STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505216	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Soundview Rehabilitation and Health Care Inc	1105 27th Street Anacortes, WA 98221

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36841 Based on interview, and record review, the facility failed to provide care in a manner that promoted resident respect and dignity for 3 of 8 sampled residents (Resident 3, 4, and 5) reviewed for dignity. Additionally, the facility failed to follow up with the residents for additional information, monitor residents for psychosocial harm, and document or make care plan revisions. This failed practice placed residents at risk for diminished self-worth, humiliation, embarrassment, and a decreased quality of life. Findings included . Review of the undated facility policy, Your Rights as a Resident, showed Your right to be treated with dignity and respect is the foundation on which all other resident rights are based. Review of the facility's Nursing Assistant Standards of Care, undated, showed Residents were to be spoken to and treated with respect. Review of a facility's abuse investigation alleged by a named resident, dated 04/02/2024, revealed three additional residents (Residents 3, 4, and 5) who reported concerns about Staff B, Certified Nursing Assistant (CNA), who was alleged to have abused the identified resident. <RESIDENT 3> Resident 3 admitted to the facility on [DATE] with diagnoses to include diabetes and depression. Review of Quarterly Minimum Data Set (MDS - an assessment tool) assessment, dated 01/31/2024, showed Resident 3 was cognitively intact. Review of facility investigation, dated 04/02/2024, showed when Resident 3 was interviewed by Social Services regarding any concerns about Staff B; they responded they had not allowed Staff B near them anymore because Staff B accused them of being racist. Resident 3 also stated Staff B had given them mean looks. Review of a late entry nursing progress note, dated 02/02/2024, showed a CNA reported Resident 3 made racist comments a few nights prior. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a nursing progress note, dated 02/03/2024, note showed a CNA reported to the nurse that Resident 3 was being bossy and demanding. When the nurse asked Resident 3 about it, they stated, I'm not racist, and denied making any racist remarks. The nurse advised the CNA (who was identified as Staff B) not care for the resident the rest of the shift and documented this incident was reported to the Director of Nursing Services (DNS) and did want that CNA to provide them care again. Review of nursing progress notes, dated 02/02/2024 through 0/07/2024, showed no further documentation about the situation or monitoring Resident 3 for any psychosocial impact. Review of Resident 3's current care plan showed no entries regarding concerns with any CNA staff, or any interventions to monitor/ensure the identified CNA (Staff B) work with the resident going forward. In an interview on 04/16/2024 at 1:45 PM, Resident 3 stated Staff B had provided cares for them many times, but they had requested Staff B never come in their room again. Resident 3 stated the reason for their request was because about two months ago Staff B had called her a racist and the resident stated they were not racist and was very shocked and offended by the statement. Resident 3 stated they did not recall exact details, but said they were talking about something to their roommate and did not include Staff B, so they (Staff B) got upset. Resident 3 stated they were flabbergasted and felt shocked and insulted and they would never be able to have a conversation or have Staff B take care of them again. Resident 3 stated Staff B also had given them bad looks, glared at them at times and it made them feel uncomfortable. Resident 3 stated they felt Staff B was very rude and they did not need someone like that around. Resident 3 stated Staff B had never apologized. Resident 3 stated staff cannot be treating and talking like that to residents. Resident 3 stated they were still upset by the way Staff B had treated them and accused them of being racist and appeared shook up while talking about it. Resident 3 said they had reported it to a nurse and other than sometimes helping their roommate, Staff B had not come back in their room, and they had not spoken. On 04/17/2024 at 1:35 PM, Staff I, CNA, stated some residents had complained about Staff B being rough and/or rude with their care on night shift. Staff I said the only resident they could recall that was still at the facility was Resident 3. <RESIDENT 4> Resident 4 admitted to the facility on [DATE] with diagnoses to include stroke with left sided weakness, major depressive episode, mood disorder, and anxiety. Review of Resident 4's Quarterly MDS assessment, dated 02/19/2024, showed they had moderate cognitive impairment. Resident 4 required maximum assist with most mobility and activities of daily living (dressing, toileting, grooming, personal hygiene, etc.). Review of a facility investigation, dated 04/02/2024, showed when Resident 4 was interviewed by Social Services regarding any concerns about Staff B; they responded that Staff B was always grumpy, put them down, and was unkind. Review of nursing progress notes, dated 04/01/2024 through 04/26/2024, showed no documentation related to concerns Resident 4 voiced about Staff B. There was no documentation of assessment for signs/symptoms of injury or psychosocial harm. