

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505240	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER Emerald Bay Care		STREET ADDRESS, CITY, STATE, ZIP CODE 140 South Marion Avenue Bremerton, WA 98312	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>46068</p> <p>Based on observations and interviews, the facility failed to ensure rooms were clean and linens changed timely for 4 of 9 residents (Residents 5, 6, 2, and 1) reviewed for physical environment. This failure placed residents at risk for dissatisfaction with their living environment, compromised dignity and a diminished quality of life.</p> <p>Findings included .</p> <p><RESIDENT 5></p> <p>On 05/17/2024 at 2:02 PM, Collateral Contact 1 (CC1), said Resident 5 was often ignored and left in their room without care. CC1 said the resident's room and sheets were filthy.</p> <p>On 05/20/2024 at 9:34 AM, Resident 5's room was observed to have a sticky, red substance covering the bedside table and on the floor. The floor was littered with a Kleenex box and paper. The bed next to Resident 5 was a bare mattress without linens. The curtains were closed, and the lights were off.</p> <p>At 11:27 AM, the sticky, red substance remained on the bedside table and floor, Kleenex box and paper were on the floor. The pad underneath Resident 5 appeared wet with dark yellow colored liquid and the room smelled of urine.</p> <p>At 1:00 PM, the bed linen was observed changed, the floor and bedside table was observed with the red, sticky substance on them.</p> <p>At 2:03 PM, Housekeeping was observed cleaning the floor and table. The bed next to Resident 5 remained unmade.</p> <p>On 05/22/2024 at 10:46 AM, Resident 5 was observed lying in bed. A red substance was observed on the sheet covering the resident, the bottom sheet, and the pad under the resident. The overbed table had a red sticky substance on it and applesauce was observed on the floor. A staff member was observed cleaning the applesauce and the overbed table.</p> <p>At 11:54 AM, Resident 5's linen was observed with the red substance still on them.</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
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><RESIDENT 6></p> <p>On 05/22/2024 at 11:07 AM, Resident 6 was observed sitting in their wheelchair beside the bed with eyes closed. The bed had no linen on it, a urinal full of urine was on the nightstand, Kleenex and a lancet were on the floor. Resident 6 said they wanted to lay on the bed but the bed had not been made and they did not want to sleep on the plastic.</p> <p>At 12:28 PM, Resident 6's bed was observed with no linen, the urinal which was full of urine was on the nightstand and the dirty Kleenex and the lancet remained under the bed.</p> <p>At 12:50 PM, Staff B, Certified Nursing Assistant, said they had gotten busy and forgot to make Resident 6's bed and clean up but had just taken care of it and emptied the urinal too.</p> <p><RESIDENT 2></p> <p>On 05/20/2024 at 11:45 AM, Resident 2 was observed lying in bed. The bottom sheet was a flat sheet and was partially off the bed resulting in the resident laying on a bare mattress. Resident 2 said that would happen frequently because they went through sheets quickly and the facility did not have enough of the fitted sheets.</p> <p><RESIDENT 1></p> <p>On 05/22/2024 at 11:44 AM, Resident 1 was observed sitting next to their bed in a wheelchair. The bed was without linens. Resident 1 said their bed had not been made that day, isn't that awful?</p> <p>At 12:59 PM, Resident 1's bed was observed without linens.</p> <p>On 05/22/2024 at 1:46 PM, Staff A, Director of Nursing, said the residents' rooms should be cleaned and picked up and beds made timely with clean linen. Staff A said the rooms did not meet her expectation.</p> <p>Reference WAC 388-97-0880</p>		

