileting, bathing, and dressing the lower extremities.</p> <p>Observations on 04/14/2025 at 1:27 PM revealed Resident 30 lying in bed and was noted with a moderate amount of crusty, reddish debris on the medial (inside) left great toe nail bed. The resident stated, I get ingrown toenails, I have to see a diabetic doctor to get my nails trimmed .No, I haven't seen a podiatrist since I've been here.</p> <p>During observations on 04/18/2025 at 10:19 AM, Staff B (Director of Nursing) confirmed the resident had brownish rust colored discharge to both the left and right great toes and the resident appeared to have, ingrown toenails. Staff B stated nursing staff should have noted these skin issues during the daily treatments to the feet and notified the provider to ensure treatment.</p> <p>Review of April 2025 Treatment Administration Records (TARs) showed staff provided daily treatments to both feet. According to the 04/16/2025 Total Body Skin evaluation weekly form, there was a treatment to the right heel, an open area left lower leg, and a pressure ulcer to their tailbone.</p> <p>&lt;Resident 52&gt;</p> <p>Resident 52 admitted to the facility on [DATE] and according to the 02/24/2025 Quarterly MDS, Resident 52 had heart disease, and was dependant on staff for toileting, bathing, and was assessed as not able to walk due to medical condition or safety concerns.</p> <p>Review of the Cardiovascular Care Plan (CP) dated 04/30/2024 staff were directed to observe edema daily. A CP dated 10/22/2024 showed the resident had, edema and lymphedema (a condition causing swelling due to a buildup of lymph fluid in the body's tissues). This CP directed staff to Monitor/document for excessive edema and encourage resident to elevate legs.</p> <p>Review of 12/18/2024 Physician Orders directed staff to apply compression stockings to Resident 52's bilateral lower extremities on in the morning and remove them on night shift, and to assess edema every morning. According to staff, the resident had edema assessed as 1 (Immediate rebound of skin tissue with 2-millimeter (mm) pit.)</p> <p>Observations on 04/14/2025 at 2:12 PM showed Resident 52 lying in bed with lower extremities exposed. No compression stockings were applied. The resident's lower legs were enlarged and puffy. The lower extremities were not elevated on pillows. The resident stated at this time that they did experience some edema but staff did not offer to elevate their legs. Similar observations of the resident having enlarged lower extremities without benefit of compression stockings were made on 04/15/2025 at 12:41 PM, 04/16/2025 at 11:44 AM, and 04/18/2025 at 12:30 PM.</p> <p>During observations on 04/18/2025 at 12:30 PM Staff C (Corporate Nurse) confirmed the resident had what was described as 3+ (Tissue rebound greater than 15 seconds but less than 60 seconds with 5 to 6 mm pit pitting edema in the bilateral lower extremities. At that time, Staff C confirmed the treatment records that reflected edema levels of 1+ were not reflective of the resident's lower extremity edema.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>47836</p> <p>&lt;Resident 7&gt;</p> <p>According to an 11/08/2024 Annual MDS, Resident 7 had a diagnosis of, but not limited to, Vitamin D Deficiency.</p> <p>Review of Resident 7's health records showed a physician order for a high dose Vitamin D supplement. Resident 7's records showed no blood work was obtained to check their Vitamin D level.</p> <p>In an interview on 04/17/2025 at 9:26 AM, Staff O (Resident Care Manager) stated they would expect a Vitamin D to be obtained prior to implementing a high dose Vitamin D Supplement, but a Vitamin D level was not completed for Resident 7.</p> <p>In an interview on 04/18/2025 at 12:05 PM Staff E reviewed Resident 7's health records and stated they did not see a Vitamin D level was ever obtained for Resident 7, but it should be, prior to starting the high dose Vitamin D supplement. Staff E stated it was important to obtain the Vitamin D level to ensure they were not administering unnecessary medications.</p> <p>REFERENCE: WAC 388-97-1060 (1).</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264</b></p> <p>Based on observation, interview and record review the facility failed to ensure residents received proper treatment and assistive devices to maintain vision and hearing abilities for 1 (Resident 30) of 2 residents reviewed for vision services. Failure to ensure Resident 30 received assistance in obtaining vision devices placed this resident at risk for decline in Activities of Daily Living (ADLs) related to vision.</p> <p>Findings included .</p> <p>&lt;Resident 30&gt;</p> <p>Resident 30 admitted to the facility on [DATE] and according to the 09/13/2024 Admission Minimum Data Set (an assessment tool) had adequate vision and did not require the use of corrective lenses.</p> <p>Observation on 04/14/2025 at 1:20 PM showed Resident 30 lying in bed, a pair of eyeglasses were noted on the overbed table. In an interview at this time, Resident 30 indicated they needed an eye exam stating, I put in for an eye exam a few months ago, but it didn't happen, nobody's gotten back to me.</p> <p>In an interview on 04/16/2025 at 8:19 AM, Resident 30 stated. I can't read and when attempting to read a written document stated, it's a blur. The resident clarified at this time, I got glasses over two years ago . I need new glasses.</p> <p>Record review showed a progress note dated 11/01/2024 which indicated, Resident scheduled to be seen by [NAME] Vision on 11/01/2024, (resident) has declined due to feeling ill. Next F/U (follow up) will be December 2024. Record review showed no evidence Resident 30 received vision services.</p> <p>In an interview on 04/21/2025 at 9:16 AM, Staff G (Social Service Director) stated the facility has an eye service that comes in and sees residents when requested. Staff G confirmed staff should have, but did not, reschedule the resident until survey staff brought it to their attention on 04/17/25 with the next available appointment being in June. Staff G indicated they forgot about Resident 30.</p> <p>Refer to F641 Accuracy of MDS</p> <p>REFERENCE: WAC 388-97-1060(3)(a).</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>47836</p> <p>Based on observation, interview, and record review the facility failed to ensure 2 of 3 sampled residents (Residents 6 &amp; 7) reviewed for Pressure Ulcers (PUs), received appropriate pressure reducing measures and repositioning on a consistent basis. This failure placed all residents at risk for PU development, and a diminished quality of life.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to a facility policy titled, Safety Device Application, revised 04/07/2023, showed the facility would apply the safety device as directed. The policy showed staff would follow the safety device Care Plan (CP) and interventions.</p> <p>According to a facility policy titled, Wound Prevention and Treatment, revised 02/03/2023, the facility would reduce the occurrence of pressure over bony prominence to minimize injury, manage risk factors, and provide preventive interventions. The policy showed the staff would ensure residents received continuous preventative interventions to promote healing and prevent skin issues.</p> <p>&lt;Resident 6&gt;</p> <p>According to a 01/04/2025 Annual Minimum Data Set (MDS - an assessment tool) Resident 6 had no memory impairment. The MDS showed Resident 6 was at risk of developing PUs and had three PUs.</p> <p>Review of Resident 6's health records showed a 04/22/2023 physician order for air mattress settings to be at alternate level 5 and staff would check for correct settings every shift. Residents 6's records showed a 10/24/2023 air mattress CP with an intervention for staff to monitor appropriate functioning of air mattress every shift. Resident 6's records showed a 03/05/2025 right heel PU CP with an intervention for staff to frequently reposition the resident to prevent new PU's or worsening of active PUs.