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 4's current care plan showed no focus or interventions related to their allegations of abuse regarding Staff B. In an interview on 04/25/2024 at 2:30 PM, Resident 4 stated they knew who Staff B was. Resident 4 stated Staff B was always very short with them, impatient, and very rude. Resident 4 stated when Staff B handled them physically to assist with a transfer or bed mobility, they would handle and push them roughly. Resident 4 stated Staff B had always glared at them and spoke down to them and was very demeaning. Resident 4 stated Staff B should not be taking care of anyone. Resident 4 said they were afraid Staff B would push them right off the edge of the bed and said no matter what they said about feeling unsafe and being too close to the edge of the bed, Staff B continued to push or pull them right to the very edge of the bed. Resident 4 said they worried every time Staff B worked and they could not afford to fall off the bed and get hurt. Resident 4 said during each day they had worried and hoped Staff B would not be the one to put them to bed that night or get them up in the morning. Staff B stated I am here for rehab, not for relapse. I shouldn't have to be afraid of who is going to take care of me. <RESIDENT 5> Resident 5 admitted to the facility on [DATE] with diagnoses to include fractured sacrum (triangular bone just below the lumbar vertebrae), respiratory failure, and congestive heart failure. Review of the Admission MDS assessment, dated 03/26/2024, showed Resident 5 had moderate cognitive impairment. Resident 5 required staff assistance with mobility and activities of daily living. Review of a facility investigation, dated 04/02/2024, showed when Resident 5 was interviewed by Social Services regarding any concerns about Staff B; they responded that Staff B was rough, not gentle. Review of progress notes from 03/20/2024 through 04/20/2024, showed no documentation related to Resident 5's allegation of potential abuse regarding Staff B on 04/02/2024 (during the investigation), including no monitoring for psychosocial harm. In a telephone interview with Resident 5 and their spouse on 04/25/2024 at 10:49 AM, Resident 5 was on hospice services and sounded quite ill. Resident 5 stated they did not remember many details about Staff B. The resident's spouse stated the only thing they recalled was Resident 5 had voiced concerns the night shift CNA was so short with them and had not had time for the resident. In an interview on 04/15/2024 at 1:30 PM, Staff A, DNS, stated Staff B just doesn't get it. Staff A stated Staff B had no softness and had not seemed to understand why they could not talk/act this way towards residents. In an interview on 04/16/2024 at 2:35 PM, Staff C, CNA, stated at times Staff B had not seemed to have the nicest tone and it could make residents feel like they were an annoyance. In an interview on 04/23/2024 at 1:32 PM, Staff D, CNA, stated they had witnessed Staff B speaking rudely to residents' numerous times. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/25/2024 at 2:10 PM, Staff A stated they had not done any additional investigation or monitoring of the three residents who had expressed concerns about Staff B when interviewed by Social Service staff on 04/02/2024 as part of the abuse allegation made by another resident that the facility was investigating. Refer to CFR 483.12, F-600- Free from Abuse and Neglect. Refer to WAC 388-97-0860(1)(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36841 Based on interview, and record review, the facility failed to protect the resident's right to be free from verbal and physical abuse for 1 of 3 sample residents (Resident 2) reviewed for abuse. Resident 2 experienced harm when they had increased discomfort when a caregiver was physically forceful in providing care, and psychological harm when the resident expressed there was a delay in seeking continence care and remained in soiled briefs until the next shift due to fear and humiliation. This failure placed all other residents at potential risk for abuse, discomfort, risk of injury, psychosocial harm, and diminished quality of life. Findings included . Review of the facility policy, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property, dated 09/21/2022, showed it is the facility policy that residents had the right to be free from abuse, neglect, misappropriation, and exploitation, and included freedom from verbal, mental, or physical abuse. All staff are expected to report any signs/symptoms of abuse to the Administrator or Director of Nursing Services (DNS) immediately. Resident 2 admitted to the facility on [DATE] with diagnoses to include an inoperable fracture around the prosthetic (artificial joint) in their right hip, anxiety, depression, and chronic pain. Review of the Admission Minimum Data Set (MDS - an assessment