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	12/10/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46068 Based on observation, interview and record review, the facility failed to provide assistance with Activities of Daily Living (ADL) related to incontinent care, cleanliness and positioning in bed for 2 of 3 residents (Resident 1 and 2) reviewed for ADLs. This failure placed residents at risk for poor hygiene, impaired skin integrity, discomfort and loss of dignity. Findings included . <RESIDENT 1> Resident 1 was admitted on [DATE] with diagnoses including failure to thrive. The Minimum Data Set (MDS), an assessment tool, dated [DATE], showed the resident was cognitively intact, required substantial/maximal assistance with dressing, personal hygiene, toileting hygiene and rolling side to side. The MDS showed the resident was always incontinent of urine and bowels. Resident 1's Kardex (care instructions for staff), dated [DATE], showed the resident required extensive assistance with bed mobility, personal hygiene, toilet use and was to be checked and changed every two hours and as needed for incontinence. The Kardex showed the resident was to be checked and changed AM, PM, after meals and twice at night. On [DATE] during a continuous observation of Resident 1's room, from 6:33 AM until 10:07 AM (3 ,d+[DATE] hours) Resident 1 was observed lying on their back in bed and received no incontinent care, turning and/or repositioning. At 10:08 AM, an observation showed Staff C, Restorative Aide (RA), and Staff D, RA, entering the resident's room to weigh the resident using the mechanical lift. Staff C and Staff D turned the resident onto their side to place the lift sling underneath the resident. Resident 1 said yikes, I am wet, I am in a puddle. Staff C and Staff D raised the resident off the bed utilizing the sling and a lift machine. The draw sheet under the resident was observed to have a large dark colored stain on it and when the draw sheet was removed the fitted sheet on the mattress and the vinyl mattress were observed to be wet. The resident's brief was observed to be full of liquid. Staff C and D proceeded to change the sheets on the bed and placed a new draw sheet. They lowered the resident back onto the bed and the draw sheet was immediately wet from the brief. Staff C and D rolled the resident over, provided perineal care, placed a new brief on the resident, removed the nightgown and without washing the resident's body, placed a new nightgown on the resident. Staff C indicated the nightgown they removed was wet. <RESIDENT 2> (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 2 was admitted on [DATE]. The MDS, dated [DATE], showed the resident was cognitively intact, required substantial/maximal assistance with toileting hygiene and rolling side to side. The MDS showed the resident was dependent for transfers from the bed to the chair and was always incontinent of urine. On [DATE] at 12:15 PM, Resident 2 said that they did not like to wait longer than four to five hours to have their briefs changed. The resident said staff were frequently late getting them out of bed in the morning. The resident said they had to wait one hour or more after they requested to get out of bed. The resident said in the afternoon they would have to go and hunt down staff to change their brief at 3:00 PM and to be put to bed at night. Resident 2 said the staff that came to assist them were often delayed looking for lifts with charged batteries and/or a second staff person to assist with the transfer. The resident said the delay caused them to sit in wet briefs and it was uncomfortable and were concerned about their skin and said that if it was Summer, it would smell worse. Resident 2's Kardex, dated [DATE], showed the resident preferred to get out of bed between the hours of 9 AM - 10 AM or otherwise indicated by the resident. The Kardex showed the resident preferred their brief to be changed between the hours of ,d+[DATE] PM and the transfer required a dependent lift, assist of two persons and the resident only used the electric lift labeled 'number 2' for transfers and showed to not use the manual lift with resident 2. The Kardex showed for the resident's bladder/bowel, the resident was a scheduled check and change: check upon rising, before and after meals, before bed and as needed for incontinence. On [DATE] at 10:35 AM, Resident 2 was observed lying in bed with their call light on. The resident said they had requested to get up between 9:00 AM and 10:00 AM and was told their aide was giving another resident a shower. The resident said they had their call light on since 10:00 AM because no one had come to get them out of bed, but the staff kept coming in and saying that their aide was coming but was in the shower