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<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46068</p> <p>Based on interviews and record reviews, the facility failed to provide bathing assistance for 3 of 8 residents (Resident 1, 2 and 3) reviewed for bathing. This failure placed residents at risk for poor hygiene, skin conditions and a diminished quality of life.</p> <p>Findings included .</p> <p><RESIDENT 1></p> <p>Resident 1 was admitted to the facility on [DATE]. The Minimum Data Set (MDS), an assessment tool, dated 04/26/2024, showed Resident 1 was cognitively intact and required substantial assistance of staff to bathe.</p> <p>On 05/20/2024 at 1:51 PM, Resident 1 said since their admission they maybe had two or three showers and the staff did not routinely offer showers. Resident 1 said they would like more showers, but the staff made them feel bad because there were so many other residents ahead of them.</p> <p>Resident 1's Bathing Record, dated 04/24/2024 through 05/21/2024, showed Resident 1 was to receive showers on Tuesday and Friday evenings. The record showed the resident received one shower during that time frame.</p> <p><RESIDENT 2></p> <p>Resident 2 was admitted to the facility on [DATE]. The MDS, dated [DATE], showed the resident was cognitively intact and required substantial assistance of staff to bathe.</p> <p>On 05/20/2024 at 11:45 AM, Resident 2 said they asked almost every day for a shower but had not received one. When asked if the resident refused showers they said, why would I do that, I have been waiting daily for one?</p> <p>Resident 2's Bathing Record, dated 05/09/2024 through 05/21/2024, showed the resident was to receive showers on Tuesdays and Fridays. The record showed the resident had not received a shower.</p> <p><RESIDENT 3></p> <p>Resident 3 was admitted to the facility on [DATE]. The MDS, dated [DATE], showed the resident was cognitively intact.</p> <p>Resident 3's care plan, revised on 04/11/2024, showed the resident required assistance from staff to shower.</p> <p>Resident 3's Bathing Record, dated 05/01/2024 through 05/21/2024, showed Resident 3 was to receive a shower on Saturdays. The record showed the resident had not received a shower and had refused them.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/20/2024 at 1:41 PM, Resident 1 said they had not received a shower for a long time. When asked if they had refused the opportunity to have a shower in May, the resident said, absolutely not, they have not even asked me this month.</p> <p>On 05/20/2024 at 1:51 PM, Staff A, Director of Nursing, said they expected residents to be offered showers and receive them. Staff A said it was a process that they were already looking at and had started education with staff.</p> <p>Reference WAC 388-97-1060 (2)(c)</p>		

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<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46068</p> <p>Based on observations, interviews and record reviews, the facility failed to provide wound care per physician orders for 2 of 2 residents (Resident 2 and 4) reviewed for wound care. This failure placed the residents at risk for medical complications and infection.</p> <p>Findings included .</p> <p><RESIDENT 2></p> <p>Resident 2 was admitted to the facility on [DATE] with diagnosis of surgical repair for a fracture of their right leg. The Minimum Data Set (MDS), an assessment tool, dated 05/10/2024, showed the resident was cognitively intact.</p> <p>Resident 2's physician's orders, dated 05/16/2024, showed an order for staff to change the wound dressing to the resident's right hip daily.</p> <p>On 05/20/2024 at 11:45 AM, Resident 2 was observed with a wound dressing on their right leg, dated 05/18/2024. Resident 2 said the wound dressing was not changed daily, that has not happened since I got here.</p> <p><RESIDENT 4></p> <p>Resident 4 was admitted to the facility on [DATE].</p> <p>Resident 4's Wound Specialist's progress report, dated 05/14/2024, showed Resident 4 had a traumatic ulceration (wound) of the left lateral (side) knee.</p> <p>Resident 4's physician orders, dated 05/15/2024, showed orders for staff to provide wound care to the left lateral knee. The order showed the staff were to change the dressing three times per week on Tuesdays, Thursdays, and Saturdays.</p> <p>Resident 4's treatment administration record, dated May 2024, showed no documentation wound care to the left lateral knee was provided on Thursday 05/16/2024 or Saturday 05/18/2024.</p> <p>On 05/20/2024 at 2:24 PM, Resident 4 was observed with no dressing covering the ulceration on the left lateral knee.</p> <p>On 05/20/2024 at 2:31 PM, Staff A, Director of Nursing, said they expected staff to follow the physician orders for wound care.</p> <p>Reference WAC 388-97-1060 (1)</p>		