tool) assessment, dated 04/01/2024, showed Resident 2 was cognitively intact. Resident 2 required maximum assist for bed mobility. Review of Care Area Assessments (CAA - a systematic process to interpret the triggered information from the MDS assessment to assess the potential problem and determine if the area should be care planned), dated 04/01/2024, showed Resident 2 was noted to have a significant decline from their baseline activity of daily living functions due to decreased strength, acute right hip pain, impaired mobility, decreased activity tolerance and required moderate to total assistance with mobility. Review of a nursing progress note, dated 03/26/2024, showed Resident 2 was alert and oriented and able to make their needs known. In addition to the peri-prosthetic right hip fracture, Resident 2 had a left wrist sprain. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a facility investigation, dated 04/02/2024, showed Resident 2 reported concerns with cares provided by Staff B, Certified Nursing Assistant (CNA), starting on their date of admission, 03/26/2024. Resident 2 reported on their first day at the facility, while providing care, Staff B told the resident You got to do better than that, and told the resident's family to leave the room. Resident 2 reported Staff B pulled on their broken hip during their brief change and told the resident If you want it done you have to roll over. The resident stated Staff B showed disrespect and manhandled them, told them to do what you are told, it's my job I know how. Resident 2 stated they had grabbed Staff H, CNA, who helped Staff B provide incontinent care, shirt to steady themselves and Staff B told them to not touch the CNA, and if you hurt him, you hurt me. Resident 2 stated Staff B yanked their pants down roughly and was nasty, curt, and rude. The resident stated they stopped talking. Resident 2 stated when they put their call light on, Staff B would turn the light off, not offer help, and not return. The resident stated they laid in bed wet until the next shift came because they were afraid and humiliated. Review of the facility's interview with Collateral Contact 1 (CC1), Resident 2's family member, dated 04/02/2024 at 1:30 PM, showed on the day of admit (03/26/2024) when Staff B and another CNA were providing care, CC1 had to support the resident's leg when staff turned Resident 2 because Staff B was pulling on the resident without supporting their injured leg. CC1 stated Staff B had not shown any kindness. They stated had Resident B been unable to verbalize their needs, they didn't know what may have happened. CC1 stated this type of treatment occurred not just on admission but also the following days, and stated the resident was worried about whether Staff B would return to work. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview on 04/11/2024 at 12:30 PM, Resident 2 stated the day they arrived at the facility they were useless to do anything on my own and having horrific pain. Resident 2 stated they had just arrived at the facility and did not yet have quarter length side rails on their bed to assist with mobility, so were unable to do anything to help with rolling back and forth in bed. The resident stated Staff B and Staff H assisted with changing their brief, and Staff B ordered them, in a sharp tone, to turn over. Resident 2 stated when they informed Staff B they couldn't roll over, Staff B said they had to and started pushing them over. Resident 2 informed Staff B they were hurting them, and Staff B said It's going to hurt worse if you don't move and kept pushing until they were on their side against Staff H on the other side of the bed. Resident 2 stated they were scared, and spontaneously grabbed Staff H's shirt. Resident 2 stated when they were rolling back, Staff B yelled at them you are pushing against me, I don't want you to hurt my back. Resident 2 stated they asked Staff B if they knew why they were at the facility, and Staff B said, I know my job, and left the room. Resident 2 stated Staff B had a sergeant-like attitude; each time they entered their room they gave orders, had a very forceful attitude and were very forceful with their movements and not at all gentle. Resident 2 said Staff B would make them roll totally against the rail, and said their treatment and attitude was awful. Resident 2 stated Staff B flipped them over, pulled on them, and grabbed their injured leg. When they told Staff B they were hurting them, Staff B said they had to do it if they wanted to be changed. Resident 2 stated they did not understand why Staff B treated them so rough and would not listen to them. The resident said, I couldn't do what Staff B wanted; they continued with the commands, and I needed help. Resident 2 stated when they put their call light on, often Staff B came in and turned it off without saying a word or asking what was needed, so they just laid in bed with a wet brief until the next shift came because they were humiliated and afraid to persist with trying to get care. Resident 2 stated Staff B was nasty, curt, and very rude, so they just quit talking. Resident 2 stated they had tried to give Staff B a chance, but by the third day of their