</p> <p>In an observation and interview on 04/14/2025 at 9:25 AM showed Resident 6's air mattress settings at float level 8. Staff S (Registered Nurse) stated Residents 6's air mattress should be at alternate level 5. Staff S stated nursing staff were responsible for checking the air mattress settings every shift to ensure they were set per physician orders to prevent skin breakdown.</p> <p>In an interview on 04/14/2025 at 12:51 PM Resident 6 stated they depended on staff to reposition them in their bed with the air mattress. Resident 6 stated the staff were supposed to reposition them every two to three hours but often did not.</p> <p>In a continuous observation on 04/17/2025 from 7:56 AM until 12:06 PM Resident 6 was lying in bed flat on their back.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/17/2025 at 11:46 AM Staff V (Certified Nursing Assistant) stated they were expected to reposition Resident 6 per their CP instructions. Staff V stated they repositioned Resident 6 off their left side and onto their back just before breakfast came out and were just about to get them up in their wheelchair. Staff V stated this was not per Resident 6's CP instructions for repositioning.</p> <p>In an interview on 04/18/2025 at 12:05 PM Staff E (Assistant Director of Nursing) stated they expected staff to reposition residents at a minimum of every two hours while in bed or up in a chair.</p> <p>&lt;Resident 7&gt;</p> <p>According to the 11/08/2024 Annual MDS Resident 7 had no memory impairment. The MDS showed Resident 7 was at risk for PUs. The MDS showed Resident 7 had a pressure a reduction device to their bed.</p> <p>Review of Resident 7's health records showed a safety device air mattress with bolsters CP with an intervention to keep the air mattress set at 180 pounds and 30-minute cycle time/alternating. Resident 7's records showed a physician order to set the air mattress at 165 pounds and cycle time/alternating with the staff to check for correct settings every shift.</p> <p>In an interview on 04/18/2025 at 8:28 AM Staff L (Resident Care Manager) stated Resident 7's bed was set incorrectly and should not be set at 340 pounds. Staff L stated the nursing staff are to monitor air mattress settings every shift to ensure they are set according to the physician order to prevent skin breakdown.</p> <p>REFERENCE WAC: 388-97-1060 (3)(b).</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264</b></p> <p>Based on observation, interview, and record review the facility failed to provide necessary foot care and treatment in accordance with professional standards, including provision of nail care and Podiatry Services. Deficient practice was identified for 3 (Residents 30, 17, &amp; 23) of four residents reviewed for nail care. Failure to provide timely toenail care placed the residents at risk for negative health outcomes.</p> <p>Findings included .</p> <p>&lt;Resident 30&gt;</p> <p>Resident 30 admitted to the facility on [DATE] and according to the 03/05/2025 Significant Change Minimum Data Set (MDS - an assessment tool) the resident was cognitively intact and had multiple diagnoses including diabetes. Resident 30 was assessed with functional limitations in range of motion to both lower extremities and was dependant on staff for dressing the lower extremities. Record review showed no evidence Resident 30 received Podiatry services since admission.</p> <p>Observations on 04/14/2025 at 1:27 PM revealed Resident 30 lying in bed and was noted with a moderate amount of crusty reddish debris on the inside of their left great toe nail bed. The resident stated, I get ingrown toenails, I have to see a diabetic doctor to get my nails trimmed .No, I haven't seen a podiatrist since I've been here.</p> <p>In an interview on 04/16/2025 at 7:24 AM Staff G (Social Service Director) stated, Anyone who wants to be seen (by the Podiatrist -Foot doctor), anyone who has diabetes needs to be seen; I always check with nursing. Staff G elaborated, If we couldn't get an in house podiatrist, we would send them out for that service .</p> <p>In an interview on 04/18/2025 at 10:50 AM, when asked how long after admission should a diabetic resident be seen by podiatry, Staff C (Corporate Nurse) stated, I prefer diabetic residents are seen quarterly; so a resident admitted in September should have been seen twice by now. Staff C confirmed Resident 30 should have, but did not receive, Podiatry services.</p> <p>During observations on 04/18/2025 at 10:19 AM Staff B (Director of Nursing Services) stated Resident 30 appeared to have, ingrown toenails. Staff B confirmed the resident should be referred to Podiatry upon admission.</p> <p>&lt;Resident 17&gt;</p> <p>Resident 17 admitted to the facility on [DATE] and according to the most recent Quarterly MDS assessment, was assessed as cognitively intact with multiple medically complex diagnoses, including diabetes.</p> <p>Observations on 04/16/2025 at 10:31 AM showed the resident lying in bed. In an interview at that time the resident stated, It's been awhile since seeing a podiatrist.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review showed a 09/19/2024 Podiatry Consult that documented treatments received and recommended Follow up in 2-3 months or as needed for a more acute problem. Record review showed no documentation to support the resident had any subsequent Podiatry services.</p> <p>In an interview on 04/16/2025 at 7:24 AM Staff G provided a 02/26/2025 Podiatry Consult for Resident 17, which was not in the record. Staff G stated there were problems with the previous Podiatrist which caused delay in services, but they currently had a new Podiatrist service.</p> <p>In an interview on 04/18/2025 at 12:57 PM, Staff C stated Resident 17 should have been seen prior to the 02/26/2025 visit and staff did not ensure Podiatry follow up in 2-3 months as recommended at the 09/19/2025 visit.</p> <p>46479</p> <p>&lt;Resident 23&gt;</p> <p>Review of the 02/08/2025 Quarterly MDS showed Resident 23 had diagnoses including heart failure, end-stage kidney failure, and diabetes (inability to control their blood sugar levels). The MDS showed Resident 23 had a diabetic foot ulcer.</p> <p>Review of Resident 23's progress notes showed an 11/17/2025 consulting wound provider note recommending a Podiatry referral for management and evaluation of hammer toes as foot deformity may complicate wound healing. The consulting wound provider wrote additional notes recommending a podiatry referral for Resident 23 on 11/23/2024, 12/08/2024, 12/13/2024, 12/22/2024, 12/28/2024, 01/04/2025, 01/11/2025, 01/19/2025, and 01/24/2025.</p> <p>Review of Resident 23's 04/14/2025 order summary showed a 01/14/2025 physician's order instructing staff to refer the resident to a podiatrist for a right foot wound.</p> <p>Review of Resident 23's comprehensive records on 04/21/2025 showed no progress notes, orders, or scanned documents indicating facility staff followed the wound provider's recommendation to refer Resident 23 to a podiatrist.</p> <p>In an interview on 04/21/2025 at 8:11 AM, Staff G stated they were responsible for arranging the facility's podiatry services and confirmed Resident 23 was not seen by a podiatrist since the referral made in November 2024. Staff G stated the facility was having issues with podiatry services and did not currently have a date of when the podiatrist would be available to the facility.</p> <p>In an interview on 04/21/2025 at 9:17 AM, Staff E (Assistant Director of Nursing) confirmed Resident 23 was not seen by a podiatrist as recommended. Staff E stated staff should have followed the wound provider's recommendation for a podiatrist but they did not.</p> <p>Refer to: F684</p> <p>REFERENCE: WAC 388-97-1060(3)(j)(viii).</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>45941</p> <p>Based on observation, interview, and record review the facility failed to identify, assess, and implement interventions to prevent accidents for 1 of 1 resident (Residents 62) reviewed for smoking. These failures left the resident at risk for injury and a diminished quality of life.