

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505255	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER Othello Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 495 North Thirteenth Street Othello, WA 99344	
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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on observation, interview, and record review, the facility failed to honor a resident's choice for community outings for 1 of 4 sampled residents (Resident 4), reviewed for resident rights. This failure placed residents at risk of violations to their resident rights, unmet social needs, and diminished quality of life. Findings included . Review of the facility policy titled, Leave of Absence revised July 2023, showed a cognitively intact resident may leave the facility independently or family and/or friends may take a cognitively impaired resident from the facility when approved by the interdisciplinary team. A logbook would be used to track departures and returns of residents on the unit. The policy outlined the procedure for a leave of absence for a resident with cognitive impairment, an intended absence from the facility for a period in excess of eight hours in a day, and an intended absence beyond midnight. The policy directed staff to refer to the missing person procedure if a resident had not returned from their leave of absence within two to four hours of the anticipated return time. Review of the facility policy titled, Resident Rights dated August 2022, showed residents would be informed of their rights upon admission and resident rights were to be reviewed with the resident and/or their representative at least annually or as often as needed. A list of resident rights would be posted in the facility. The policy showed staff would be educated on resident rights upon hire and yearly thereafter. Review of the facility undated Resident [NAME] of Rights showed residents had the right to interact with members of the community both inside and outside the facility and make choices about aspects of their life that were significant to them to enhance their quality of life. The bill of rights further showed residents had the right to participate in social, religious, and community activities that did not interfere with the right of other facility residents. Review of the quarterly assessment, dated 07/08/2024, showed Resident 4 had diagnoses including abnormal posture and cerebral palsy (group of disorders that affect movement, balance, and posture). The assessment further showed Resident 4 used a motorized wheelchair (WC), was able to wheel/maneuver at least 50 feet with two turns and wheel at least 150 feet independently. Resident 4 was cognitively intact and able to clearly verbalize their needs. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 505255	Facility ID: 505255 If continuation sheet Page 1 of 38

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 10/03/2024 activity care plan showed Resident 4 enjoyed strolling around the facility in their motorized WC and was able to make independent choices regarding their leisure time. The 01/18/2024 limited physical mobility care plan showed Resident 4 was able to use their motorized WC independently. Review of the 07/11/2024 elopement risk evaluation showed Resident 4 was alert and oriented to person, place, time, and situation, had no history of elopement attempts and was identified as not at risk for elopement. Review of September 2024 through October 2024 nursing progress notes showed on 09/18/2024 at 12:39 PM Resident 4 became agitated and yelled throughout the hall. Resident 4 was upset because they wanted to go to the store in their motorized WC independently. Resident 4 was notified they could not go to the store independently for safety reasons and needed an escort, Resident 4 became very upset, began cursing and hollering again. At 1:55 PM the same day, Resident 4 screamed at staff in the hall and expressed they wanted to go to the store alone. Review of the 10/03/2024 quarterly nursing evaluation showed Resident 4 was alert and oriented to person, place, time, and situation, had no exit seeking behaviors and was identified as not at risk for elopement. Review of the 10/04/2024 social service quarterly evaluation showed Resident 4 had no change in cognitive status in the last quarter. During observation on 10/07/2024 at 11:27 AM, Resident 4 drove and maneuvered their motorized WC without safety concerns. Similar observations were made on 10/07/2024 at 2:49 PM, 10/09/2024 at 10 AM and 11:35 AM, and on 10/11/2024 at 7:58 AM. In an interview on 10/07/2024 at 2:32 PM, Resident 4 stated they were recently informed they needed an escort to leave the facility because of events from another sister facility. Resident 4 stated they were previously allowed to sign out and leave the facility independently, Resident 4 began to raise their voice as they explained they had lived in the area for [AGE] years, had never gotten lost, had not experienced a fall or accident when out in the community previously, and did not have difficulty driving or maneuvering their motorized WC. Resident 4 stated I feel I am in prison because of the new rule. In an interview on 10/11/2024 at 8:10 