rough and rude treatment they had to report it. Resident 2 stated they could not handle how demeaning and disrespectful Staff B was and had manhandled and ordered me around. Resident 2 stated it was very distressing those first three days when Staff B was their CNA, but they have tried not to dwell on it and currently felt safe at the facility. In an interview on 04/15/2024, Staff A, Registered Nurse/DNS, stated Staff B just doesn't get it, sees everything in black and white, and there was no softness about them. Staff A stated they worried about those residents who were unable to speak up and report if Staff B was abusive. Staff A stated Staff B did not seem to understand they could not talk/act that way to residents. In an interview on 04/17/2024 at 1:35 PM, Staff I, CNA, said some residents had complained to them about Staff B being rough and rude with cares on night shift. Staff I stated most had already been discharged . In an interview on 04/23/2024 at 1:32 PM, Staff D stated they had worked with Staff B a few years ago and had observed them being physically rough with residents. Staff D stated since Staff B was re-hired, they had not worked with them, but had worked day shifts, following many night shifts when Staff B had worked. Staff D recalled several residents had informed them they were relieved when Staff B's shift was over. Staff D stated an unidentified former resident told them almost the identical complaints about Staff B as Resident 2 had; Staff B handled them rough and was rude and spoke down to them. Staff D stated Resident 2 informed them numerous times that Staff B had been rough and rude to them. Staff D stated the resident had declined to file a grievance due to Resident 2 wanted to win [Staff B] over. Resident 2 finally agreed to have Staff D report Staff B's abusive behavior to the facility's management. Staff D realized they should have reported the allegations when first told. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 04/25/2024 at 2:10 PM, Staff A stated when making the decision on whether abuse was substantiated, they reviewed the investigation, consulted with the company's nurse consultant and the owner of the company who was acting as interim Administrator. Staff A stated they used nursing judgment to determine if abuse occurred; if a resident was not alert, oriented, and able to report, and the same events happened, would the resident have been harmed and facility not been aware. Staff A stated they discovered Staff B's history of similar behaviors and treatment of residents and made the decision to terminate their employment. Refer to CFR 483.10(e), F-557 - Respect, Dignity/right to have Personal Property. Refer to CFR 483.12(b), F607 - Develop/implement abuse/neglect policies. Refer to CFR 483.12 (c), F-610 - Investigate/prevent/correct alleged violation. Refer to WAC 388-97-0640(1)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36841 Based on interview, and record review, the facility failed to implement their policy regarding identifying and investigating potential allegations of abuse and neglect for 3 of4 residents (Resident 3, 4, and 5) reviewed for abuse and neglect. The failure to identify potential abuse, timely report allegations of potential abuse, complete timely and thorough investigations of the potential abuse, assess and monitor the residents for physical and psychosocial harm, notify responsible parties and providers, and to document the allegations and revise resident care plans placed residents at risk for injury, fearfulness, frustration, humiliation, and further potential abuse. Findings included . Review of a facility investigation, dated 04/02/2024, showed a sample of residents were interviewed to determine if there were additional residents who had concerns with Staff B, Certified Nursing Assistant (CNA). The results of the interviews revealed three residents (Resident 3, 4, and 5) who had voiced allegations of abuse which involved Staff B's treatment and care. Review of the Grievance and Incident Logs, dated 04/01/2024 through 04/23/2024, showed no entry for Residents 3, 4, and 5's allegations of abuse regarding Staff B's treatment and care. Review of the Crisis Resolution Center reports, dated 04/01/2024 through 04/23/2024, showed no reports were received for Residents 3, 4, and 5. <RESIDENT 3> Resident 3 admitted to the facility on [DATE] with diagnoses to include depression. Resident 3 was named in a facility abuse investigation that another resident had reported, dated 04/02/2024, as one of the residents interviewed to determine if the resident had any reports of concerns about care and treatment by Staff B. Review of facility investigation, dated 04/02/2024, showed Resident 3 stated I do not allow Staff B near me anymore. (Staff B) accused me of being racist. Resident 3 stated Staff B had given them mean looks. No further investigation was completed to gain potential additional information regarding Resident 3's concerns. Review of Resident 3's clinical record showed a nurse progress note, dated 02/02/2023, showing there was a concern between Resident 3 and Staff B. Action taken was to remove Staff B from providing care for Resident 3 