STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505240	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Bay Care	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)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46068 Based on interview and record review, the facility failed to develop a personalized discharge plan based on each resident's identified needs, goals and preferences and implement it timely for 2 of 3 residents (Resident 1 and 2) reviewed for discharge planning. This failure placed residents at risk for delayed discharge, unmet care needs after discharge and a diminished quality of life. Findings included . Review of the facility's policy titled, Resident Discharge, revised 05/18/2023, showed the facility must initiate discharge planning at the request of the resident and prepare a detailed, written transfer or discharge plan for the resident and ensure the plan was an integral part of the resident's comprehensive plan of care and as such, include measurable objectives and timetables for completion and incorporate in the plan the resident's preferences, support system, assessments and plan of care and availability of appropriate resources to match the resident's preferences an needs. <Resident 1> Resident 1 admitted on [DATE] with diagnoses including kidney disease and diabetes (a condition that affects blood sugar levels). The Minimum Data Set (MDS), dated [DATE], showed the resident had moderate cognitive impairment, was independent with transfers, dressing and walking a short distance, had dialysis (procedure to clean and filter waste from the blood) at an outpatient clinic and received medication by injection for their diabetes. Resident 1's discharge care plan, dated 04/12/2024, the date of admission to the facility, showed the resident did not want to discharge from the center at that time but wanted to return home once they were well. The care plan intervention showed staff would ensure the resident and family knew when the resident was healthy enough to discharge. The care plan had no further interventions documented as of 07/23/2024. On 07/22/2024 at 2:41 PM, Collateral Contact 1 (CC 1), interested party, said Resident 1 wanted to go home and was told by the facility they could not leave the facility and had contacted emergency services. On 07/23/2024 at 12:51 PM, Resident 1 said the only thing they wanted was to go home and get out of the facility. The resident said they were very frustrated that no one was helping them get home. (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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1's discharge planning progress note, dated 05/10/2024, showed the resident wanted to be discharged home with the assistance of home health aides once they were ready for discharge. Resident 1's discharge planning progress note, dated Sunday 05/19/2024, showed the resident had expressed concern for their spouse and belongings at home and said there was no reason to still be at the facility. The note showed staff had reassured the resident discharge plans would be made the following day, Monday, so that the resident could discharge safely and not AMA (against medical advice). Resident 1's discharge planning progress notes, dated 06/17/2024, showed Staff B, Social Service Director (SSD) and Staff C, Social Services Assistant (SSA) spoke to the resident about their discharge plan. Resident 1 said they wanted to go home and could take care of themselves. The note showed Staff B & Staff C said in order for Resident 1 to discharge safely they needed home health services, and they would help find services in order for the resident to discharge safely. Resident 1's progress notes, dated 06/25/2024, showed Staff B had followed up with the resident after Resident 1 had called law enforcement who came to the facility and the resident had decided to stay at the facility for the time being because they did not have a key to get into their house. Resident 1's Social Services Quarterly Evaluation, dated 07/18/2024, showed under the Discharge Plan Review, remain LTC [long term care] - resident desires to return home. During a joint interview on 07/23/2024 at 1:23 PM, with Staff B & Staff C, Staff B said they asked residents on admission and quarterly what their discharge plan was. Staff B said they completed the discharge care plan and normally they documented how the resident was doing and projected discharge date s. Staff B said Resident 1 did not have a discharge care plan because the quarterly care plan had not been completed. Staff B said Resident 1's goal was to return home, and they were working on that but Resident 1's spouse did not want the resident to return home. Staff C said the resident felt they were stuck at the facility and as a last resort had called the police. Staff C said the resident wanted to go home and felt trapped. When asked if they had a discharge plan that identified Resident 1's specific needs and resources available for them to discharge home, Staff B said they did not. <Resident 2> Resident 2 was admitted on [DATE]. The MDS, dated [DATE], showed the resident was cognitively intact, had an indwelling catheter (tube that carries urine outside of the bladder to an external bag) and multiple wounds that required wound care and a pressure reducing device for the bed. On 07/23/2024 at 10:24 AM, Collateral Contact 2, CC 2, an interested party, said Resident 2 had secured a spot at an Adult Family Home (AFH) on 05/31/2024 and had not been able to transfer to the setting because the facility had not followed through with setting up needed medical equipment and/or securing a primary care physician. On 08/07/2024 at 1:33 PM, Resident 2 said they had signed papers with an AFH at least six weeks prior but still had not been transferred because the hospital bed, air mattress and wound care were still not arranged. The resident said they were eager to transfer to the home. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 2's discharge care plan, dated 06/11/2024, showed the resident continued to wish to be discharged to an AFH. The care plan's goal was to continue to look for an adult family home and the intervention showed staff would continue assessing the need for DME [durable medical equipment] and home health services before discharge. No further interventions were listed in the care plan as of 08/07/2024. On 08/07/2024 at 3:33 PM, Staff B, Social Service Director, said the AFH had accepted Resident 2 for admission in early May of 2024. Staff B said they had attempted to find suppliers for the medical equipment and medical providers for the wound care from early May until end of July but had been turned down from many providers due to insurance. Staff B said on 07/26/2024, they looked on the back of the resident's insurance card and found a number to contact and they requested a list of providers from the insurance company. When asked why they didn't do this previously, Staff B said it did not occur to them and they were very busy with other tasks. Staff B said they did not have a discharge plan for Resident 2 with their identified medical, equipment and resource needs and instead had retained the information in her head. On 08/07/2023 at 5:10 PM, Staff A, Administrator, said the discharge planning did not meet their expectations and they would educate staff on identifying barriers to discharge, care plans and they would correct the system. Reference WAC 388-97-0080