STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505232	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Convalescent Center	310 Fourth Street Woodland, WA 98674

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49452 Based on observation, interview and record review, the facility failed to provide care in a manner that promoted dignity while assisting with meals for 1 of 11 sampled residents (Resident 47) observed during dining services in their rooms. This failure placed residents at risk for being treated with a lack of dignity, lack of respect, and a diminished quality of life. Findings included . Resident 47 was admitted to the facility on [DATE]. The admission Minimum Data Set assessment, dated 04/03/2024, showed Resident 47 had severely impaired cognition, but could adequately hear, was able to make self understood, and was able to understand others. Review of Resident 47's care plan, dated 04/01/2024, documented interventions including all staff were to converse with the resident while providing care, the resident needed time to talk daily, to allow the resident time to answer questions and encourage them to express their feelings, and to provide the resident with a homelike environment. On 05/01/2024 at 8:57 AM, Staff G, Certified Nursing Assistant (CNA), was observed walking into Resident 47's room, asked the resident if they wanted to eat some food and placed a clothing protector on the resident without warning them or asking their permission. Staff G stood over the resident while assisting them with eating. No conversation was heard at this time. This surveyor was standing approximately 10 feet outside Resident 47's door with the ability to see and hear the CNA assisting the resident with breakfast. At 9:10 AM, Staff G was observed leaving Resident 47's room after only periodic conversation was heard about the menu items on the resident's plate and after standing the entire meal over the resident while assisting them. On 05/02/2024 at 8:42 AM, Staff G was observed assisting Resident 47 with breakfast in their room and was standing over the resident while assisting. At 1:47 PM, when asked about expectations of staff when assisting with meals for residents in their rooms, Staff E, Registered Nurse (RN), said they hoped staff would sit next to the resident when they assisted them and carry on a conversation. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 1:50 PM, Staff F, RN, said their expectation was that staff communicated with the residents and sat at their level while assisting the residents with meals in their rooms. Reference WAC 388-97-0180 (2)

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50416 . Based on observation, interview and record review, the facility failed to maintain comfortable sound levels for 2 of 6 sampled residents (21 & 34) reviewed for homelike environment. This failure placed residents at risk of loss of control over unwanted noise and a diminished quality of life. Findings included . 1) Resident 34 was admitted to the facility on [DATE]. The admission's 5-day Minimum Data Set (MDS) assessment, dated 03/22/2024, documented Resident 34 was cognitively intact. On 04/29/2024 at 11:27 AM, when asked if the resident had any concerns, Resident 34 said it was too noisy at night. Resident 34 said the TV in the hallway was on early in the morning and woke him up. Resident 34 said he had his wife buy him headphones to help him sleep because of the noise. Resident 34 said he wanted to see the TV/noise policy. 2) Resident 21 was admitted to the facility on [DATE]. The quarterly MDS assessment, dated 02/29/2024, documented Resident 21 was moderately cognitively impaired and could make needs known. The facility's progress note, dated 04/29/2024 at 10:14 AM, documented, MSW [Social Worker] received a call from resident's mother regarding resident's roommate having TV volume on too loud. On 04/29/2024 at 11:41 AM, Resident 21 was observed seated in the main lounge, watching TV. Resident 21 indicated she was in the lounge because of the noise in the hallway and in her room because her roommate's TV was too loud. On 05/03/2024 at 8:50 AM, Resident 21 indicated since her initial interview with the surveyor, the noise level in her room had not improved and was still going on. On 05/03/2024 at 8:34 AM, Staff J, Social Services Director, said normally the complaint of noise happened around 10:00 PM and early in the morning. Staff J said there were instances where TVs were too loud. Staff J said he addressed noise complaints by interviewing the residents, discussed the concerns with the Director of Nursing Services or charge nurse. Staff J said he would bring up the concerns during the morning meeting. At 8:42 AM, Staff I, Licensed Practical Nurse, stated, Residents constantly complain of noise, especially at 10:00 PM. It gets so loud. Staff I said the residents complained of TVs being loud, and staff talking loud to each other or to the residents. At 8:51 AM, Staff K, Admissions Director, said the residents complained of TV volumes being high. Staff K said the managers would ask residents to lower their TV volume. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 9:32 AM, Staff A, Administrator, said he had not heard a lot about noise concerns in the facility. Staff A said concerns would go through the grievances process. Staff A said the facility had a noise policy. Reference WAC 388-97-0880