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>Record review of the facility policy titled, Smoking, revised 06/2023, showed the facility would screen all residents for smoking via the nursing admission evaluation. Residents who wished to continue smoking would have smoking reflected in their care plan. The policy showed the facility would store all smoking materials in a locked storage cabinet in the resident's room, at the nurse's station, or another designated location in the facility.</p> <p>&lt;Resident 62&gt;</p> <p>According to the 01/03/2025 Admission Minimum Data Set (MDS - an assessment tool), Resident 62 had clear speech, their memory was intact, and they understood others during communication. The MDS showed Resident 62 required one person assistance with transfers, toileting, and bed mobility. The MDS showed Resident 62 used a wheelchair for mobility.</p> <p>In an interview on 04/14/2025 at 10:57 AM, Resident 62 stated they smoked once or twice a day and had their smoking materials in a drawer in their room. Resident 62 stated they knew the rule to not smoke on facility property and they had to go 50 feet away from the facility property.</p> <p>Review of Resident 62's record showed Resident 62 did not have a smoking assessment completed.</p> <p>Review of a Social Services evaluation completed on 03/31/2025 showed Resident 62 as a smoker.</p> <p>In an interview on 04/16/2025 at 7:44 AM, Resident 62 stated the facility staff knew they smoked. Resident 62 stated the facility staff provided them with a metal lock box to keep their smoking materials in their room in a drawer. Resident 62 stated they last smoked yesterday around 5:00 PM.</p> <p>Observation on 04/16/2025 at 7:50 AM showed Resident 62 had a curtain of cigarettes and a lighter in a metal box in a drawer in Resident 62's room.</p> <p>In an interview on 04/16/2025 at 8:44 AM, Staff G (Social Services Director) stated Resident 62 was not smoking currently. Staff G stated Resident 62 was found vaping outside the facility a couple of months ago and it was discussed with the resident that the facility was a non-smoking facility. Staff G stated they were not aware of Resident 62 currently smoking or of the lock box in their room.</p> <p>In an interview on 04/16/2025 at 9:10 AM, Staff B (Director of Nursing) stated they were a non-smoking facility and everyone had to follow the facility policy.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/16/2025 at 9:15 AM, Staff D (Chief Nursing Officer) stated the facility was a non-smoking facility. Staff D stated they were unaware Resident 62 smoked or that Resident 62 kept smoking materials in their room. Staff D stated the expectation was to assess residents who smoked to determine if they were safe to smoke independently or needed supervision, but they did not complete the smoking assessment.</p> <p>In an interview on 04/16/2025 at 9:36 AM, Staff A (Administrator) stated they were unaware Resident 62 smoked. Staff A stated the facility staff should complete the smoking assessment but they did not.</p> <p>REFERENCE: WAC 388-97-1060(3)(g).</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264</b></p> <p>Based on observation, interview, and record review the facility failed to ensure indwelling urinary catheters (device that drains urine from the bladder to an external bag) had a valid medical justification for the use of or a plan for discontinuation for one (Resident 36) of two residents reviewed for catheter use. These failures placed residents at risk for urinary tract infections and decline of normal bladder function.</p> <p>Findings included .</p> <p>According to the facility policy on indwelling catheters dated 12/2024, all residents with an indwelling catheter required a medical justification for the initiation and continuing need for catheter use. A comprehensive assessment included underlying factors supporting medical justification, determination of which factors could be reversed and development of a plan for appropriate indications for continuing use of an indwelling catheter beyond 14 days which may include: urinary retention that could not be treated or corrected medically or surgically, and characterized by documented post void residual volumes in a range over 200 mls (milliliters), inability to manage the retention/incontinence with intermittent catheterization, and persistent overflow incontinence (a type of urinary incontinence where the bladder doesn't empty completely, causing urine to leak out when it becomes too full), symptomatic infections, and/or renal (kidney) dysfunction, contamination of . pressure ulcer wounds</p> <p>&lt;Resident 36&gt;</p> <p>Resident 36 admitted to the facility on [DATE] and according to the 12/10/2024 Admission Minimum Data Set (MDS - an assessment tool) had diagnoses including renal insufficiency but no obstructive uropathy (a condition where the normal flow of urine through the urinary tract is blocked, potentially leading to kidney damage) and no neurogenic bladder (a condition where damage to the brain, spinal cord, or nerves affected bladder control, leading to issues like urinary retention, incontinence, or both) . This MDS showed the resident had an indwelling urinary catheter. The 03/12/2025 Quarterly MDS showed a new diagnosis of obstructive uropathy.</p> <p>Observation on 04/14/2025 at 10:31 AM revealed Resident 36 lying in bed, a catheter bag was attached to the bed frame. In an interview at that time, the resident could not recall how long they had the catheter or why they had it stating, I have a shoddy memory.</p> <p>In an interview on 04/16/2025 at 7:31 AM, Resident 36's family member stated Resident 36 did not have the catheter until they were hospitalized prior to (the resident's) admission to the facility. The family member stated the resident had, No previous need for the catheter, never had urinary problems.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>According to progress notes dated 12/06/2024 staff documented, Patient to start voiding trial (procedure to determine if a patient could empty their bladder adequately without the need for a catheter. The process typically involves removing a catheter, encouraging the patient to void into a measuring cup or container, and then measuring the amount of urine voided and the amount of urine left in the bladder after voiding.) on the 9th.</p> <p>Staff documented on 12/09/2024 at 2:33 PM, Foley catheter [discontinued] per provider order. Will monitor for ability to urinate. At 11:28 PM on 12/09/2024 staff documented, Foley catheter [discontinued]. Resident can go bedside commode to urine out several times. There was no indication facility staff documented the number of times the resident urinated, the volume of urine output, or attempted post void residuals (catheterizing the resident after urination to determine if urine remained in the bladder). There was no further assessment of the resident's urinary status until a note on 12/10/2024 at 1:51 PM when staff documented, Resident noted with urinary retention Foley catheter placed with 1000 cc (cubic centimeters) of urine return noted. Foley catheter left in place. Provider aware.</p> <p>According to the Urinary Elimination Care Plan dated 12/06/2024, interventions included, Urology consult as needed but the record revealed staff did not consider a urology consult to confirm the resident's urinary retention could not be treated or corrected medically.</p> <p>Record review showed no documentation to support the resident had untreatable urinary blockage or any history of being unable to void prior to the most recent hospitalization . There was no indication in the record facility staff considered prolonged use of the indwelling urinary catheter could lead to a decrease in bladder tone and function, or what interventions might be done to mitigate those effects.