AM, Staff F, Nursing Assistant, stated they had not seen residents go on personal outings independently, they typically had an escort, even if they were cognitively intact. In an interview on 10/11/2024 at 8:28 AM, Staff D, Licensed Practical Nurse, stated residents were not allowed to go on community outings without a companion. Staff D further stated Resident 4 was cognitively intact, could drive/maneuver their motorized WC without safety concerns and had not experienced any accidents. Staff D acknowledged Resident 4 wanted to go on community outings independently but still required an escort for their safety. (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/11/2024 at 8:44 AM, Staff H, Social Service Director, explained resident rights. Staff H stated residents could go on community outings independently depending on their cognitive status and transportation method. Staff H further explained if a cognitively intact resident chose to go on a community outing in their WC, then the facility would ask them to have a companion for their safety but if they had other transportation arrangements then they could go out independently. Staff H stated Resident 4 was able to drive and maneuver their motorized WC without safety concerns and had a history of following the rules related to leaves of absence. Staff H further stated Resident 4 would need an escort if they chose to leave the facility in their motorized WC, for their safety. In an interview on 10/11/2024 at 10:47 AM, Staff B, Director of Nursing, stated residents could go on community outings depending on their cognition and transportation method. Staff B stated they were concerned about Resident 4 going on community outings because of traffic. Staff B was unsure if Resident 4 had been assessed for WC mobility in the community. Staff B acknowledged requiring Resident 4 to have an escort on community outings without justification could be a resident right issue. In an interview on 10/11/2024 at 11:25 AM, Staff G, Director of Therapy, stated residents were required to pass a motorized WC assessment that included a drive test to ensure they could safely navigate around others inside and outside the facility, prior to being allowed to use the motorized WC. Staff G acknowledged Resident 4 had not been recently assessed for WC mobility. In an interview on 10/11/2024 at 12:43 PM, Staff A, Administrator, acknowledged Resident 4 was required to have an escort to go on community outings because of traffic and the community environment. Refer to WAC 388-97-0900 (1)-(4)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on observation, interview and record review, the facility failed to repeatedly review care plan intervention effectiveness and timely revise ineffective interventions for 3 of 14 sampled residents (Residents 3, 6, and 12), reviewed for care planning. This failed practice placed residents at risk of unmet care needs and diminished quality of life. Findings included . Review of the facility policy titled, Care Planning revised May 2023, showed the care plan should contain description of services to be provided to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Individualized care plan interventions would be added with a date to indicate when the intervention was started. The policy further showed the care plan was to be reviewed upon admission, quarterly and with significant changes in condition. <Resident 3> Review of the quarterly assessment, dated 09/28/2024, showed Resident 3 admitted to the facility on [DATE] with diagnoses including chronic liver failure and high blood pressure. Resident 3 had no pressure injuries or no intravenous (IV) access. Resident 3 was cognitively intact and able to clearly verbalize their needs. Review of the care plan revised 06/24/2024 showed Resident 3 had a laceration to their right shin and instructed staff to complete treatments per provider orders and monitor for signs and/or symptoms of infection. The care plan revised 08/30/2024 showed Resident 3 had a pressure injury to their buttocks and instructed staff to keep skin clean, monitor bony prominences for signs of skin breakdown and provide wound care per provider orders. The care plan initiated on 09/11/2024 showed Resident 3 used a perimeter mattress (mattress with a raised or defined edge) for safety and instructed staff to ensure proper positioning with proper body alignment when in bed. The care plan revised 09/16/2024 showed Resident 3 had IV access and instructed staff to follow enhanced barrier precautions (EBP, infection control measures used to reduce the spread of drug-resistant organisms) for infection control, provide IV site care, and notify the provider if signs and/or symptoms of infection were observed. Review of provider orders showed a 08/19/2024 order for Resident 3 to use a protective barrier cream twice daily to their buttocks for itchy and dry skin. A 09/25/2024 order showed Resident 3 was to use an alternating air mattress with bolsters to promote pressure relief and comfort. Review of the 09/07/2024 through 10/05/2024 weekly skin evaluations showed Resident 3 had no pressure injuries to their buttocks nor a laceration to right shin. Review of September 2024 through October 2024 nursing progress notes showed on 09/26/2024 Resident 3 removed their IV access line, and it was not reinserted. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/07/2024 at 9:46 AM showed an enhanced barrier precaution sign posted on Resident 3's room door with a plastic black storage container full of personal protective equipment (PPE, gowns, gloves, masks, eye protection) right outside of the room. Observation on 10/08/2024 at 8:51 AM, showed the enhanced barrier precaution sign was no longer posted on Resident 3's room door and the black storage container containing PPE had been removed. During observation and interview on 10/08/2024 at 9:18 AM, Resident 3 laid in bed wearing a short sleeve hospital gown, on top of an alternating air mattress, and did not have IV access to either arm. Resident 3 stated they only had a rash to their buttock that staff treated with a barrier cream and denied other skin issues. Similar observation were made on 10/09/2024 at 9:43 AM. In an interview on 10/10/2024 at 11:24 AM, Staff E, Nursing Assistant (NA), stated care plans should be updated with a resident's needs because staff referred to them to determine a resident's care needs. Staff E stated Resident 3 no longer had IV access, no longer required a bandage to their buttocks, and used a barrier cream for skin integrity. In an interview on 10/10/2024 at 12:09 PM, Staff B, Director of Nursing (DNS), stated care plans were reviewed as needed, quarterly, and with changes of condition. Staff B further stated care plans should accurately reflect a resident's care needs, if not updated accurately then staff might not know what care a resident needed and the facility might not meet a resident's care needs. Staff B reviewed Resident 3's records. Staff B stated Resident 3's right shin laceration and buttock pressure injury had resolved, Resident 3 no longer had IV access, and Resident 3 used an alternating air mattress for pressure reduction not a perimeter mattress. Staff B acknowledged Resident 3's care plan did not reflect their current needs. <Resident 6> Review of the admission assessment, dated 09/11/2024, showed Resident 6 admitted to the facility on [DATE] with diagnoses including dementia (loss of cognitive function- thinking, remembering, and reasoning that interferes with a person's daily life), and hemiplegia (paralysis on one side of the body) following a stroke. The assessment further showed Resident 6 sustained one injury fall since admission and used a chair that prevented rising. Resident 6 had two unhealed pressure injuries with dressings applied to their feet and was on isolation or quarantine precautions. Review of provider orders dated 09/10/2024 showed Resident 6 was to be on EBP due to wounds on their buttocks and both legs. A 09/13/2024 order showed Resident 6 was to use a Broda (low to the ground chair with tension seating with a back that reclined) chair for safety and positioning related to profound weakness. Review of the 09/11/2024 facility fall incident report showed Resident 6 was seated in their WC, leaned forward, and fell out of the chair hitting their head. The incident summary showed the WC was switched to a Broda chair and the care plan was updated. Review of the 09/10/2024 skin care plan showed Resident 6 had wounds to their buttock, both legs and instructed staff to follow EBP. The 09/12/2024 falls care plan showed Resident 6 had a history of falls and instructed staff to place Resident 6's bed in the low position when occupied, keep frequently used items within reach, and use a Broda chair for safety and positioning. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of September 2024 nursing progress notes showed on 09/10/2024, Resident 6 was on EBP due to pressure injuries to their buttocks and both legs. On 09/13/2024 Resident 6 began to use a tilt in space type WC (chair height wheelchair that swiveled to elevate the legs and recline the back). Review of 09/22/2024 through 10/06/2024 weekly skin evaluations showed Resident 6 had no pressure injuries to their buttocks or legs. Observation on 10/07/2024 at 9:46 AM, showed an EBP sign posted on Resident 6's room door with a plastic black storage container full of PPE right outside of the room. Similar observation were made on 10/08/2024 at 8:48 AM. Observation on 10/08/2024 at 2:19 PM, showed the EBP sign was no longer posted on Resident 6's room door and the black storage container containing PPE had been removed. During an observation on 10/09/2024 at 9:44 AM, Resident 6 sat in a tilt in space type WC, not a Broda. Similar observations were made on 10/09/2024 at 10:36 AM, 10/10/2024 at 7:53 AM and 10:16 AM. In an interview on 10/11/2024 at 8:08 AM, Staff F, NA, stated Resident 6 did not have skin issues. In an interview on 10/11/2024 at 8:22 AM, Staff D, Licensed Practical Nurse (LPN), stated Resident 6's skin issues resolved. Staff D further stated Resident 6 sustained a fall September 2024 and their WC was exchanged. In an interview on 10/11/2024 at 10:57 AM, Staff B, DNS, reviewed Resident 6's record. Staff B stated Resident 6 no longer had skin issues. Staff B acknowledged Resident 6's care plan showed they used a Broda chair but it had been exchanged for a tilt in space type WC