

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER Olympia Transitional Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Lilly Road Northeast Olympia, WA 98506	

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 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** 46472</p> <p>Based on observations, interviews, and record review the facility failed to provide timely toileting assistance for 7 of 9 Residents (Residents 1, 2, 3, 6, 7, 8, & 9) and bathing services for 3 of 4 Residents (Residents 3, 4, & 11) reviewed for Activities of Daily Living (ADLs). These failures placed the residents at risk for skin breakdown, discomfort, urinary tract infections, undignified quality of care, and diminished quality of life.</p> <p>Findings included .</p> <p>POLICY</p> <p>Review of the facility's Policy/Procedure-Activities of Daily Living policy, revised 07/2015, showed the facility would develop care plans (CP) for ADL's that were personalized with resident preferences for care such as day/time/type of bathing, waking time, bedtime, and any other quality of life choice that was important to the resident. The interventions provided to staff would be in accordance with professional standards of quality, clinical practice, and be on the Kardex (simplified care plan) and accessible in the Point of Care (POC) electronic charting system. ADL support and performance would be documented in the POC.</p> <p>TOILETING ASSISTANCE</p> <p><Resident 1></p> <p>Review of the 02/03/2024 quarterly Minimum Data Set (MDS-an assessment tool) showed Resident 1 had no cognition problems and was incontinent. Resident 1 diagnoses included a broken leg, Post Traumatic Stress Disorder (PTSD-a mental health condition triggered by a terrifying or traumatic event), and obesity. Resident 1 was dependent on staff assistance for toileting and bed mobility.</p> <p>Review of the ADL (CP) dated 07/20/2023 showed Resident 1 was incontinent, wore a disposable brief, and required two-person assistance for toileting and bed mobility. The CP directed staff to check and change Resident 1 when waking up for the day, before and after meals, and at Resident 1's request. Resident 1 was dependent on staff to use the bed pan when requested.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a State Agency compliant report provided by a State Employee (SE), dated 04/04/2024, showed SE went to visit Resident 1 on 04/04/2024 at 10:15 AM. Resident 1 reported to SE [they] requested toileting assistance for stool incontinence at 7:15 am, and was told by care staff they would be changed after breakfast. By 10:15 AM, Resident 1 still had not been changed. SE requested staff provide toileting assistance prior to starting their visit with Resident 1. Facility staff returned approximately 15 minutes later to provide incontinence care. Resident 1 sat in a stool soiled brief, through breakfast, and for more than three hours before they were provided care.</p> <p>In an interview on 04/29/2024 at 12:47 PM, Resident 1 stated their call light was frequently not answered in a timely manner and they did not receive timely incontinence care. Resident 1 stated many times they waited for more than three hours for staff to return to provide care after they requested assistance and sometimes were told they would have to wait until after meal service to get changed; expected to eat their meal in a soiled brief. Resident 1 stated they often required medication prior to turning in bed due to pain they experienced from their broken leg, so they would try to time the pain medication and toileting within a 30-40-minute timeframe to make rolling in bed easier. Resident 1 stated staff often did not return timely after the pain medication administration which delayed care even longer.</p> <p>In an interview on 04/29/2024 at 4:30 PM, Staff C stated the facility was working to address customer service concerns that included call light response and toileting assistance. Staff C expected staff to follow the residents care plan for toileting assistance.</p> <p><Resident 8></p> <p>Review of the 05/12/2024 Admission MDS showed Resident 8 had memory problems and diagnoses included a fractured hip, a pressure ulcer, and cancer. Resident 8 was assessed to be dependent on staff assistance for toileting hygiene, transfers, and was occasionally incontinent.