</p> <p>In an interview on 04/18/2025 at 9:23 AM Staff C (Corporate Nurse) confirmed no post void residuals were obtained and there was no attempt at bladder retraining stating, We could have done better. Staff C confirmed staff failed to follow the facility policy to ensure the catheter was necessary.</p> <p>REFERENCE: WAC 388-97-1060(3)(c).</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264</b></p> <p>Based on observation, interview, and record review the facility failed to ensure residents maintained acceptable parameters of nutritional status for 1 of 2 residents (Resident 17) reviewed for nutrition and staff offered and provided hydration services to 2 of 2 residents (Resident 7 &amp; 35) reviewed for hydration. Failure to ensure consistent, timely weights, and act on the Registered Dietician (RD) recommendations, including reweighs, placed the residents at risk for delayed identification of interventions, and continued weight loss. Failure to offer and provide hydration services to residents placed all residents at risk for dehydration and decreased quality of life.</p> <p>Findings included .</p> <p>&lt;Resident 17&gt;</p> <p>Resident 17 admitted to the facility on [DATE] and according to the 07/31/2024 Admission Minimum Data Set (MDS - an assessment tool) the resident had diagnoses which included a brain injury causing the loss of muscle function, either complete or partial, in part of the body, and diabetes (unstable blood sugar levels), and weighed 260 lbs (pounds). The 01/31/2025 Quarterly MDS assessed the resident at 233 lbs and identified a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months, but was on a prescribed weight loss regimen.</p> <p>Observation on 04/16/2025 at 10:30 AM revealed Resident 17 lying in bed. At this time the resident stated they had lost a lot of weight within the last year.</p> <p>Review of Resident 17's weights showed large weight fluctuations without reweighs or assessments. On 08/28/2024 the resident was assessed to weigh 232.4 lbs with the next weight documented as 254 lbs on 09/03/2025, a weight gain of 21.6 lbs in less than a week. There was no reweigh until three weeks later on 09/28/2024 (at 251 lbs) and no assessment of the almost 22 lb weight gain. Resident 17's record showed no subsequent weight until 11/06/2024 when the resident was noted to weigh 242 lbs, a loss of 9 lbs. Staff documented monthly weights for Resident 17 until 02/04/2025 with the next subsequent weight obtained over six weeks later on 03/21/2025.</p> <p>Weight records showed the resident weighed 227.2 lbs on 03/21/2025 and on 04/03/2025 weighed 203 lbs. Four days later, on 04/07/2025 staff documented the 04/03/2025 weight was incorrect and reweighed the resident at 213 lbs, which was a 14.2 lb (6.25%) weight loss in less than three weeks.</p> <p>Review of the Therapeutic nutritional risk Care Plan (CP) dated 08/01/2024, showed Resident 17's goal was No significant changes [related to] inadequate oral intake, although gradual weight loss as able maybe beneficial. Resident 17's goal weight was 175 lbs. The CP for Resident 17 showed staff would monitor weight per protocol and weight loss desired by the resident and the RD would review/confirm appropriate goal weight. There were no interventions that directed staff when to weigh or reweigh the resident, when or what weight deviations to report, or what an objective, measurable safe weight loss goal was for any given period of time for Resident 17.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/17/2025 at 1:39 PM, when asked how staff knew when to weigh or reweigh residents, Staff C (Nurse Consultant) stated it should be on the CP. After reviewing Resident 17's record, Staff C confirmed staff were not reweighing the resident with noted weight changes and there should be, but were not, documented assessments of those weight changes.</p> <p>In an interview on 04/17/2025 at 1:48 PM Staff D (Corporate Nurse) stated, I expect reweighs for +/- 5 lbs on the same day or the following day. Staff D stated, The resident should be reweighed and there should be a measurable goal for safe weight loss for example one to two pounds per week.</p> <p>In an interview on 04/17/2025 at 2:00 PM when asked what an objective, measurable safe weight loss would be for Resident 17, Staff Q (RD) replied, I would say within 5% (weight loss) for a month; 2% in a week. Staff Q confirmed for Resident 17, Yes we identified it (weight loss) was 6%. Staff Q was asked how staff were to ensure a weight loss does not exceed 5% in a month, when the weight loss of 6% was not identified until after it occurred. No further information was provided.</p> <p>47836</p> <p>&lt;Resident 7&gt;</p> <p>Review of the 11/08/2024 Annual MDS showed Resident 7 had no memory impairment. The MDS showed Resident 7 did not have swallowing difficulties.</p> <p>Review of Resident 7's health records showed an 11/14/2024 at risk for dehydration CP indicating staff would encourage fluids with each care. Resident 7's health records showed a 04/03/2025 diet order with no restrictions on fluids.</p> <p>In an interview on 04/15/2025 at 9:21 AM, Resident 7 stated staff do not bring them water. Resident 7 stated they were always thirsty. Resident 7 stated they had to ask staff to bring them a water pitcher and sometimes they would get one, but sometimes they would not come back with one.</p> <p>Observation on 04/16/2025 at 8:56 AM showed staff did not offer Resident 7 hydration services. Resident 7 asked staff to bring them a water pitcher with fresh water.</p> <p>&lt;Resident 35&gt;</p> <p>According to a 06/29/2024 Admission MDS, Resident 35's ability to make daily decisions was severely impaired. The MDS showed a dehydration/fluid maintenance care area was triggered for Resident 35 and staff would assess and manage their fluid needs.</p> <p>Review of Resident 35's health records showed a 06/22/2024 peripheral vascular disease related to diabetes CP with an intervention for staff to encourage good hydration.</p> <p>Observations on 04/15/2025 at 12:05 PM showed no water pitcher or fluids available in Resident 35's room.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/18/2025 at 12:05 PM, Staff E (Assistant Director of Nursing) stated they expected staff to offer and provide water pitchers to all residents every shift and as needed. Staff E stated they expected staff to automatically provide hydration services, and the residents should not have to ask to get them.</p> <p>REFERENCE: WAC 388-97-1060(3)(h).</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47836</b></p> <p>Based on observation, interview, and record review the facility failed to provide risks and benefits of bed rail use prior to installation, ensure proper installation of bed rails, and provide ongoing maintenance of bed rails for 5 of 5 residents (Resident 7, 24, 28, 35, &amp; 17) reviewed for bed rails and 2 supplemental residents (Residents 30 &amp; 22) reviewed. These failures placed residents at risk for injury, entrapment, and other negative health outcomes.</p> <p>Findings included .</p> <p>&lt;Policy&gt;</p> <p>According to a facility policy titled, Safety Device Application, revised 04/07/2023, the facility would review safety devices with the resident and/or representative. The policy showed the facility would ensure proper installation as directed for the bed rails.</p> <p>&lt;Resident 7&gt;</p> <p>According to a 11/08/2024 Annual Minimum Data Set (MDS - an assessment tool) Resident 7 had no memory impairment.</p> <p>Review of Resident 7's health records showed a 06/10/2022 physician order for the bilateral bed rails. Resident 7's records showed an 11/13/2024 safety device assessment form for the bed rails with the resident's guardian name typed in the information provided to box on the form.</p> <p>Observation and interview on 04/15/2025 at 9:56 AM showed bilateral bed rails to Resident 7's bed. Resident 7 stated staff had not discussed the bed rail use with them.