going forward. There was not an investigation or grievance form completed, the resident was not monitored for potential psychosocial harm, and the resident's care plan was not revised accordingly. There was no documentation the resident's emergency contact or provider were informed of the allegation. <RESIDENT 4> (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 4 admitted to the facility on [DATE] with diagnoses to include a stroke, depression, anxiety, and mood disorder. Resident 4 was interviewed on 04/02/2024 related to the abuse allegation made by another resident on 04/02/2024. Resident 4 stated Staff B was always grumpy, put them down and was not kind. No further investigation was completed to gain potential additional information. Review of Resident 4's clinical record showed no progress notes regarding Staff B's allegation of potential mental abuse towards the resident. There was no documentation located in the resident's chart regarding the allegation, if the resident experience any psychosocial harm, care plan was not updated, nor was the resident's emergency contact or their provider informed of the allegation. <RESIDENT 5> Resident 5 admitted to the facility on [DATE] with diagnoses to include fractured sacrum (triangular bone in lower back). Resident 5 was interviewed as part of the 04/02/2024 facility investigation and the resident alleged Staff B was rough with them. No further investigation was completed to gain any potential additional information about the allegation. Review of Resident 5's clinical record showed no progress note regarding the allegation, no alert monitoring for injury or psychological harm, and there were no care plan revisions regarding the allegation. There was no documentation the resident's emergency contact or provider were informed of the allegation. In an interview on 04/25/2024 at 2:10 PM, Staff A, Director of Nursing Services (DNS), stated as part of the abuse allegation investigation, dated 04/02/2024, Social Services interviewed other residents to identify if there were other residents with similar issues with Staff B. Staff A stated they log and report to the hotline all allegations of abuse or neglect, complete thorough investigations of all allegations, monitor and document residents for physical and/or psychosocial harm, revise care plans, and notify the resident's responsible party, the provider, and the Administrator. When asked if the facility had grievances or incident report investigations for Residents 3, 4, and 5 for their allegations about Staff B identified during investigation of Resident B's allegation, Staff A stated they thought they were just part of the same investigation and had done nothing further with those allegations. Refer to WAC 388-97-0640 (2),(5),(6)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 36841 Based on interview, and record review, the facility failed to thoroughly investigate for an allegation of possible abuse and/or neglect for 1 of 3 sampled residents (Resident 2) reviewed for allegations of abuse and/or neglect. The failure to obtain witness statements from the alleged staff member Staff B, Certified Nursing Assistant (CNA), other key staff who regularly worked with Staff B, and/or received reports from residents about Staff B's treatment of them, and to investigate allegations made by additional residents, compromised the facility from making an informed decision if abuse was substantiated, identifying the extent and impact of the potential abuse, and placed residents at risk for unidentified abuse and/or neglect. Findings included . Review of the facility's policy titled, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property, dated 09/21/2022, showed all reports of resident abuse, neglect, exploitation, misappropriation, mistreatment, and injuries of unknown source would be thoroughly investigated by facility management. Review of the Nursing Home Guidelines AKA The Purple Book, published by Washington State Department of Social and Health Services October 2015, showed a thorough investigation must be completed, and to provide evidence of the thoroughness, the information must be documented. Additionally, witness statements, written, signed, and dated by the individual providing the statement should be collected as soon as possible after an incident/event, in order to avoid the witness becoming confused. The statements should include as much detail as possible. Review of a facility investigation, dated 04/02/2024, revealed no witness or other statements. There was documentation of an interview with Staff B; however, it was a general interview regarding their usual process of resident care and did not include any information about Resident 2 or their allegations of abuse. There was no statement from Staff D, CNA, who reported the allegation, Staff H, CNA, who assisted Staff B with Resident 2's cares on one of the dates of the reported allegation of abuse, or the night or evening shift staff who worked with Staff B. In an e-mail communication, dated 04/22/2024, Staff A, Director of Nursing Services (DNS), stated they had interviewed some of the staff about Staff B, however, did not know where the interviews were. In an interview on 04/23/2024 at 4:00 PM, Staff A stated they had not been able to find staff witness statements for Resident 2's allegation of abuse investigation. (continued on next page)