</p> <p>Review of Resident 9's ADL CP dated 05/08/2024 showed Resident 8 required two person assistance for toileting, transfers, and wore disposable briefs for incontinence. The CP directed staff to offer use of the bedside commode upon waking up, before and after meals, at bedtime, and as needed.</p> <p>Review of a Nurse Progress Note dated 05/22/2024 at 9:12 AM showed Resident 8 fell while trying to self-transfer to the commode.</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>In an observation and interview on 05/22/2024 at 12:35 PM, Resident 8 and their Responsible Party (RP8) were visiting. An uncovered bedside commode was positioned next to the bed. Resident 8 initially stated she had no problems with her care, and RP8 told Resident 8 they needed to speak about what they experienced. RP8 stated Resident 8 did not want to cause any problems and was reluctant to report concerns. Resident 8 stated they experienced long call light wait times but could not remember specifics due to memory problems. RP8 stated Resident 8 had experienced multiple long wait times for toileting assistance; one instance was over an hour which they notified the facility about through the facility's grievance process. RP8 stated a second instance occurred one evening at 7:30 PM- they called Resident 8 who reported they had been waiting over 40 minutes for help and in the background I could hear their roommate (Resident 9) yelling for someone to come help because they had waited so long. RP8 stated two days after they filed the second grievance regarding toileting care, they came to the facility (between 7:30 and 8:00 AM) and found the commode dirty with old urine in it, and feces on the floor that no one had cleaned up. RP8 stated Resident 8 fell over the night attempting to transfer themselves to the commode and this morning when [they] arrived, the commode was unclean and still had urine in the bucket. RP8 stated the facility administration was addressing the concerns but the conditions had not improved.</p> <p>In an interview on 05/22/2024 at 4:00 PM, Staff C stated they met with RP8 almost daily since the first grievance regarding toileting. The facility offered to move Resident 8 to a room closer to the nurse station to help with supervision and decrease call light wait times.</p> <p>In an interview on 05/23/2024 at 6:15 PM, RP8 stated Resident 8 was moved to a room across from the nurse station on 05/22/2024 with the intent they would see their call light in a more timely fashion. RP8 stated they just finished speaking with Resident 8, who was crying, and said they already waited 20 minutes to go to the bathroom, had not been assisted.</p> <p><Resident 9></p> <p>Review of the 05/09/2024 Admission MDS showed Resident 9 had no memory problems and diagnoses included heart failure, respiratory failure, and obesity. Resident 9 was assessed to have impaired range of motion of both lower extremities and one upper extremity, was dependent on staff for toileting hygiene, and required substantial assistance for transfers. Resident 9 had occasional urine incontinence.</p> <p>Review of the ADL CP dated 05/02/2024 showed Resident 9 required two staff maximum assistance for toileting transfer/hygiene and they used a bedside commode. Staff were directed to offer toileting when Resident 9 woke up, before and after meals, at bedtime and as needed.</p> <p>In an observation and interview on 05/22/2024 at 1:10 PM, Resident 9 sat on the edge of the bed wearing an oxygen nasal cannula. Resident 9 stated they often waited extended periods of time for toileting assistance after their call light was turned on, sometimes over an hour. Resident 9 stated they were on a diuretic (a medication that helps to remove excess water from the body resulting in frequent urination) and sometimes had little warning when their pill started to work but if they could get to the toilet timely, they experienced less urine incontinence. Resident 9 stated the other night I finally had to start yelling for help and transferred myself to the toilet.</p> <p><Resident 2></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>Review of the 05/05/2024 5-Day MDS showed Resident 2 had no cognition problems and diagnoses included diabetes, anxiety, depression, and PTSD. Resident 2 was assessed to require assistance with toileting, hygiene, and bathing. Resident 2 was incontinent and had incontinence-associated skin damage.