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934 Based on interview and record review, the facility failed to thoroughly investigate an allegation of inappropriate resident-to-resident touching for 1 of 6 sampled residents (2) reviewed for investigating alleged abuse and neglect. This failure placed residents at risk for not identifying corrective actions to prevent further abuse and a diminished quality of life. Findings included . The facility's policy entitled, Abuse Prevention Program, reviewed 05/04/2022, showed 4. Comprehensive policies and procedures have been developed to aid our facility in preventing abuse, neglect, or mistreatment of our residents. Our abuse prevention program provides policies and procedures that govern, as a minimum: . e. The development of investigative protocols governing resident abuse, theft/misappropriation of resident property, resident-to-resident abuse and resident-to-staff abuse; f. Timely and thorough investigation of all reports and allegations of abuse; i. The implementation of changes to prevent future occurrences of abuse. Resident 2 was admitted to the facility on [DATE]. The significant change Minimum Data Set assessment, dated 03/17/2024, documented the resident was severely cognitively impaired. The facility's grievance log, dated 04/10/2024, documented Resident 24 submitted a grievance form. The grievance noted, . another female resident was self propelling [sp] herself when the other resident was passing her, the other resident touched her breast . The April 2024 Incident Report Log did not have documentation about the 04/10/2024 aggrieved incident. Resident 2's progress notes, dates 04/01/2024 through 04/15/2024, did not have any documentation Resident 2 had been involved in a resident-to-resident incident on 04/10/2024 or any other date. There was no documentation of alert charting or interventions to ensure the safety of residents. On 05/02/2024 at 8:33 AM, Staff I, Licensed Practical Nurse, said if two residents were involved in an incident; separate paperwork should be filled out, investigated, and the residents would be put on alert charting for at least 72 hours. At 9:26 AM, Staff C, Staff Development Coordinator and Infection Preventionist, said nursing should be notified when an incident occurred. Staff C said an incident investigation would take place, the residents would be put on alert charting, and the incident would be reviewed at the nurse managers' meeting. Reference WAC 388-97-0640 (a)(b)(c)

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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** 46751 Based on interviews and record reviews, the facility failed to ensure bowel interventions were initiated for 2 of 4 sampled residents (44 & 39) reviewed for quality of care related to constipation. This failure placed residents at risk for discomfort, health complications and a diminished quality of life. Findings included . The facility's policy entitled, Bowel Management, updated 11/12/2023, documented the following interventions: Step 1: After 3 days no BM: Polyethylene Glycol [a laxative to treat constipation] - one capful (17 gms [grams]) in 4 oz (ounce) fluid of choice followed by 4 oz of fluid of choice in addition- if refuses extra fluid document refusals. Step 2: If no BM following day or stools are hard add Docusate Sodium 200 mg (milligrams) daily at bedtime. Step 3: If no BM following day MOM [milk of magnesia] 30 cc (cubic centimeters) by mouth daily. (DO NOT use if has diagnose: ESRD [end-stage renal disease]) Step 4: If no BM following day check for impaction and add Sodium Phosphate enema 133 ml (milliliter) pr (per rectal) q hs (every hour of sleep) or Bisacodyl Supp [suppository]10 mg q hs per resident choice until results achieved. 1) Resident 44 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment, dated 03/08/2024, documented the resident was cognitively intact. The Bowel and Bladder Elimination task sheet documented Resident 44 had a Bowel Movement (BM) on 04/05/2024 at 1:59 PM, and did not have another BM until 04/14/2024 at 3:24 AM, over 216 hours (9 days) since his last BM. 2) Resident 39 was admitted to the facility on [DATE]. The 5 Day Admission MDS, dated [DATE], documented the resident was severely cognitively impaired, and unable to express care needs. The Bowel & Bladder Elimination task sheet documented Resident 39 had a BM on 04/20/2024 at 4:20 PM, and did not have another BM until 04/24/2024 at 9:59 PM, over 100 hours (4 days) since his last BM. The April 2024 Medication Administration Record (MAR) showed the bowel protocol was not initiated. On 