</p> <p>&lt;Resident 24&gt;</p> <p>According to a 01/05/2025 Annual MDS Resident 24 had short term and long-term memory impairment. The MDS showed Resident 24's daily decision ability was moderately impaired. The MDS showed Resident 24's primary language was not English. The assessment showed Resident 24's family participated in the assessment.</p> <p>Review of Resident 24's health records showed a 02/28/2023 physician order for the bilateral bed rails. Resident 24's records showed a 01/18/2025 safety device assessment form for the bed rails with son typed in the information provided to box on the form.</p> <p>In an interview on 04/14/2025 at 9:25 AM Staff S (Registered Nurse) stated the maintenance department was responsible for proper safety device maintenance and installation.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 04/15/2025 at 10:52 AM showed bilateral bed rails to Resident 24's bed. Resident 24's right bed rail completely folded inward onto the bed when grabbed and the left bed rail was very loose, making them both unsafe for the resident to use for positioning in bed.</p> <p>&lt;Resident 28&gt;</p> <p>According to a 02/28/2025 Admission MDS Resident 28 had no memory impairment.</p> <p>Review of Resident 28's health records showed a 03/18/2025 physician order for the bilateral bed rails.</p> <p>Observation and interview on 04/14/2025 at 12:25 PM showed bilateral bed rails to Resident 28's bed. Resident 28 stated they did not use the bed rails because they did not want to depend on them. Resident 28 stated staff did not discuss the bed rail usage with them.</p> <p>&lt;Resident 35&gt;</p> <p>According to a 04/01/2025 Quarterly MDS Resident 35 had short term and long-term memory impairment. The MDS showed Resident 35's daily decision ability was moderately impaired.</p> <p>Review of Resident 35's health records showed a 03/25/2025 physician order for the right-side bed rail. Resident 35's health records showed a 03/25/2025 safety device evaluation form for the right-side bed rail with resident typed in the information provided to box, no signature for consent. Resident 35's health records showed they had severe cognitive impairment and had a Power of Attorney (POA - designee to make decisions on part for the resident) for their healthcare decision making.</p> <p>Observation on 04/15/2025 at 12:57 PM showed a bed rail to Resident 35's right side of bed.</p> <p>In an interview on 04/17/2025 at 9:00 AM Staff O stated they were unaware Resident 35 was unable to consent at the time and during this interview observed Resident 35 had severe cognitive impairment and had a POA in place. Staff O stated Resident 35's POA was not notified of the risks and benefits of the bed rail use.</p> <p>In an interview on 04/18/2025 at 9:20 AM Staff O stated they were unable to provide a copy of the notification signed by the resident/representative or a confirmation email notification of risks and benefits for Resident's 7, 24, or 28's bed rail use.</p> <p>In an interview on 04/18/2025 at 9:26 AM Staff H (Maintenance) assessed Resident 35's bed rails to be loose. Staff H stated maintenance was responsible for installing the bed rails, and the nursing staff were trained on how to tighten them when they become loose. Staff H stated the bed rails never stayed put and always became loose. Staff H stated maintenance was not responsible for monitoring the ongoing proper installation of the bed rails and nursing staff were supposed to fix them when they noticed the rails were loose.</p> <p>20264</p> <p>&lt;Resident 17&gt;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 17 admitted to the facility on [DATE] and according to the most recent Quarterly MDS dated [DATE] was assessed with a brain injury which caused the loss of muscle function and required partial to moderate assistance with rolling from lying on the back to left and right side.</p> <p>Observations on 04/14/2025 at 12:01 PM showed Resident 17 had loose bed rails on both the left and right side of the bed. These rails were noted perpendicular to the bed rather than parallel to the bed with the rails extending up over the mattress. In an interview at this time Resident 17 stated they used the rails for bed mobility but they were, loose. Similar observations of Resident 17's bed rails were noted on 04/16/2025 at 7:40 and 10:27 AM.</p> <p>During an observation on 04/16/2025 at 12:06 PM Staff C (Nurse Consultant) confirmed Resident 17's bed rails were loose and they should be checked on a regular basis and tightened as needed. When asked if the rails were properly installed (perpendicular rather than parallel to the bed) Staff C referred to Staff H.</p> <p>In an interview on 04/16/2025 at 1:02 PM Staff H confirmed the rails on resident 17's bed should not be installed perpendicular stating I put them (the rails) on there right, the aides keep changing it .I changed it back. Staff H confirmed the aides should not alter the application of the bed rails.</p> <p>&lt;Resident 30&gt;</p> <p>Resident 30 admitted to the facility on [DATE] and according to the Significant Change MDS dated [DATE] the resident was cognitively intact and was assessed with functional limitations in range of motion to both lower extremities and required partial/moderate assistance with bed mobility.</p> <p>Observations on 04/14/2025 at 1:22 PM showed bed rails were installed on both the right and left sides of Resident 30's bed. When the left rail was noted as loose, Resident 30 wiggled the right rail stating, Check this other one, it's loose too. Similar observations of Resident 30's loose rails were noted on 04/16/2025 at 8:17 AM and 12:56 PM.</p> <p>45941</p> <p>&lt;Resident 22&gt;</p> <p>According to the 03/13/2025 Quarterly MDS Resident 22 admitted to the facility on [DATE], and had chronic pain in their knees. Resident 22 was cognitively intact, was assessed with functional limitations in range of motion to both lower extremities, and required extensive assistance with bed mobility.</p> <p>Review of Resident 22's record showed the 09/23/2024 physician order under safety device for the bilateral bed rails for mobility. The 09/03/2024 physician order under nonpharmacological interventions to reduce pain for the resident was repositioning in bed.</p> <p>Review of the 09/23/2024 Safety devise CP showed Resident 22 had bed mobility bars related to muscle weakness and instructed staff to observe the safety device for changes regarding effectiveness of the safety device and report changes to the charge nurse.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview on 04/14/2025 at 12:04 PM showed Resident 22 lying in their bed on their back. The observation showed side rails were installed on both the right and left sides of Resident 22's bed. The rail on the right side bed rail was up and the rail on the left side of the bed was down. Resident 22 stated they reposition themselves with side rails in bed, but the left side of the bed rail was broken for a few days, and they could not reposition themselves in bed. Resident 22 stated staff knew about the left side rail was broken and maintenance director was supposed to fix it, but it was not done yet. Similar observations of the left, non-functional side rail were noted on 04/15/2025 at 10:12 AM, 04/16/2025 at 9:03 AM and 2:24 PM, on 04/17/2025 at 12:25 PM.</p> <p>In an interview on 04/17/2025 at 10:08 AM, Staff H stated they were not aware of the broken left side rail for Resident 22's bed. Staff H stated there was no record of Resident 22's left bed rail being broken on the maintenance log.</p> <p>In an interview on 04/17/2025 at 12:55 PM, Staff E stated they were not aware of the broken side rail on Resident 22's bed. Staff E stated they expected staff to notify the maintenance department about the broken side rail so maintenance could fix it, but staff did not.</p> <p>REFERENCE: WAC 388-97-1060(3)(g), -2100 (1).