with someone. The resident said it was an ongoing issue in the morning; staff assisting with showers instead of getting them out of bed. The resident said the last time they had been changed was 4:30 AM. On [DATE] at 10:25 AM, Staff E, Certified Nursing Assistant (CNA), said they cared for Resident 2 often. Staff E said they were assigned the resident and had wanted to get them up for the day earlier but were pulled away to complete other tasks. Staff E said they were currently heading to the resident's room. Staff E said they had to use the manual lift at times with the resident because the batteries were often not charged on the electric lifts. Staff E said the resident did not like the manual lift because it was uncomfortable for them. On [DATE] at 3:08 PM, Staff B, Resident Care Manager, said the facility utilized the resident's Kardex to communicate care instructions to the nursing assistants. Staff G said they expected the Nursing Assistants to follow the Kardex when they were providing care. On [DATE] at 4:00 PM, Resident 2 was observed up in their wheelchair. Resident 2 said they were waiting since 3:00 PM to have their brief changed but when the staff attempted to utilize the lift to transfer them from the wheelchair to the bed, the lift quit working because the batteries were not charged. Resident 2 said they had not had their brief changed since about 10:30 AM. Resident 2 said they were very frustrated they could not get up on time, their brief changed at 3 PM and put to bed when they requested due to lifts not working and/or staff availability. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 4:08 PM, Staff F, CNA, said they were attempting to transfer Resident 2 into bed for a brief change using the lift but the moment they started to lift the resident the battery died . Staff F said they looked for other working batteries but were unable to find any in the facility. Staff F said they have had the issue with the batteries for about five months. Staff F said if they used the manual lift that did not require batteries with Resident 2 it did not raise high enough to clear the bed causing them to physically lift the resident up using their muscles and pull the resident across the bed. Staff F said that was uncomfortable for the resident and the staff. WAC Reference [DATE] (2)(c)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46068 Based on interview and record review, the facility failed to follow physician orders and monitor clinical conditions for 2 of 4 residents (Resident 3 and 4) reviewed for quality of care. This failure placed residents at risk of medical complications, infection, pain and a diminished quality of life. Findings included . <RESIDENT 3> Resident 3 was admitted on [DATE]. The Minimum Data Set (MDS), an assessment tool, dated 10/21/2024, showed the resident was cognitively intact. Resident 3's Communication Form, dated 11/22/2024, and completed by the licensed nurse, showed the resident wanted to speak with the medical provider because they thought they had a possible bladder infection. The form showed the medical provider indicated they would see the resident that day. Resident 3's physician order, dated 11/22/2024, showed an order to obtain UA [urinalysis] for dysuria (pain when urinating). Physician orders, dated 11/26/2024, showed an order for a medication for three days for dysuria. Review of Resident 3's electronic medical record on 12/10/2024, showed no documentation a urinalysis was obtained. Resident 3's progress notes, dated 11/27/2024, showed Resident 3 refused to go to a Cardiovascular appointment due to burning with urination and not being comfortable. Review of the progress notes, dated 11/22/2024 through 12/06/2024, showed no other documentation related to nursing assessment and/or monitoring of Resident 3's urinary concerns. On 12/10/2024 at 12:37 PM, Collateral Contact 3 (CC3), Advanced Registered Nurse Practitioner (ARNP), said an order for a UA was placed on 11/22/2024 and was not completed by the nursing staff. When asked if they discontinued and/or cancelled the order for the UA, CC3 said no, nursing just did not complete it. CC3 said Resident 3 was still complaining about pain when urinating on 11/26/2024 and they ordered a medication to help with the pain. Resident 3's progress notes, dated 12/07/2024, showed Resident 3 was sent to the ED [emergency department] for eval [evaluation] and TX [treatment] of hypotension (low blood pressure). Resident 3's hospital history and physical, dated 12/07/2024, showed the resident was admitted to the hospital and diagnosed with a urinary tract infection. The resident was admitted to the intensive care unit for management of septic shock (a life-threatening condition that occurs when a severe infection leads to dangerously low blood pressure). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/10/2024 at 12:58 PM, Staff A, Director of Nursing, said they reviewed Resident 3's medical record and found no documentation a UA had been completed. Staff A said there was no documentation of nursing assessment and/or monitoring by the nursing staff following the resident's complaints of burning with urination on 11/22/2024. Staff A said the licensed nurses should have obtained the UA and documented their assessments and monitoring. <RESIDENT 4> Resident 4 was admitted on [DATE] with diagnoses including a chronic ulcer to their right foot. The MDS, dated [DATE], showed the resident was cognitively intact. On 11/21/2024 at 5:14 PM, Collateral Contact 2 (CC2), Wound Professional, said Resident 4 arrived at the wound clinic with the same dressing on the right leg that was placed a week prior, despite sending orders, a physical copy with the patient and secondary copy faxed to the facility, to complete daily dressing changes. Resident 4's Outpatient Clinic Wound Care Treatment Record, dated 11/13/2024, showed a physician order for wound treatment for the right foot to be changed daily and to return to the clinic in one week. Resident 4's electronic medical record showed the clinic treatment record was uploaded on 11/13/2024 to the resident's electronic medical record. Resident 4's Outpatient Clinic Wound Care Treatment Record, dated 11/21/2024, showed a physician order for wound treatment for the right foot to be changed daily and to return to the clinic in one week. Resident 4's Outpatient Clinic Wound Care Treatment Record, dated 11/27/2024, showed a physician order for wound treatment for the right foot to be changed daily and to return to the clinic in one week. Resident 4's physician orders, dated 10/28/2024, showed wound care to the right foot, change dressing every Tuesday, Thursday and Saturday. The physician order showed it was discontinued on 11/25/2024. A physician order, dated 11/25/2024, showed wound care to the right foot, change dressing every Tuesday, Thursday and Saturday. The physician order showed it was discontinued on 11/29/2024. On 12/04/2024 at 3:12 PM, Staff I, Resident Care Manager (RCM), said when a resident goes to the wound clinic and returns with new orders, it was the expectation that the floor nurse would note the orders and enter them into the resident's electronic medical record to be followed. Staff I said the physician orders from the wound clinic should have been carried out by the floor nurse when Resident 4 returned from their wound clinic appointment. Staff I said it must have been an oversight by the licensed nurse. Resident 4's physician orders, dated 11/29/2024, showed wound care to the right foot daily in the evening. On 12/04/2024 at 3:40 PM, Resident 4 was observed with a wound dressing on their right foot. The dressing was dated 12/02/2024. Staff H, Licensed Practical Nurse, said it was a daily dressing change, but the electronic medical record showed the resident was out on pass on 12/03/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 3:50 PM, Resident 4 said they were out on pass on 12/03/2024 but returned to the facility at approximately 6:00 PM. Review of the facility's resident sign out log on 12/04/2024, showed Resident 4 was signed back into the facility on [DATE] at 6:00 PM. On 12/04/2024 at 3:50 PM, Staff I, RCM, said the licensed nurse should have completed the wound care when Resident 4 returned to the facility at 6:00 PM. On 12/10/2024 at 11:01 AM, CC3, ARNP, said when a resident was sent to an outside wound clinic for wound care, they expected the facility staff to implement and follow orders that were received for the residents. CC3 said they send the residents to the wound clinic because they were the experts. WAC Reference 388-97-1060 (1)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46068 Based on observation, interview and record review, the facility failed to implement interventions to prevent pressure ulcers (injury to skin and underlying tissue resulting from prolonged pressure) from developing for 1 of 3 residents (Resident 1) reviewed for wounds. This failure placed the residents at risk of clinical complications, pain and a diminished quality of life. Findings included . Review of the facility's policy titled, Wound Prevention and Treatment, revised 02/03/2024, showed the center will consider all residents at risk for skin impairment and will implement the following interventions to prevent the development of pressure ulcers: reduce occurrence of pressure over bony prominence to minimize injury, protect against the adverse effects of external mechanical forces (pressure, friction, shear). The policy showed the center recognizes even the most vigilant nursing