05/01/2024 at 9:53 AM, Staff F, Registered Nurse, said if a resident did not have a BM in three days, the bowel protocol was triggered, and documented on the MAR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 10:11 AM, Staff E, MDS Coordinator and Registered Nurse, said the bowel protocol triggered after three days of no BM. Staff E was unable to provide documentation of BM protocol being initiated for Resident 44 and Resident 39. At 11:08 AM, Staff B, Director of Nursing Services and Registered Nurse, said the BM protocol should have been triggered at day 3. Staff B was unable to provide additional documentation. Reference WAC 388-97-1060 (1), (3)(c)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46751 Based on observation and interview, the facility failed to ensure food items were labeled and dated when opened in 1 of 2 kitchen freezers, and in 1 of 1 nourishment refrigerator/freezer (Unit 100) reviewed for food storage in a sanitary manner. This failure placed residents at risk for cross-contamination, food borne illness, and a diminished quality of life. Findings included . <Kitchen Freezer> On 4/29/2024 at 9:59 AM, the kitchen freezer was observed with the following undated, unlabeled opened items: 1. Plastic bag of meatballs 2. Plastic bag of potato wedges 3. Plastic bag with Chicken Cordon Blue 4. Plastic bag of French fries 5. Plastic bag of vegetables. At 10:08 AM, Staff L, Cook, said the items in the freezer should be dated, and said they were not. Staff L stated, They were opened last night. Should be dated, but are not. <Nourishment Refrigerator> On 05/01/2024 at 8:29 AM, the Unit 100 nourishment refrigerator/freezer was observed with the following undated and unlabeled opened items: 1. Jello in red plastic cup 2. Vanilla bean ice cream 14 oz (ounces) container 3. Talenti ice cream. At 9:22 AM, Staff M, Dietary Manager, said all items need to be dated when opened. Staff B, Director of Nursing Services and Registered Nurse, stated, We should toss it. At 9:41 AM, Staff said she expected food in the refrigerators and freezers to be dated and labeled. Staff B stated, It should be dated right away. Reference WAC 388-97-1100 (3) & 2980

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49452 Based on observation, interview, and record review, the facility failed to initiate Enhanced Barrier Precautions (EBP) for 8 of 51 sampled residents (16, 31, 33, 35, 36, 40, 48, 252), properly implement standard precautions during dressing changes for wound care for 2 of 2 sampled residents (40 & 41), implement proper aseptic techniques for urinary catheter maintenance for 1 of 4 sampled resident (31), and ensure staff preformed hand hygiene for 1 of 3 sampled staff (G) reviewed for infection prevention and control. These failures placed residents, staff, and visitors at risk for development and transmission of communicable diseases, contracting infectious diseases and a decreased quality of life. Findings included . <Enhanced Barrier Precautions> Record review of facility's infection control policy entitled, Isolation - Categories of Transmission-Based Precautions, revised September 2022, documented: 4. These strategies may differ depending on the prevalence or incidence of the MDRO (multidrug-resistant organism) in the facility and region. For example, additional usage of PPE (enhanced barrier precautions) may be used for residents who do not meet criteria for contact precautions but are infected or colonized with MDROs (or have risk factors for MDRO acquisition). Record reviews, during the survey process from 04/29/2024 through 05/03/2024, showed residents (Residents 252, 40, 36, 48 & 35) with pressure ulcers and residents (Residents 252, 16, 31 & 33) with indwelling catheters did not have enhanced barrier precautions in place. On 05/02/2024 at 8:47 AM, Staff C, Infection Preventionist (IP) and Registered Nurse (RN), said the facility was working on implementing EBP. Staff C said they were trying to find a good solution instead of having isolation carts all over the hallway. Staff C said the plan would be implemented in a couple of weeks. At 10:32 AM, Staff F, RN, said EBPs were put in care plans on 05/01/2024. Staff F said staff needed to gown up while caring for residents with a drainage system. Staff F said the Head Resident Care Manager (RCM) educated the staff and staff were to have more training this month. <Wound Care> Record review of the facility's undated procedure entitled, Wound Care Observation, documented facility staff are required to remove and discard dirty gloves after the old dressing is removed and discarded. The next documented required step is for hand hygiene (the process of washing hands with soap and water or sanitizing hands with an alcohol-based hand rub) to be performed properly before accessing clean supplies and donning clean gloves. The document noted gloves should be changed and hand hygiene performed when moving from dirty to clean wound care activities. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1) Resident 40 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment, dated 02/27/2024, showed Resident 40 was severely cognitively impaired and was being treated for a Stage 2 (partial thickness injury involving the outer two layers of skin) pressure ulcer (pressure injuries of the skin also called bed sores). Review of Resident 40's skin observation tool, dated 04/29/2024, for the gluteal cleft crease (the groove between the buttocks) noted the size was 3 centimeters (cm) by 1.5 cm. Resident 40's physicians/treatment order, dated 04/30/2024, for the split open area at coccyx (an area at the base of the spine also referred to as the tailbone), Cleanse with wound cleanser, dry. Apply collagen to wound bed with calcium alginate overlaying. Cover with foam gauze every dayshift for wound treatment and as needed for soiled or coming loose. On 05/02/2024 at 10:00, Staff F, RN, was observed providing wound care to Resident 40's coccyx with the assistance of Staff E, RN, and Staff H, Certified Nursing Assistant (CNA). At 10:15 AM, Staff F was observed using their sterile gloved hand and a wettened sterile gauze with wound cleanser to wipe Resident 40's rectum, that was in close proximity to the wound, of bowel movement (BM). Staff F said the BM kept oozing out. Staff H said that was normal for the resident. At 10:18 AM, Staff F was observed not changing gloves or performing hand hygiene and proceeded to clean the wound with two more sterile gauze wettened with wound cleanser, and continued with Resident 40's dressing change. At 10:45 AM, Staff F said she did not recall cleaning Resident 40's BM with her sterile gloved hand and proceeding with the dressing change. Staff F stated, I shouldn't have done that. Staff F said if she had realized, she would have taken off her gloves, washed her hands and applied new gloves. At 2:05 PM, Staff C, IP, said the facility's expectation was to use aseptic techniques (procedures used to prevent the spread of infections) during wound care including: cleanse hands before entering, don gloves to remove old dressing, take off dirty gloves, sanitize hands, and put on new gloves before the application of a new dressing. When asked if it would be acceptable if a dressing change took place without hand hygiene performed and a glove change between the dirty to clean wound care, Staff C said no. 2) Resident 41 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], showed Resident 41 was cognitively intact and was being treated for surgical wounds. Resident 41's physicians/treatment order, dated 03/28/2024, for the middle abdominal wound noted, 1. Gently remove old dressing, 2. clean wound with normal saline and pat dry with gauze, 3. Apply no-sting barrier film around wound, 4. Place saline moist gauze roll into open wound and trim excess, 5. Soak gauze with saline, ring it out, then lightly pack it into tunnel area at edge of wound and cover entire wound, 6. Cover with dry gauze and absorbent pad, 7. Hold in place with Medi-pore tape. Change daily and as needed every dayshift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 41's physicians/treatment order, dated 04/10/2024, for the left abdominal wound noted, 1. Gently remove old dressing, 2. clean wound with normal saline and pat dry with gauze, 3. Apply no-sting barrier film around wound, 4. Place saline moist gauze roll into open wound and trim excess, 5. Soak gauze with saline, ring it out, then lightly pack it into tunnel area at edge of wound and cover entire wound, 6. Cover with dry gauze and absorbent pad, 7. Hold in place with Medi-pore tape. Change daily and as needed every dayshift. Review of Resident 41's skin/wound assessment, dated 04/15/2024, noted the size for the left abdominal surgical incision (a wound of the tissue caused by a surgeon using a surgical tool) was 2.5 cm by 11.5 cm by 9.0 cm. The middle abdominal surgical incision was measured at 23.0 cm by 11.0 cm by 0.5 cm. On 04/29/2024 at 2:54 PM, Staff D, RN, was observed providing wound care to Resident 41's left abdominal surgical incision. After the dirty dressing and packing was removed, it was placed in the garbage along with their dirty gloves. Staff D put on new clean gloves without performing hand hygiene. At 3:07 PM, Staff D was observed providing wound care to Resident 41's middle abdominal surgical incision. After the dirty dressing and packing was removed it was placed in the garbage along with their dirty gloves. Staff D put on new clean gloves without performing hand hygiene. On 05/02/2024 at 2:05 PM, Staff C said the facility's expectation was to use aseptic techniques (procedures used to prevent the spread of infections) during wound care including: cleanse hands before entering, don gloves to remove old dressing, take off dirty gloves, sanitize hands, put on new gloves before the application of a new dressing. When asked if it would be acceptable if a dressing change took place without hand hygiene performed and a glove change between the dirty to clean wound care, Staff C said