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	505216	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Soundview Rehabilitation and Health Care Inc	1105 27th Street Anacortes, WA 98221

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/25/2024 at 2:10 PM, Staff A stated a key part of the facility abuse/neglect allegation investigation process was to interview and obtain statements from pertinent staff, to include the staff who reported the allegation, the staff who worked with the alleged staff, any witnesses, and anyone who had information about the allegation. Staff A said they spoke with Resident 2, Collateral Contact 1, the resident's family member, and spoke with some of the night shift staff about Staff B. Staff A stated they could not figure out what happened to the staff statements. Staff A stated they decide of whether abuse was substantiated by reviewing all investigation information and discussing the investigation with the Administrator. Refer to CFR 483.12, F-600- Free from Abuse and Neglect. Refer to WAC 388-97-0640 (1), (6)(a)(b)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36841 Based on interview, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 of 3 sampled residents (Resident 1) reviewed for quality of care. Failure to monitor and document Resident 1's condition when they were diagnosed with a urinary tract infection and pneumonia and failure to accurately and timely document when clots/bleeding were observed in the resident's brief, resulted in inaccurate and missing information in Resident 1's clinical record and placed the resident at risk for unidentified complications. This failure placed residents at risk for medical complications, unidentified change in condition, and a diminished quality of life. Findings included . Resident 1 admitted to the facility on [DATE] with diagnoses to include inoperable right ankle fracture and heart attack. Review of Significant Change Minimum Data Set (MDS- and assessment tool), assessment, dated 01/05/2024, showed Resident 1 was cognitively intact. Resident 1 was frequently incontinent of bowel and bladder. Review of a provider order signed by Collateral Contact 2 (CC2), Advanced Registered Nurse Practitioner (ARNP), dated 03/12/2024, showed Resident 1 was to have a chest x-ray to rule out pneumonia and effusion (build-up of fluid between the tissues that line the lungs and the chest). Review of a chest x-ray (CXR) results, dated 03/12/2024, showed Resident 1 had changes in their lungs which may represent viral pneumonia. Review of a nursing progress note, dated 03/12/2024, showed Resident 1 was seen by CC2 and orders received for a chest x-ray and urinalysis with culture and sensitivity if indicated. There was no documentation of assessment or symptoms leading to the orders. Review of a urinalysis (UA), dated 03/12/2024, showed Resident 1 had a urinary tract infection (UTI) and culture and sensitivity were indicated. CC2 wrote orders, dated 03/14/2024, on the lab result form, to wait for culture and sensitivity results before starting antibiotic treatment, monitor for urinary retention (difficulty urinating and emptying the bladder), and to start albuterol nebulizer treatments (aerosol treatment that opens the airways to improve breathing ability). Review of a nursing progress note, dated 03/14/2024, showed CC2 was notified Resident 1's urine culture was still pending for final results. CC2 gave order to not start antibiotic until results were available. Review of a urine culture and sensitivity results, received on 03/15/2024, showed the organism was Escherichia coli (E. coli - bacteria that normally live in the intestines) and was extended-spectrum beta-lactamase (ESBL - a type of enzyme found in some strains of bacteria) positive. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) for March 2024, showed Resident 1 had an order, dated 03/15/2024, for nitrofurantoin macrocrystal (an antibiotic) twice daily for five days. This antibiotic was administered from 03/15/2024 through 03/20/2024. Review of Resident 1's nursing progress notes, dated 03/07/2024 through 03/26/2024, revealed no documentation as to symptoms that resulted in an order for a UA and CXR, and no assessment documentation for UTI, pneumonia, and antibiotic treatment, other than vital signs and three-day monitor for urinary retention entered on the MAR and Treatment Administration Record. Review of a nursing progress note, dated 03/27/2024 at 5:35 AM, showed Resident 1 was found to have light to moderate amount of what appeared to be blood on the nurse documented that appeared to be vaginal. Resident 1 denied pain or discomfort, their abdomen was soft, flat, and not tender. Review of a nursing progress note, dated 03/27/2024 at 11:37 AM, showed Resident 1 had continued bleeding observed in their brief with a moderate amount of small clots. CC2 was notified, and aspirin placed on hold for seven days to see if bleeding stopped. Resident 1 denied pain, discomfort, dysuria (pain with