so they could better participate in therapies and increase their independence. Staff B acknowledged Resident 6's care plan was not up to date. <Resident 12> Review of the quarterly assessment, dated 09/16/2024, showed Resident 12 had a diagnosis of severe dementia with severe cognitive impairment. Resident 12 had not sustained any falls since admission, reentry or the prior assessment. Review of the 06/10/2024 self-care deficit care plan showed Resident 12 required total assistance of two staff for bed mobility. The care plan revised 06/10/2024 showed Resident 12 was at risk for falls out of bed and instructed staff to place the bed in the lowest position when occupied and place fall mats on both sides of the bed. A fall intervention initiated 01/16/2024 instructed staff to position Resident 12 in the center of the bed, the intervention was revised/reworded on 10/02/2024 to ensure Resident 12 was positioned in the center of the bed. Review of the 09/27/2024 facility fall incident report showed Resident 12 rolled out of bed onto the floor. The incident summary showed the care plan was updated to ensure Resident 12 was positioned in the center of the bed. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/11/2024 at 8:14 AM, Staff D, LPN, explained the facility process when a fall occurred and stated a new fall intervention should be implemented immediately to prevent incident recurrence because the sooner the intervention the better the [fall] prevention. In an interview on 10/11/2024 at 11:07 AM, Staff B, DNS, reviewed Resident 12's record. Staff B acknowledged Resident 12's fall intervention to position them in the center of the bed was initially initiated January 2024 and not a new intervention after sustaining a fall out of bed September 2024. Reference WAC 388-97-1020 (5)(b) Refer to F880 for additional information.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 46033 Based on observation, interview and record review, the facility failed to provide necessary services to support activities of daily living (ADLs) for 2 of 4 sampled residents (Residents 1 and 22) reviewed. Specifically, Resident 1 was not receiving restorative nursing services as careplanned, and a robust system was not implemented for Resident 22, who had communication challenges after suffering a stroke. Findings included . The Facility Assessment Tool dated 08/15/2024 documented Othello Care Center resident population might require and would be provided Restorative Nursing care. <Resident 1> The 08/09/2024 quarterly assessment documented Resident 1 had diagnoses including quadriplegia (paralysis that affected all four extremities and the body from the neck down), was cognitively intact and able to make their needs known. Resident 1 was dependent on staff for their ADLs and had no minutes of active or passive restorative range of motion completed. The care plan updated on 03/22/2023 documented Resident 1 had an alteration in physical mobility related to their quadriplegia; staff were instructed to cue the resident to perform active range of motion (AROM, where the resident carries out the movement) exercises for their head and neck of turning side to side, placing their left side to their left shoulder, and right side to their right shoulder, and moving the chin to the chest for 2 sets of 10 repetitions during cares for 15 minutes. Staff were also to perform passive ROM (PROM, where staff complete the movement for the resident) for both upper and lower extremities for 10 repetitions each, for 15-30 minutes 6-7 times per week. On 10/09/2024 at 11:49 AM, Resident 1 was observed seated in their electric wheelchair. The resident used their head to push on levers that operated the wheelchair. The resident had limited spastic movements of their arms. Resident 1 stated staff used to help move their arms and stretch them, but this had not happened in a long time. Resident 1 could not remember when the stretches had been done last and wondered why it had stopped. On 10/10/2024 at 10:09 AM, Staff E, Nursing Assistant (NA) and Staff N, NA, were observed transferring Resident 1 from their bed to their wheelchair using a mechanical lift. Resident 1 was totally dependent on the NA's for how they were positioned in their wheelchair, and their arms and legs had to be positioned on the appropriate supports. When asked, Staff E and Staff N stated therapy completed and documented the stretches and PROM for Resident 1. The NAs did not complete those tasks. During an interview on 10/10/2024 at 1:26 PM, Staff G, Director of Therapy, stated there were no restorative aides at present and they were trying to bring back the restorative nursing program. (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/11/2024 at 2:16 PM, Staff A, Administrator, stated it was their plan to bring back the restorative nursing care. It was important for the residents so they could maintain their functionality. 