no. On 05/03/2024 at 8:45 AM, when asked about expectation for staff regarding hand hygiene during a dressing change, Staff D said to wash hands before getting the supplies and getting them ready, and before donning gloves. Staff D said to take off the old dressing, change gloves and apply the new dressing. Staff D said after applying the dressing and removing your gloves, you need to wash your hands before leaving the room. When asked if hand hygiene was completed between the dirty and clean step of the two dressing changes for Resident 41 on 04/29/2024, Staff D stated, I didn't, and you're right, I should have. I guess I could bring a small container of hand sanitizer in with me to do that step. <Hand Hygiene> Record review of the facility's undated procedure entitled, Wound Care Observation, documented proper hand hygiene is that which occurs at the right time, uses the right method, and uses correct technique and duration. The procedure directed staff to follow the CDC (Centers for Disease Control and Prevention) Guideline for Hand Hygiene in Health-care Settings. Record review of the CDC Guideline for Hand Hygiene in Health-care Settings, dated 10/25/2002, listed three indications for hand hygiene in health-care workers: Contact with a patient's intact skin, contact with environmental surfaces in the immediate vicinity of patients and after glove removal. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy entitled, Isolation - Categories of Transmission-Based Precautions, revised September 2022, documented standard precautions (work practices required to achieve a basic level of infection prevention and control) are to be used when caring for residents, at all times, regardless of their suspected or confirmed infection status. On 05/01/2024 at 8:57 AM, Staff G, CNA, was observed entering Resident 47's room without completing hand hygiene, placed a clothing protector on the resident and assisted with feeding the resident without hand hygiene observed. At 9:10 AM, Staff G was observed exiting Resident 47's room without hand sanitizing, carried the dirty meal tray to the centralized dining cart in the hall, placed the dirty tray in the cart, retrieved a pen and paper from their pocket to write something down, put the items back in their pocket and walked down the hall without performing hand hygiene since assisting Resident 47 with their meal. On 05/02/2024 at 8:42 AM, Staff G was observed assisting Resident 47 with their meal. At 8:48 AM, Staff G was observed exiting Resident 47's room without hand sanitizing, carried the dirty meal tray to the centralized dining cart in the hall, threw the clothing protector in the hamper in the hall (Staff G had to lift the hamper lid), retrieved a pen and paper from their pocket to write something down, put the items back in their pocket and walked down the hall without performing hand hygiene since assisting Resident 47 with their meal. At 9:00 AM, Staff G said staff should wash their hands before and after assisting a resident with their meal and between handling trays. When asked about doing that the last two days during breakfast service, Staff G said they had been using Purell before and after. When asked when and where they were using the Purell, Staff G said from the dispensers on the walls in the hall. (Purell use was not observed during the 8:57 AM and 9:10 AM observations on 05/01/2024 and not observed during the 8:48 AM observation on 05/02/2024.) At 9:15 AM Staff B, Director of Nursing Services (DNS) and RN, said she expected staff to clean their hands upon entering and leaving a room, and after every interaction with a resident. Staff B said there was hand sanitizers in every room and in the hallways. On 05/03/2024 at 8:50 AM, Staff D was asked what their expectations were for the staff regarding hand hygiene during meal services, specifically if assisting with residents eating in their rooms. Staff D replied to hand sanitize before touching a tray, after touching and dropping off tray, and ideally in the hall again before grabbing the next tray. 47518 <Foley Catheter Drainage Bag on Floor> Resident 31 was admitted to the facility on [DATE]. The Admission/Medicare-5 day MDS assessment, dated 02/11/2024, documented Resident 31 was cognitively intact and had an indwelling catheter (a tube inserted into the bladder that drains urine into a bag outside of the body). On 04/30/2024 at 10:47 AM, Resident 31 was observed lying in bed with the Foley catheter drainage bag lying on the floor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024