urinating), and their urine had no foul odor. The resident's family member had been notified of their bleeding. Review of a progress note, dated 03/28/2024, revealed Resident 1 took their morning medications without difficulty, was responsive per their baseline and their lungs were clear. Later in the morning, Staff J, Registered Nurse (RN), checked on Resident 1, and found the resident unresponsive to touch or voice, unable to obtain oxygen saturation (how much oxygen is traveling through the body in the red blood cells) reading, pulse was 78 beats per minute and thready, and respirations were 29 on two liters of oxygen. CC2 assessed Resident 1. Staff J contacted the resident's emergency contact, verified Do Not Resuscitate with selective treatments, and asked if they wanted the resident sent to the Emergency Department (ED) or to remain at the facility on comfort care. Staff J stated diagnostic testing and treatment would be done much faster at the ED. After conferring with other family members and being updated on Resident 1's continued decline, the emergency contact requested to send the resident to the hospital. Resident 1 left the facility at 12:10 PM per emergency transport documentation. Review of hospital records, dated 03/28/2024, showed Resident 1 was admitted with diagnoses to include acute UTI, acute hematuria (blood in urine), and severe sepsis (an infection of the blood stream). In an interview on 04/16/2024 at 2:35 PM, Staff C, Certified Nursing Assistant (CNA), stated during the last two weeks of Resident 1's stay, they had a red jello-like substance in their brief. Staff C stated they did not observe a strong odor to the resident's urine. Staff C stated they reported the red substance to Staff E, Licensed Practical Nurse (LPN). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/16/2024 at 3:00 PM, Staff E stated an CNA had reported a red substance in Resident 1's brief. Staff E said upon observation the substance was bloody, clot consistency and looked like it was vaginal; when they wiped the vaginal area that was where the clots seemed to be coming from. Staff E stated they informed CC2. Staff E stated the next day Resident 1 seemed very normal and vital signs were stable and then the following day Resident 1 was sent to the hospital. Staff E stated the last day they were assigned to Resident 1, their appearance and responsiveness was normal and the resident was laughing and talking. A day or two later the resident had a sudden decreased level of consciousness. In an interview on 04/17/2024 at 1:35 PM, Staff I, CNA, stated Resident 1's urine was darker and odorous toward the end of their stay. Staff I stated they reported this to an unidentified nurse. In an interview on 04/17/2024 at 3:40 PM, Staff H, CNA, stated one night they observed abnormal bloody discharge in Resident 1's brief and reported it to Staff E and Staff J. Staff H stated the resident had not complained about discomfort with urinating or any lower abdomen or back discomfort. In an interview on 04/23/2024 at 12:00 PM, Staff A stated their expectation when a resident had an illness, started a new medication, or had other changes was to put the resident on alert for at least 72 hours, monitor the resident closely, and to document their status each shift. Staff A stated there was no documentation until the day prior to discharge, when Resident 1 was diagnosed with pneumonia and a UTI in March 2024 and then developed bleeding from unclear source. Staff A stated nurses should have monitored and documented Resident 1's condition and interventions for the infections each shift and there should have been clear documentation of the bleeding. Staff A was asked about the lack of CC2's notes in Resident 1's record, when nurses notes showed CC2 had rounded in the facility on the resident multiple days, and stated CC2 had been ill, but had continued resident rounds and writing orders. In an interview on 04/23/2024 at 12:20 PM, Staff G, LPN, stated Resident 1 had vaginal bleeding a day or two before they were sent to the hospital. Staff G stated they informed the resident's family member and CC2. In an interview on 04/24/2024 at 2:52 PM, Staff E stated when a resident had any change in condition or new orders, they were to be placed on alert monitoring/charting for at least 72 hours. Staff E stated they were to assess, monitor, and document specific to what the situation was, and stated in Resident 1's case with UTI and pneumonia, and then the bleeding, they should have assessed and documented UTI symptoms, respiratory symptoms, any adverse reaction to the antibiotic and then detailed documentation of the bleeding. Staff E stated when they assessed Resident 1's bleeding in attempt to determine the source, the clots appeared to be coming from the vaginal area. Staff E stated there was no suprapubic area rigidity, complaints of discomfort, burning with urination, strong/foul odor, fever, lethargy, or confusion and the resident responded appropriately. Staff E stated the resident had urinated during care and urine did not appear bloody. Staff E stated Resident 1 seemed just fine the night prior to being sent to the hospital. Refer to WAC 388-97-1060(1)