</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>20264</p> <p>Based on observation, interview, and record review the facility failed to ensure a medication error rate of less than 5%. Failure to properly administer 5 of 25 medications for 3 of 4 residents (Residents 2, 30, &amp; 19) observed during medication pass resulted in a medication error rate of 20%. This failure placed residents at risk for not receiving the correct dose or receiving less than the intended therapeutic effects of physician ordered medications.</p> <p>Findings included .</p> <p>&lt;Policy&gt;</p> <p>According to the facility policy on ophthalmic (eye) drops, dated 11/15/2024, when administering multiple medications to the same eye, staff would wait 3-5 minutes between drops and staff would apply gentle pressure to the tear duct after administration or instruct the resident to close their eye. Waiting between eye drops was important to maximize their effectiveness and prevent potential side effects. It allows each drop to be absorbed by the eye before the next one is administered, preventing dilution and ensuring the medication stays in contact with the eye longer. Failure to follow Physician Ordered time parameters between eye drops decreases effectiveness of the respective medication and constitutes a medication error. Pressing gently on the tear duct, the small opening in the inner corner of the eye, after applying eye drops helps prevent the medication from draining into the nose and throat and ensures adequate dosage. This technique helps keep the medication in the eye longer, allowing it to be absorbed more effectively and potentially reducing systemic side effects. The facility procedure for oral metered dose inhalers instructed staff to wait 20-30 seconds between administration of doses for the same medication, and 2-5 minutes if medications were different.</p> <p>&lt;Resident 2&gt;</p> <p>Observation on 04/16/2025 at 8:21 AM showed Staff J (Licensed Practical Nurse) bring multiple medications into Resident 2's room, administering them in quick succession. Staff J was observed to administer two drops of an eye drop into each of Resident 2's eyes at 8:26 AM. Staff J then administered a nasal spray according to physician orders at 8:26 AM. Staff J administered one drop of another medicated eye drop to the left eye at 8:26 AM and proceeded to give a tissue to the resident who then wiped their eye. Staff J did not instruct Resident 2 to apply gentle pressure to the tear duct after eye drop administration or instruct the resident to close their eye per facility policy. These medications for Resident 2 were scheduled on the Medication Administration Record (MAR) to be given at 7:00 AM. Staff J administered another medicated inhaler at 8:26 AM to Resident 2. Staff J then administered a different medicated eye drop at 8:27 AM to Resident 2's left eye. The resident blinked and wiped their eye with a tissue. Staff J did not instruct Resident 2 to depress the tear duct or close their eye as directed in the facility policy. According to the manufacturer insert for this eye drop, there should be a 5-minute wait between eye drop administrations but the MAR instructed staff to wait only three to ten minutes between administration from other eye drops. Staff J then administered two puffs of another inhaler at 8:27 AM.</p> <p>In an interview on 04/16/2025 at 8:29 Staff J stated, I know I gotta wait like 5 minutes between eye drops and they want you to wait a couple of minutes between the inhaler.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 04/16/2025 at 9:23 AM Staff B (Director of Nursing) and Staff C (Nurse Consultant) stated the spacing between the inhalers, should be at least five minutes.</p> <p>In an interview on 04/16/2025 at 1:50 PM, Staff B and Staff C confirmed this was an error and the medicated eye drops should be given before 8:00 AM and not within 3 minutes of other eye drops.</p> <p>&lt;Resident 30&gt;</p> <p>Observation of medication pass on 04/14/2025 at 12:50 PM showed Staff J obtain a blood sugar level of 230 from Resident 30, after the resident had started consuming their meal. Staff J then administered an injectable medication to Resident 30 based on blood sugar parameters in the physician order.</p> <p>According to the April 2025 MAR, the blood sugar check and injectable medication coverage for the blood sugar results was ordered for 11:30 AM but completed at 12:52 PM.</p> <p>In an interview on 04/16/2025 at 9:23 AM, Staff B and Staff C confirmed if the physician's order for blood sugar check and the injectable medication were scheduled at 11:30 AM, they should be done within 30 minutes of that scheduled time. Staff B and Staff C stated if the injectable medication was done late, You need to call the doctor .yes that would be an error.</p> <p>47836</p> <p>&lt;Resident 19&gt;</p> <p>Observation of medication pass on 04/16/2025 at 7:00 AM showed Staff W (Licensed Practical Nurse) administer Resident 19 nine medications.</p> <p>Review of Resident 19's physician orders on 04/16/2025 showed one of the nine medications administered to the resident was not ordered for Resident 19. Resident 19's records showed a single stool softener ordered for the residents that Staff W did not administer and instead Staff W administered a medication that had two stool softeners in one tablet.</p> <p>In an interview on 04/16/2025 at 9:38 AM, Staff W stated they administered the wrong stool softener to Resident 19. Staff W stated they should have administered the single stool softener and not the medication with two stool softeners in it.</p> <p>In an interview on 04/18/2025 at 12:05 PM Staff E (Assistant Director of Nursing) stated they expected staff to follow physician orders when administering residents their medications. Staff E stated it was important to follow physician orders to ensure administration of correct medications.</p> <p>REFERENCE: WAC 388-97-1060(3)(k)(ii).</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264</b></p> <p>Based on observation, interview, and record review the facility failed to ensure drugs and biologicals were stored in accordance with current accepted professional standards in 2 of 2 medication carts and 1 medication room reviewed. Additionally, the facility failed to ensure medications were stored in a secure manner for 1 (Resident 52) of 1 residents with medications at bedside. These failures placed residents at risk to receive expired and/or improperly administered medications and biologicals.</p> <p>Findings included .</p> <p>&lt;MEDICATION CART A&gt;</p> <p>Observation of Medication Cart A on [DATE] at 7:44 AM revealed a topical skin treatment that suppresses the immune system for Resident 22 which was discontinued on [DATE] and a topical cream used to treat fungal or yeast infections for which there was no current order. In an interview at this time, Staff S (Registered Nurse) indicated the resident no longer received either of the treatments stating, they should be discarded. A topical treatment to decrease inflammation was noted for Resident 49. Staff S stated, (The resident) doesn't have an order for that anymore, it should be removed.</p> <p>&lt;MEDICATION CART B&gt;</p> <p>Observation of Medication Cart B showed a bottle of heart medication used to treat chest pain for Resident 220 who discharged from the facility on [DATE], over six months ago, and for Resident 221 who discharged from the facility on [DATE], 10 months ago. Another bottle of this medication was noted and was not labeled with a resident name, prescribing physician, or directions for use. A Hemocult test fluid (a chemical used to test stool samples) was stored in with the oral medications.