NAME OF PROVIDER OR SUPPLIER Woodland Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE 310 Fourth Street Woodland, WA 98674	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 2:00 PM, Resident 31's Foley catheter drainage bag was observed on the floor on the right side of the bed. On 05/01/2024 at 8:29 AM, Resident 31 was observed lying in bed with the Foley catheter drainage bag on the floor on the right side of the bed. The bedside tray table wheel was on top of the Foley catheter drainage bag. At 9:56 AM, Resident 31's Foley catheter drainage bag was observed on the floor on the right side of the bed. At 10:25 AM, Staff G, CNA, was observed exiting Resident 31's room. Resident 31's Foley catheter drainage bag was on the floor on the right side of the bed. At 10:31 AM, Staff G was observed exiting Resident 31's room. Resident 31's Foley catheter drainage bag was observed on the floor on the right side of the bed. At 10:39 AM, Staff G said Foley catheter drainage bags should be hung off the side of the bed. Staff G said Resident 31 did not like the Foley catheter drainage bag hung off the side of the bed. Staff G said they would leave Resident 31's Foley catheter drainage bag lying on the floor and make sure it did not get caught under wheels. At 11:06 AM, Staff C said Foley catheter drainage bags should be placed below the level of the bladder and hung off the side of the bed. When asked if a Foley catheter drainage bag should ever be on the floor, Staff C stated, No. After observing the placement of Resident 31's Foley catheter drainage bag on the floor, Staff C stated, We're going to have to think of a way so you're [Resident 31] not at risk for infection. At 11:21 AM, Staff B said it was her expectation Foley catheter drainage bags did not lie on the floor. Reference WAC 388-97-1060 (3)(c) & -1320 (1)(c)

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47518 Based on interview and record review, the facility failed to offer and/or administer the influenza and pneumococcal vaccine to 2 of 5 sampled residents (46 & 39) reviewed for immunizations. This failure placed residents at risk for developing influenza and/or pneumonia with potential negative outcomes and a diminished quality of life. Findings included . Record review of the facility's policy entitled, Influenza Vaccine, revised October 2019, showed residents admitted between October 1st and March 31st shall be offered the vaccine within five (5) working days of admission to the facility. Record review of the facility's policy entitled, Pneumococcal Vaccine, revised October 2019, showed Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. 1) Resident 46 was admitted to the facility on [DATE]. The significant change Minimum Data Set (MDS) assessment, dated 04/22/2024, documented Resident 46 was severely cognitively impaired. The MDS indicated the resident had not received, in the facility, this year's (2024) influenza vaccination, the influenza vaccination had not been offered, and the resident's pneumococcal vaccination was not up-to date. Review of Resident 46's physician's orders, dated 03/21/2024, documented Annual Influenza vaccine: Yes, . Pneumonia Vaccine: Yes. Review of Resident 46's Vaccine(s) Consent-- V2, dated 03/22/2024, showed the consent was reviewed with the resident's guardian and permission was given to the facility to administer an influenza and pneumococcal vaccination, unless medically contraindicated. The document showed the resident was due for the PSV 23 pneumococcal vaccination. Resident 46's medical record did not show documentation of the administration of an influenza or pneumococcal vaccination. On 05/01/2024 at 1:42 PM, Staff C, Infection Preventionist and Registered Nurse (RN), said upon admission they would check for influenza and pneumonia vaccine status. Staff C said if the resident wanted the vaccine, they would order them. At 2:42 PM, Staff C said after they got Resident 46's consent signed, it should have been put on the Medication Administration Record for the vaccines to be given. Staff C stated, I could not find them. They weren't given. At 3:36 PM, Staff B, Director of Nursing Services and RN, said it was her expectation Resident 46's immunizations were given after the consent was signed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024
NAME OF PROVIDER OR SUPPLIER: Woodland Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 310 Fourth Street, Woodland, WA 98674	

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	46751 2) Resident 39 was admitted to the facility on [DATE]. The 5 Day MDS assessment, dated 04/01/2024, documented Resident 39 was severely cognitively impaired. Review of Resident 39's Vaccine(s) Consent - V2, dated 04/20/2024 (23 days after admission), showed the consent was reviewed with the resident's Power of Attorney (POA) and permission was given to the facility to administer an influenza, pneumococcal, and COVID vaccinations, unless medically contraindicated. Resident 39's medical record did not show documentation of the administration of pneumococcal vaccination. On 05/01/2024 at 1:42 PM, Staff C said upon admission they would check for influenza and pneumonia vaccine status. Staff C said if the resident wanted the vaccine, they would order them. Staff C said the facility used (Hard Charts) and would provide it once found. Staff C was unable to provide any additional documentation showing the pneumococcal vaccine was administered. Reference WAC 388-97-1340 (1)(2)(3)