</p> <p>Review of Resident 2's ADL CP dated 03/29/2024 directed staff to use two people to perform bed mobility, toileting care, hygiene, and transfers. Resident 2 did not have an incontinence CP.</p> <p>In an observation and interview on 04/29/2024 at 12:38 PM, Resident 2 was observed to have multiple long curling facial chin hairs. Resident 2 stated they had a shaver they brought with them but could not find it and staff did not offer to shave them. Resident 2 stated their call light was often not answered timely and they were rarely provided timely toileting assistance. Resident 2 stated they were told by staff on more than one occasion to wait for incontinence care until after meal service and ate their meal while sitting in a soiled brief and have chaffing on their buttocks/upper legs (a skin condition caused by friction, made worse by moisture).</p> <p>In an interview on 04/29/2024 at 12:44 PM, Resident 2' Collateral Contact (CC2) stated they observed Resident 2 press their call light for help to toilet and the response took 45 minutes.</p> <p><Resident 3></p> <p>Review of the 02/23/2024 quarterly MDS showed Resident 3 had severe cognition problems and diagnoses included dementia and depression. Resident 3 was assessed to be incontinent and required staff assistance for toileting and hygiene.</p> <p>Review of the incontinence CP dated 09/24/2023, directed staff to check Resident 3 as required for incontinence, provide incontinence care, and change clothing as needed after incontinence episodes. The CP showed Resident 3 wore disposable briefs and to check/change in the morning when they woke up, before and after meals, at bedtime, and as needed.</p> <p>In an observation on 04/29/2024 at 1:28 PM, in the hall outside room [ROOM NUMBER] was the presence of a very strong urine odor. The door to room [ROOM NUMBER] was cracked open and staff were heard in the room providing care to Resident 3. At 1:32 PM, Resident 3 was wheeled out of the room, taken to a table in the dining room area. An observation at 1:33 PM of Resident 3's bed and room showed the bed with no sheets and a puddle of liquid (four inches in diameter) that smelled like urine sitting on the center surface of the mattress.</p> <p>In an interview on 05/22/2024 at 11:05 AM, Staff F, Licensed Practical Nurse (LPN) stated residents should be checked and changed at least two times per shift. Staff F did not know what the facility policy for incontinence care for dependent residents was but would find out. No further information was provided.</p> <p><Resident 6></p> <p>Review of the 10/23/2023 Discharge Return Not Anticipated MDS showed Resident 6 was occasionally incontinent and required assistance for toileting and dressing. Resident 6 diagnoses included stroke, heart failure, and dementia.</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>In an interview on 05/28/2024 at 5:00 PM, Resident 6's Collateral Contact (CC6) stated they visited Resident 6 daily while they were a resident of the facility. CC6 stated Resident 6 could be continent of urine if they were assisted promptly because they still had the occasional ability to recognize when they needed to use the toilet and could use the call light for help. CC6 stated they often found Resident 6's disposable brief saturated with urine to the point their clothing required changing. CC6 recalled on one visit when they arrived at Resident 6's room, the call light was on, and they were waiting for toileting assistance but became incontinent while waiting. Resident 6's roommate told CC6 Resident 6 had been waiting for help for over an hour.</p> <p><Resident 7></p> <p>Review of the 03/06/2024 Admission MDS showed Resident 7 had memory problems and diagnoses included a fractured arm and dementia. Resident 7 was assessed to be dependent on staff assistance for toileting care and was frequently incontinent.</p> <p>Review of Resident 7's bowel/bladder incontinence CP showed they used disposable briefs and to check/change upon waking, before and after meals, at bedtime, and as needed.</p> <p>Review of a facility investigation report, initiated 04/16/2024, showed Resident 7 was found during morning care rounds lying in a urine and stool soaked brief that leaked through the brief to the bedding. Resident 7 was lying on top of three layers of bed pads with dried urine and stool on them and was provided a shower to get clean. An email included in the IR, from Staff H, LPN/Staff Development Coordinator, to Staff A, Administrator, dated 04/19/2024 at 9:22 AM, showed the CNA was educated the facility policy for check and change was every two hours.