</p> <p>The medication cart contained: a topical treatment to treat dry or scaly skin for Resident 222 who discharged from the facility on [DATE]. A medicated topical treatment to treat infected skin lesions was observed for Resident 23 which was discontinued on [DATE]. An ointment used to treat fungus infections for Resident 23 which was ordered [DATE] and discontinued on [DATE]. A second treatment to treat fungal infections for Resident 23 was dispensed on [DATE]. According to Staff J (Licensed Practical Nurse) the resident, doesn't use that anymore and, we should get rid of it. An open bottle of irrigation solution (used to clean wounds) was observed and dated [DATE] but did not have a resident name on the bottle.</p> <p>In an interview on [DATE] at 10:11 AM, Staff J stated medications and treatments should be removed from the medication cart when the treatments were discontinued or if the resident discharged from the facility. Staff J confirmed staff should have, but did not, remove the medications and treatments.</p> <p>&lt;Medication Room&gt;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of the Medication Room refrigerator on [DATE] at 8:35 AM revealed an open, undated bottle of an injectable medication used to test for Tuberculosis (a communicable respiratory disease) and a vaccine for shingles (a painful, blistering rash caused by a virus) syringe for Resident 39 that was dispensed on [DATE] but not administered. In an interview at this time, Staff L (Licensed Practical Nurse) stated the Tuberculosis testing solution should be dated when opened and the vaccine medication should be administered or destroyed.</p> <p>Observation at this time showed 15 bags of Intravenous antibiotics were identified in the refrigerator for Resident 28. While the order for the antibiotic was discontinued on [DATE], additional bags of antibiotics were dispensed by the pharmacy on [DATE] and [DATE]. In an interview on [DATE] at 10:33 AM, Staff C (Corporate Nurse) stated staff should have contacted the pharmacy after the medication was received on [DATE] and destroyed the medication when there was no longer an order for it.</p> <p>In an interview on [DATE] at 10:35 AM Staff C stated staff should dispose of discontinued medications, as soon as possible, we try to do it once a week. When asked at what time, after a resident is discharged , their medications should be destroyed/removed from the medication cart, Staff C stated, I would take it out within 24 hours of discharge.</p> <p>&lt;Medications at Bedside&gt;</p> <p>Observations on [DATE] at 12:41 PM showed Resident 52 had a bottle of vision supplements for eye health and one bottle of multivitamins on their overbed table. Similar observations were noted on [DATE] at 7:38 AM and [DATE] at 8:31 AM.</p> <p>In an interview on [DATE] at 12:14 PM Staff E (Assistant Director of Nursing), confirmed the presence of the unsecured medications at the bedside and stated the resident should have their medications in a lockbox. Staff E stated staff should, but did not, report when they found medications at the bedside.</p> <p>REFERENCE: WAC [DATE](1)(B)(II), (c)(ii-iv)(2).</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>20264</p> <p>Based on observation, interview, and record review the facility failed to ensure food was served under sanitary conditions. Facility staff failed to: monitor and ensure adequate sanitation for the dishwasher and ensure staff reported when sanitation levels were inadequate. These failures placed residents at risk for food-borne illness.</p> <p>Findings included .</p> <p>Observation of the kitchen during rounds, on 04/17/2025 at 9:47 AM, showed Staff I (Dishwasher) running dishes from breakfast service through the dishwasher. Staff F (Dietary Manger) explained the facility used a low temperature dishwasher which required chemical sanitation (Chlorine used to kill viruses, bacteria, and other microorganisms to prevent foodborne illness) to clean dishes and kitchen utensils stating, I try to keep it (test strips which registered chlorine) at 200 Parts Per Million. During this observation, Staff F, tested the dishwasher for proper sanitizing solution. The chlorine test strip was dipped into the dishwasher water and was noted to be white, indicating an absence of chlorine. Staff F tested for adequate levels of sanitizer two additional times with the same results of a white strip (no/low levels chlorine/sanitizer in the solution).</p> <p>In an interview at 9:54 AM, Staff F stated the dishwasher checks for sanitizer three times a day with each meal but was unable to locate the log that staff used to documented testing of the dishwasher function.</p> <p>Staff I, in an interview on 04/17/2025 at 9:47 AM stated the sanitizer test was really low when it was checked before breakfast. Staff I acknowledged that if the test strip remained white it meant, there was no chemical. When asked to whom this issue was reported, Staff I replied, No one. In an interview at this time, Staff F stated Staff I should have reported there was no sanitizer and that the log on which staff documented the sanitation levels was missing.</p> <p>Staff F proceeded to contact the company that services the dishwasher, and was instructed to Prime the sanitizer bucket by toggling a switch on the side of the dishwasher. Observations on 04/17/2025 at 10:52 AM, showed that after replacing the sanitizer bucket and priming the machine two times, chlorine levels were noted to meet required sanitizing levels.</p> <p>Further interview revealed Staff F replaced the sanitizer bucket the previous day at 3:00 PM but was not aware of the need to prime the new sanitizer bucket. Staff F said it was reasonable to conclude the sanitizer was not functioned since then.</p> <p>Staff F was requested to provide documentation to support staff were educated / trained on how to replace the sanitizer bucket and what to do if inadequate amounts of sanitizer were noted. No information was provided.</p> <p>REFERENCE: WAC 388-97-1100(3) &amp; -2980.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264</b></p> <p>Based on interview and record review, the facility failed to maintain complete and accurate records for 10 (Residents 17, 52, 61, 40, 47, 6, 7, 36, 62, &amp; 35) of 20 current sampled residents reviewed and 15 supplemental residents (9, 2, 51, 19, 27, 32, 4, 5, 18, 15, 29, 49, 24, 33, &amp; 21) reviewed. The facility failed to ensure: physician orders were clear/accurate, assessment documents accurately reflected resident condition, behaviors were monitored, personal inventories were accurate/updated/available, informed consents were signed/dated, and resident inventory lists were complete. Failure to ensure clinical records were complete and accurate placed residents at risk of not having their needs met.</p> <p>Findings included .</p> <p>&lt;Podiatry Consults&gt;</p> <p>&lt;Resident 17&gt;</p> <p>Resident 17 admitted to the facility on [DATE] and according to the most recent Quarterly Minimum Data Set (MDS - an assessment tool) was assessed as cognitively intact with multiple medically complex diagnoses, including diabetes.</p> <p>Record review showed a Podiatry Consult dated 09/19/2024 that was not scanned into the resident's record until 02/11/2025. Record review showed no subsequent Podiatry Consults.</p> <p>In an interview on 04/16/2025 at 7:24 AM Staff G (Social Service Director) provided a 02/26/2025 Podiatry Consult for Resident 17, which was not in the residents records. Staff G stated the consults were provided to Medical Records, who should scan the consults into the record. Staff G stated they kept a notebook with the visits as backup but confirmed it was important for medical consults to be scanned into resident records.</p> <p>&lt;Resident 61&gt;</p> <p>Resident 61 admitted to the facility on [DATE] and according to the 04/04/2025 Quarterly MDS had multiple medically complex diagnoses, including diabetes.</p> <p>Record review on 04/21/2025 showed no documented Podiatry Consults in Resident 61's health records.</p> <p>In an interview on 04/16/2025 at 7:24 AM Staff G provided a 02/26/2025 Podiatry Consult for Resident 61, which was not in the record.