care may not prevent the development and/or worsening of pressure ulcers in some residents, in those cases, intensive efforts will be directed at the following: managing risk factors, providing preventive interventions and providing treatment. Resident 1 was admitted on [DATE] with a diagnosis of failure to thrive. The Minimum Data Set (MDS), an assessment tool, dated 11/30/2024, showed the resident was cognitively intact, required substantial/maximal assistance with activities of daily living and rolling side to side. The MDS showed the resident had no pressure ulcers and was at risk of developing pressure ulcers. Resident 1's care plan, dated 08/05/2024, showed the resident had a potential for a pressure ulcer related to immobility. The care plan showed the goal was for the resident to have intact skin, free of redness and to notify the nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration noted during bath or daily care. Resident 1's activity of daily living care plan, dated 07/17/2024, showed the resident required extensive assistance with bed mobility and was to be checked and changed every two hours and as needed for incontinence. Resident 1's skin evaluation on 12/03/2024, showed slight redness noted on left heel. On 12/07/2024 during a continuous observation of Resident 1's room, from 6:33 AM until 10:07 AM, Resident 1 was observed lying on their back in bed and received no incontinent care, turning and/or repositioning. At 8:11 AM, 8:32 AM, 9:10 AM and 10:07 AM, Resident 1 was observed lying in bed with both heels resting on the bed. Resident 1's right leg was rotated outward with the lateral (outside) ankle bone resting on the bed. At 10:08 AM, Resident 1 was observed receiving incontinent care, when staff turned the resident to their side, the resident's right lateral ankle bone was observed to be red with a black area in the center. The resident's left heel was observed to be red. On 12/07/2024 at 11:00 AM, Staff A, Director of Nursing (DNS), said they were unaware of a wound on Resident 1's ankle. Staff A reviewed the resident's medical record and said there was no documentation of a wound on the right ankle. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 12/07/2024 at 11:07 AM, Staff A, DNS observed Resident 1's right lateral ankle bone and said there was redness on the bony prominence, and it appeared there was eschar (dead tissue) in the center of the red area. When asked what type of wound it was, Staff A said they referred to the wound consultant because they were the professionals, but it appeared to be a DTI [deep tissue injury]. Staff A observed the resident's left heel and said they were not concerned about the left heel because it was not open, and the redness came from the heel being placed on the bed. Staff A said the resident's heels should be floated (heels not resting directly on the bed) and the redness came from pressure. Resident 1 asked Staff A if they needed booties on their feet and Staff A said they preferred to use pillows to float the heels. Staff A asked the resident how long the wound had been on their ankle and the resident said about a week or so. A review of Resident 1's care plan on 12/10/2024 at 10:14 AM, showed no documentation of the right ankle wound, red heel and/or interventions to include floating the heels. On 12/10/2024 at 10:41 AM, Collateral Contact (CC1), hospice nurse, said they had just assessed the resident's ankles and heels and the wound on the right ankle appeared to be a pressure ulcer. CC1 said the resident's heels were not floated and/or on pillows at the time of the assessment. CC1said the facility notified hospice on 12/03/2024 of the redness on Resident 1's left heel. CC1 said they expected that when the facility discovered the skin concerns on Resident 1, they would have floated the resident's heels and updated the care plan. On 12/10/2024 at 3:08 PM, Staff B, Resident Care Manager, reviewed Resident 1's care plan and said the care plan was not updated after the staff observed the red heel on 12/03/2024 and/or when the wound on the right ankle was discovered on 12/07/2024. Staff B said they expected the staff to update the care plan with interventions to include, floating the heels, applying skin prep (wound treatment) and/or booties for the resident's feet. Resident 1's wound consultant progress report, dated 12/10/2024, showed the resident had an unstageable (full-thickness pressure injuries in which the base of the wound is covered with dead tissue) pressure ulceration on the right lateral malleolus (outer bone of the ankle). The report showed the consultant recommended placement of cushioned boots at all times while in bed and to float ankles and heels off the mattress at all times while in bed. WAC Reference 388-97-1060 (3)(b)