</p> <p>In an interview on 04/29/2024 at 4:40 PM Staff A, Administrator, stated Resident 7 was found in the reported condition at 8:00 AM on 04/16/2024. An investigation was initiated that included a skin check, and no skin problems were found.</p> <p>In an interview on 04/29/2024 at 4:43 PM Staff B, Director of Nursing, stated their expectation was staff provided incontinence care according to the residents care plan and should not lay residents over multiple bed pads.</p> <p>BATHING/NAIL CARE</p> <p><Resident 3></p> <p>Review of the 02/23/2024 quarterly MDS showed Resident 3 was dependent on staff for bathing.</p> <p>Review of the ADL CP dated 08/25/2023 showed Resident 3 required total assistance for showering twice a week and as needed, but the CP did not show Resident 3's preferences for bathing or any pattern/history of refusals.</p> <p>In an observation on 04/29/2024 at 1:32 PM, Resident 3 was sitting at a table in the dining room eating a banana. Resident 3 had dark matter under their nails and smelled of urine.</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>Review of Resident 3's POC shower record (30-day look back) on 05/22/2024 showed Resident 3 had a sponge bath on 04/26/2024 and 05/16/2024, and a shower on 05/19/2024. There was no other documentation to show a bath was provided, offered, or refused at least twice a week.</p> <p>Review of Resident 3's POC nail care record (30-day look back) on 05/15/2024 showed no documentation nail care was ever provided.</p> <p>In an interview on 05/22/2024 at 11:30 PM, Staff E, Licensed Practical Nurse (LPN), Resident Care Manager (RCM), stated residents were scheduled for two showers per week, and the shower schedule was in a binder at the nurse station. Review of the Shower Schedule showed Resident 3 was scheduled for a shower every Sunday and Thursday evening. Staff E provided a printout of Resident 3's POC shower record and stated the staff should either document the shower was provided in the POC shower record or on the Shower Sheet Check Off (SSCO-a paper document). Staff E stated they knew showers got done because they reviewed the SSCOs. Staff E stated after they reviewed the SSCO it was scanned into their electronic record.</p> <p>Review of Resident 3's SSCO dated 05/19/2024 showed they had a shower, their hair was washed, and they had lotion applied. No other SSCO's were provide upon request.</p> <p>Review of Resident 3's electronic health record (EHR) showed no SSCO present in the record and no further information was provided.</p> <p><Resident 4></p> <p>Review of the 02/15/2024 Significant Change in Status MDS showed Resident 4 had severe cognition problems and diagnoses included dementia, glaucoma, and mobility problems. Resident 4 was assessed to be incontinent and required staff assistance for toileting and hygiene. Resident 4 was dependent on staff for bathing.</p> <p>Review of the ADL CP dated 05/22/2023, showed Resident 4 was on a toileting program that directed staff to offer toileting assistance in the morning when they woke up, before and after each meal, at bedtime and as needed. The CP showed Resident 4 was scheduled bathing twice a week and as needed, but the CP did not show Resident 4's preference for bathing or any pattern/history of refusals.</p> <p>Review of the incontinence CP dated 05/26/2023, directed staff to check Resident 4 as required for incontinence, provide incontinence care, and change clothing as needed after incontinence episodes. The CP showed Resident 4 wore disposable briefs and to check/change in the morning when they woke up, before and after meals, at bedtime and as needed.</p> <p>Interview on 4/29/24 at 10:34 AM, Resident 4's Collateral Contact (CC4) stated they had concerns regarding Resident 4's hygiene and body odor. CC4 stated when they visited, Resident frequently smelled of urine, appeared unbathed, and their hair was greasy and uncombed. CC4 stated they would often be wearing the same clothes on consecutive visits. CC4 was concerned Resident 4 was provided showers. CC4 stated they had provided the facility with shampoo and body wash that has never been opened or used. CC4 stated they had reported their concerns to the facility but did not feel their concerns were addressed.