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review for Residents 52, 40, 47, 6, 7, 36, 62, and 35 showed evidence these sample residents received Podiatry services on 02/26/2025. Record review performed on 04/21/2025 for supplemental residents 9, 2, 51, 19, 27, 33, 32, 4, 5, 18, 15, 29, 49, 24, &amp; 21 showed they received Podiatry services on 02/26/2025 had no documentation in the record to support the visits occurred. In an interview on 04/16/2025 at 7:24 AM, Staff G confirmed documentation to support these services occurred were not in the resident's records.</p> <p>Refer to F585 - Grievances.</p> <p>Refer to F658 - Services Provided Meet Professional Standards.</p> <p>Refer to F687 - Foot Care.</p> <p>Refer to F641 - Accuracy of Assessments.</p> <p>Refer to F758 - Free From Unnecessary Psychotropic Medications.</p> <p>REFERENCE: WAC 388-97-1720 (1)(a)(i-iv); (2)(a-m).</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264</b></p> <p>Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the transmission of communicable diseases. The facility failed to: ensure staff performed hand hygiene before and after resident care for 3 of 3 staff observed, ensure proper labeling and containment of resident's personal care items observed in 2 resident rooms, administer medications while maintaining infection control measures, and wear facility required face masks appropriately to prevent the spread of infection. These failures placed residents at risk for the development of infectious diseases and living in an unclean environment.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's October 2023 revised Handwashing/Hand Hygiene policy, all personnel were trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. This policy showed staff were expected to perform hand hygiene before applying non-sterile gloves and before touching a resident.</p> <p>&lt;Environment&gt;</p> <p>&lt;room [ROOM NUMBER]&gt;</p> <p>Observations during initial rounds showed: on 04/14/2025 at 9:14 AM the bathroom for room [ROOM NUMBER] had a blue basin on the floor that was not bagged or labeled, two unlabeled urinals with no lids on the back of the toilet and a bag of garbage on the floor. Similar observations of the unbagged basin on the floor and unlabeled urinals on the toilet were made on 04/16/2025 at 5:52 AM and 04/17/2025 at 2:17 PM.</p> <p>&lt;room [ROOM NUMBER]&gt;</p> <p>Observation of the bathroom for room [ROOM NUMBER] on 04/14/2025 at 9:14 AM showed a lidless urinal on the back of the toilet not labeled or bagged; a blue basin in a bag on floor which was not labeled, one graduate cylinder (a plastic container used to collect or measure bodily fluids) on the back of the toilet labeled for 32-2 but not bagged, and a denture cup at the sink which was not labeled. Similar observations of the urinal, basin, graduate cylinder were noted on 04/16/2025 at 6:06 AM.</p> <p>In an interview on 04/21/25 12:15 PM Staff E (Assistant Director of Nursing) stated that personal care items in bathrooms should be labeled with resident names, anything stored on the floor should be bagged. and urinals should have lids and be stored in a bag.</p> <p>&lt;Medication Administration&gt;</p> <p>&lt;Resident 2&gt;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 04/14/2025 at 8:35 AM showed Staff J (Licensed Practical Nurse) administer medications to Resident 2. Staff J was observed to place three bottles of eye drops, two inhalers, and a nasal spray on the resident's bed without a barrier, then proceeded to administer each medication. Staff J placed the now cross contaminated medication containers on top of the medication cart without cleaning medication bottles or using a barrier.</p> <p>Observation on 04/15/2025 at 8:18 AM showed Staff J remove a hand held inhaler from their pocket and place into Medication Cart B.</p> <p>In an interview on 04/16/2025 at 9:23 AM, Staff B (Director of Nursing) stated staff should use barriers to prevent cross contamination during medication pass.</p> <p>&lt;Mask Use&gt;</p> <p>&lt;C Hall&gt;</p> <p>Observations on 04/14/2025 at 11:43 AM showed unidentified therapy staff walking a resident in C Hall wearing their face mask below their nose.</p> <p>&lt;A Hall&gt;</p> <p>Observation and interview on 04/16/2025 at 5:31 AM showed Staff Y (Restorative Aide) sitting in a chair on A hall without a mask on. Staff Y stated the facility required staff to wear a surgical mask while in care areas of residents. Staff Y stated they should always wear a surgical mask in the resident hallways but forgot to put one on.</p> <p>46479</p> <p>&lt;Hand Hygiene&gt;</p> <p>&lt;Resident 36&gt;</p> <p>Observation of personal care provided to Resident 36 on 04/17/2025 at 9:33 AM showed Staff K (Certified Nursing Assistant - CNA) and Staff U (Lead CNA) initiate catheter care for Resident 36. Observation showed Staff K don gloves, then empty urine from the catheter into an unlabeled urinal touching the bathroom door with the now contaminated right hand used to clamp the urinal tubing. Staff K then changed gloves without performing hand hygiene. Staff U directed Staff K to remove their gloves and perform hand hygiene. As there was no hand sanitizer in the room, Staff K left the room to use the hand sanitizer in the hall before returning to the room. At this time the resident stated, That's not helpful, (they) touched the doorknob then touched it again on the way back in. Staff K received a soiled washcloth from Staff U to place in a bag retrieved from the overbed table which was then moved to the foot of the bed. With contaminated hands, Staff K then dried the resident as Staff U performed catheter care.</p> <p>&lt;Resident 64&gt;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2830 I Street Northeast Auburn, WA 98002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 64's 04/16/2025 physician orders showed a 03/12/2025 order directing staff to provide nutrition by enteral feeding (method of delivering nutrition directly into the gastrointestinal tract through a tube). A 03/04/2025 order directed staff to use enhanced barrier precautions related to the resident's enteral feeding tube.</p> <p>Observations on 04/18/2025 at 11:37 AM showed Staff W (Licensed Practical Nurse) preparing to stop Resident 64's enteral feeding for the day. Staff W put on a gown prior and entered Resident 64's room without performing hand hygiene and was observed talking with the resident. Staff W had their surgical mask below their nose and proceeded to use their bare hand to reposition the mask. Staff W grabbed pair of gloves and did not complete hand hygiene prior to putting on the gloves. Staff W removed a new syringe and placed it in a graduate cylinder used for Resident 64's enteral feeding. Staff W instructed Resident 64 to lift their gown, Staff W stopped the feeding and removed the external portion of the enteral feeding tube from the resident. Staff W placed a plug in the resident's enteral tube and repositioned their gown. Staff W removed their gloves, completed hand hygiene, and exited the room.</p> <p>47836</p> <p>&lt;Resident 6&gt;</p> <p>Observation on 04/17/2025 at 12:06 PM showed Staff V (CNA) providing incontinent cares to Resident 6 for an incontinent episode of loose stool in their brief. Staff V was observed to clean Resident 6's loose stool off their catheter (tube inserted into the bladder to drain urine) tubing. Staff V changed their gloves between dirty and clean cares without performing hand hygiene.</p> <p>04/17/2025 at 1:45 PM Staff V stated they should have performed hand hygiene between dirty and clean care glove changes, but they did not.</p> <p>In an interview on 04/21/2025 at 9:40 AM Staff P (Infection Preventionist) stated they expected staff to wear surgical masks in resident areas. Staff P stated they expected staff to perform hand hygiene upon entering a resident room, prior to providing resident care, between clean and dirty cares, and between glove changes.</p> <p>REFERENCE: WAC 388-97-1320 (1)(c)(2)(a).</p>		