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 09/12/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46068 Based on observation, interview, and record review, the facility failed to provide a call light (device to request help as needed) within reach and failed to provide a bed extender for 1 of 5 residents (Resident 3) reviewed for environment. This failure placed the resident at risk for unmet care needs, pain and pressure injury, and a diminished quality of life. Findings included . Resident 3 admitted to the facility on [DATE] with diagnoses including hemiparesis (weakness or paralysis to one side of the body) and hemiplegia (complete paralysis to one side of the body) of the left side due to a stroke (damage to the brain due to lack of blood flow). The quarterly Minimum Data Set (an assessment tool), dated 07/19/2024, indicated Resident 3 needed extensive assistance for most activities of daily living. Resident 3 was cognitively intact. On 09/11/2024 at 10:15 AM, Resident 3's call light was observed on the left side of the bed, wedged in the frame, with the end dangling towards the floor. On 09/11/2024 at 11:45 AM, Resident 3's call light was observed on the left side of the bed, wedged in the frame, with the end dangling towards the floor. Resident 3 said they were unable to request assistance at times due to not being able to find or to reach the call light. Resident 3 said staff were instructed to attach the call light to the front of the gown where it could be reached with the right hand. Resident 3 said not being able to reach the call light had caused periods of laying in soiled briefs, needs not being attended to, and pain to the feet due to them being pressed against the foot board. At 12:33 PM and 2:38 PM, Resident 3's call light was observed to be on the left side of the bed, wedged in the bed frame, end dangling towards the floor. At 2:13 PM, Staff F, Licensed Practical Nurse, said all staff should make sure call lights were within reach before leaving any resident in a room. Staff F said Resident 3's call light should be attached to the front of the gown per stated preference. On 09/12/2024 at 12:45 PM, Staff G, Housekeeper, said she had gone into Resident 3's room on several occasions and found the call light out of reach. Staff G said she became very frustrated with staff. Staff G said she filled out a grievance form on 08/16/2024. (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

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	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Bay Care	140 South Marion Avenue Bremerton, WA 98312

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 3's care plan, dated 09/22/2017, stated, Be sure call light is within reach and encourage resident to use it for assistance as needed. The Kardex, a guide for nursing aides that is driven by the care plan, showed the same. A medical provider note, dated 08/19/2024, stated Resident 3 complains of right foot hitting the end of the bed, increasing pain. Will plan to request an extended bed with nursing department and order for Q4 [every four hour] turns to reduce development of pressure injuries. At 3:00 PM, Staff E, Director of Nursing Services, was asked if the facility provided bed extenders. Staff E said they did. Staff E said the expectation would be that nurses would have read the medical provider notes and followed up on recommendations. Staff E said Resident 3 should have always had access to the call light and staff should have positioned it according to preference and accessibility. Reference WAC 388-97-0860(2) 50488

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NAME OF PROVIDER OR SUPPLIER Emerald Bay Care		STREET ADDRESS, CITY, STATE, ZIP CODE 140 South Marion Avenue Bremerton, WA 98312	

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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 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** 46068 Based on observation, interview and record review, the facility failed to ensure infection control standards were followed related to use of required personal protective equipment (PPE) with residents on transmission-based precautions (TBP) for 2 of 3 residents (Resident 1 and 2), reviewed for infection control. This failure placed residents, staff and visitors at risk for contracting and spreading infections. Findings included . Review of the facility's policy titled, Isolation-Categories of Transmission-Based Precautions, revised October 2018, showed transmission-based precautions were additional measures that protect staff, visitors and other residents from becoming infected and when a resident was placed on transmission-based precautions, appropriate notification was placed on the room entrance door so that personnel and visitors were aware of the need for and the type of precaution. The signage informs the staff of the type of CDC [Centers for Disease Control] precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room. <RESIDENT 1> Resident 1 was admitted to the facility on [DATE], with diagnoses including infectious gastroenteritis and colitis (stomach and bowel infection). Review of Resident 1's physician orders, dated 09/06/2024, showed Resident 1 was on contact precautions. On 09/11/2024 at 1:03 PM, Staff A, Certified Nursing Assistant (CNA), was observed entering Resident 1's room without their washing hands and/or wearing PPE. A sign on the wall next to the door indicated the resident was on contact precautions and directed the staff to wash hands and don a gown and gloves prior to entering the room and wash hands prior to exiting the room. Staff A exited the room without washing their hands and when asked if the resident was on TBP, Staff A said they usually put on a gown when giving care to a resident that was on precautions, but they had not noticed the sign prior to entering the room. On 09/11/2024 at 2:43 PM, Staff D, CNA, was observed entering Resident 1's room without donning PPE. Staff D turned off the resident's call light, picked up the food tray with their bare hands and exited the room without washing hands. At 2:48 PM, Staff D said if a resident was on TBP, there would be a sign by the resident's door indicating the type of precautions needed and indicate what PPE to wear. Staff D said they had not noticed the sign by Resident 1's door until they exited the room. Staff D said they should have worn a gown and gloves upon entering the room and washed their hands prior to exiting the room. <RESIDENT 2> Resident 2 was admitted to the facility on [DATE] with diagnoses including infection of the skin. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 2's physician orders, dated 09/09/2024, showed Resident 2 was on enhanced barrier precautions (EBP) related to a wound. On 09/11/2024 at 1:45 PM, Staff B, Resident Care Manager (RCM), and Staff C, CNA, were observed entering Resident 2's room pushing a manual lift (a device used to lift residents out of bed and into their wheelchairs) without donning PPE. A sign on the wall next to Resident 2's door indicated the resident was on EBP and directed the staff to wash hands prior to entering the room and don a gown and gloves if they were assisting the resident with transferring, dressing, bathing, changing linens, providing hygiene, changing briefs and/or providing wound care and/or device care. At 1:54 PM, Staff B, exited the room and said they had assisted transferring Resident 2 back to bed. When asked if they wore a gown and gloves when they transferred the resident, Staff B said they wore gloves but no gown because Resident 2's roommate was on EBP, but Resident 2 was not. At 1:58 PM, Staff C, exited the room and said they had transferred Resident 2 back to bed. Staff C said they had changed the resident's briefs earlier in the day. When asked if they wore a gown and gloves when changing the resident's briefs and transferring the resident, Staff C said they wore gloves but no gown because Resident 2's roommate was on EBP but Resident 2 was not. At 2:01 PM, Staff B, said they had reviewed Resident 2's medical record and they were on EBP. Staff B said they should have had gowns and gloves on when transferring the resident. On 09/12/2024 at 3:47 PM, Staff E, Director of Nursing, said when residents were placed on TBP, a sign was placed on the wall adjacent to the resident's room door. Staff E said the sign indicated the type of TBP the resident was on and type of PPE the staff were to wear when caring for the resident. Staff E said for contact precautions the staff were expected to wash hands prior to entering the room, don gown and gloves and wash hands prior to exiting the room. Staff E said when residents were placed on EBP, staff were expected to don a gown and gloves when there was close contact with the resident. When asked if transferring a resident and/or changing briefs was considered close contact, Staff E said yes, and they expected them to wear a gown and gloves when completing those tasks. Staff E said the staff had not followed the facility policy and their practice had not met their expectations. Reference WAC 388-97-1320 (2)(b) 50488