</p> <p>In an observation on 04/29/2024 at 1:20 PM, Resident 4s hair was uncombed and appeared greasy.</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>In an observation on 05/22/2024 at 11:00 AM, Resident 4's hair was uncombed and messy on the back of the head, appeared greasy, and had a musty odor. On Resident 4's dresser was three two bottles of shampoo that were brand new, and a box with shampoo and body wash set, never opened.</p> <p>An observation on 05/22/2024 at 11:15 AM of the shower room showed two open bottles of a house-stock shampoo and body wash, with no names on it. On top of the cabinet was a tall bottle of shampoo with no name on it. The shower room floor was dry.</p> <p>Review of Resident 4's shower record (30-day look back) on 05/22/2024 showed Resident 4 received a sponge bath on Sunday 04/30/2024, and showers on Monday 05/01/2024 and Friday 05/09/2024. There were refusals documented on 04/26/2024, 05/03/2024, 05/07/2024, 05/14/2024, and 05/17/2024. There was no documentation a shower was provided, offered, or refused on 04/23/2024, 05/10/2024, or 05/21/2024. Resident 4 had not been showered or had their hair washed in 13 days.</p> <p>In an interview on 05/22/2024 at 11:45 AM, Staff F, Licensed Practical Nurse, stated when residents refused their showers the CNAs were expected to re-approach later and to notify the nurse when they were not able to provide the shower. Staff F expected staff to document their attempts and to try to make up the shower on other shifts. Staff F stated the CP should include the Resident's preferences for shower days and interventions for staff to use when they refuse showers. Staff F was unaware of Resident 4's shower refusals.</p> <p>Review of Resident 4's SSCOs dated 05/09/2024 showed their hair was washed and their toenails needed to be trimmed. No other SSCOs were provided.</p> <p>Review of Resident 4's nail care record (30-day look back) on 05/15/2024 showed no documentation nail care was provided.</p> <p><Resident 11></p> <p>Similar findings for Resident 11; the shower schedule showed they were scheduled for Wednesday and Saturday day shift showers.</p> <p>Review of Resident 11's POC shower record showed they received a shower on 05/01/2024, and sponge baths on 05/04/2024 and 05/15/2024. The shower record showed Resident 11 refused bathing on 05/08/2024. There was no documentation to show Resident 11 received, was offered, or refused bathing on five scheduled bath days or any other unscheduled bath day.</p> <p>REFERENCE WAC: 388-97-1060(1)(2)(a)(i)(c)(3)(b)(c).</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>46472</p> <p>Based on observations, interviews, and record review the facility failed to ensure residents were free from avoidable accidents for 1 of 3 residents (Resident 1) reviewed for Activities of Daily Living (ADLs-such as bed mobility, toileting, eating, and transferring) and accidents. This failure placed residents at risk for injury and diminished quality of care. Resident 1 experienced harm when facility staff did not follow resident's individualized care plan (CP) and use two people for bed mobility during incontinence care, resulting in a fall from the bed and a broken leg.</p> <p>Findings included</p> <p>POLICY</p> <p>Review of the facility's Policy/Procedure - Activities of Daily Living policy, revised 07/2015, showed nursing assistants would provide assistance with ADLs based on the resident's individualized care plan and in accordance with professional standards of quality and clinical practices.</p> <p><Resident 1></p> <p>Review of the 12/21/2023 quarterly Minimum Data Set (MDS-assessment tool) showed Resident 1 had no cognition problems, no behaviors, and no rejection of care. Resident 1's diagnoses included chronic heart and lung disease, Post Traumatic Stress Disorder (PTSD-a mental health condition triggered by a terrifying or traumatic event), depression, obesity, and no fractures. Resident 1 was incontinent and dependent on staff assistance for toileting hygiene and rolling side to side in bed. Resident 1 received scheduled and PRN (as needed) pain medication for almost constant severe pain (that affected their sleep and daily activities) and no recent history of falls.</p> <p>Review of the ADL CP, dated 07/20/2023, directed staff to check and change Resident 1 when waking up, before and after meals, and at their request. Resident 1 was dependent on staff to use the bed pan when requested, required two-person assistance for bed mobility, and used the trapeze to help turn and reposition.</p> <p>Review of a Nurse Progress Note (NPN), dated 01/07/2024 at 7:12 PM, showed the on-call Registered Nurse (RN) was contacted regarding Resident 1's bed width and the difficulty staff had positioning Resident 1 in bed, [Resident 1] appears to be on the edge of the bed and CNAs [Certified Nursing Assistants] are afraid of [Resident 1] rolling out of bed. A request was made about obtaining a larger bed for resident and staff safety.</p> <p>Review of a NPN, dated 01/08/2024 at 10:33 AM, showed the Interdisciplinary Team (IDT) determined Resident 1's bed was appropriate, and staff would be educated on proper techniques for turning and repositioning. The NPN did not show rationale for the determination of correct bed size.</p> <p>Review of the 01/09/2024 Kardex (simplified care directive for care staff) showed Resident 1 required care-in-pairs (two people for all personal cares), two people for bed mobility, and wore disposable briefs for incontinence.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a NPN, dated 01/09/2024 at 6:21 AM, showed Resident 1 rolled out of bed during resident care at 5:02 AM and was assisted to the floor by the CNA. When paramedics arrived and attempted to roll Resident 1 onto their back, the resident hollered out in pain and was transferred to the Emergency Department (ED).</p> <p>Review of the facility Fall Incident Report (IR), dated 01/09/2024 at 5:02 AM, showed Resident 1 was on an air mattress and Staff D, CNA, attempted to turn Resident 1 on their side, without another staff member's assistance, by pushing Resident 1 away them and Resident 1 rolled off the opposite side of the bed.</p> <p>Review of a Fall Committee IDT progress note, dated 01/15/2024 at 1:16 PM, showed during the provision of incontinence care, Resident 1 slid off the side of the bed, right leg first. Post fall interventions included education to staff on the standards of nursing practice for bed mobility</p> <p>Review of a NPN, dated 01/27/2024 at 6:18 PM, showed Resident 1 readmitted to the facility with diagnoses of a right leg fracture. Once Resident 1 was transferred from the stretcher to the bed, they required five staff to roll them and provide personal cares. Resident 1 was very anxious and scared of falling out of bed.</p> <p>In an interview on 04/29/2024 at 12:30 PM, Resident 1 stated they broke their leg in January during a fall from the bed because the CNA did not use two people to change their disposable brief. Resident 1 stated the bed they had at that time was too narrow for their body and did not have siderails to help roll, facility staff were made aware, but a wider bed was not provided until after they broke their leg. Resident 1 stated Staff D (who was of smaller stature) was on the left side of the bed and pushed on the resident's left hip to help them roll to the right side. As the resident began to roll over, the resident realized there was not another CNA on the right side of the bed, Resident 1 said they felt the air mattress sink on the right edge, and they then fell off the right side of the bed. Resident 1 stated they felt excruciating pain in their right leg and hip. Resident 1 stated Staff D could not assist them to help break the fall because they were on the left side of the bed and because, I am a big [person]. Resident 1 stated they were taken to the hospital and found they had a right leg fracture. Resident 1 stated this incident had caused them considerable pain whenever they roll in bed, delayed their recovery and discharge, and made their overall quality of life worse. Resident 1 stated the orthopedic (bone) specialist was not able to operate on the leg and may never be able to fix it; and either way they had lost the use of their leg and feared they might never walk again.</p> <p>In an interview on 04/29/2024 at 4:45 PM, Staff C, Director of Nursing, stated Staff D did not follow the care plan for cares-in-pairs and two-person bed mobility while they attempted to provide incontinence care but should have.</p> <p>Reference WAC 388-97-1060(3)(g)</p>		