50027 <Resident 22> The quarterly assessment, dated 08/31/2024, documented Resident 22 had diagnoses including stroke and aphasia (the inability to understand or express speech). Resident 22 had no speech, rarely expressed ideas and wants, and sometimes understood simple, direct communication. Resident 22's cognition was severely impaired, although oriented to their location. The resident's preferred language was Spanish and they needed an interpreter to communicate with health care staff. The care plan, dated 05/26/2024, documented Resident 22 had an alteration in communication related to aphasia and was Spanish speaking only. Staff were instructed to allow Resident 22 adequate time to respond, ask yes/no questions, face resident when speaking, identify the resident's primary mode of communication, observe non-verbal cues that would indicate needs or understanding (e.g., nodding, facial grimacing, shaking head), and use visual aids to demonstrate daily cares. During an observation on 10/08/2024 at 9:13 AM, Resident 22 was in their room. They were seated in their wheelchair and watched the Spanish-language channel on television. There were two identical signs posted in English on the walls (above their television and left side of the bed) that read as followed: Please Call, Don't Fall .Your safety is Important to us. If you need to get up, use the call button for assistance. There was an Activities Monthly Calendar and Menu printed in English posted on the bathroom door. During an observation on 10/09/2024 at 11:53 AM, Resident 22 was in their room watching television on an English-language channel. The resident initiated communication with the surveyor verbalizing words and phrases that were not understood, in addition to using hand gestures (i.e., pointing). The surveyor had to ask yes/no questions several times to determine that the resident wanted the television remote. Resident 22 confirmed with a head nod and used the television remote to change to a Spanish-language channel. On 10/10/2024 at 9:45 AM, an observation and interview were conducted with Resident 22 in their room using an interpretation service over the phone for translating in Spanish. The resident communicated using gestures and single word phrases when speaking. The interpreter stated they could not understand Resident 22 when they spoke. The resident gestured that it was difficult to express to staff what their basic wants and needs were. Resident 22 stated that they did not receive speech therapy, but desired to so that they could improve their communication skills. Review of the speech therapy record, from 05/29/2024 to 10/07/2024, documented Resident 22 was not provided skilled services for aphasia until 07/22/2024, then received speech therapy 11 of 32 sessions planned and had no refusals. Further review showed a decline in Resident 22's expressive language skills when there was a lapse in treatment. There was no documentation of other communication tools attempted nor implemented. (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/11/2024 at 10:44 AM, Staff O, NA, stated it took a long time to understand what Resident 22 wanted or needed during ADLs which impacted how long it took to provide the resident care. During an interview on 10/11/2024 at 1:35 PM, Staff P, Speech-Language Pathologist, confirmed they minimally treated Resident 22's communication skills. Staff P stated that Resident 22 understood limited English and they engaged with them speaking primarily Spanish. Staff P confirmed that the signs in Resident 22's room should be posted in Spanish. Staff P also stated they had not implemented any other communication tools for Resident 22. Staff P confirmed that Resident 22 would benefit from other communication tools. During an interview on 10/11/2024 at 2:36 PM, Staff B, Director of Nursing, stated it was important for Resident 22 to have a better mode of communication so the facility could meet their needs. Reference: WAC 388-97-1060 (2)(a)(v) See F688 for additional information.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 46115 Based on observation, interview and record review, the facility failed to ensure a resident received consistent showers for 1 of 3 dependent sampled residents (Resident 2), reviewed for activities of daily living (ADL's). This failure placed the resident at risk for not being bathed per their preferences and poor hygiene. Findings included According to the 08/07/2024 quarterly assessment, Resident 2 had severe cognitive impairments, needed total assistance from staff for ADL's, such as bathing, and it was somewhat important to them to choose between a bed bath and a shower. In an interview on 10/07/2024 at 12:12 PM, Resident 2's guardian stated the resident had been bathed twice in the shower room and that was by them. The guardian added they would like the resident to be bathed in the shower room and staff had never attempted to do so to their knowledge. Per the 02/20/2024 care plan, Resident 2 was to be kept neat, clean, and well-groomed daily and required total dependence for bathing. Review of the bathing documentation from 09/09/2024 to 10/05/2024 documented Resident 2 had been given a bed bath on 09/09/2024, 09/13/2024, 09/21/2024, 10/04/2024 and 10/05/2024. In addition, the documentation showed the resident had not refused to be bathed. During an observation on 10/07/2024 at 12:12 PM, Resident 2's hair was greasy. Subsequent observations of Resident 2 with greasy hair were made on 10/08/2024 at 9:38 AM and 12:01, 10/09/2024 at 9:35 AM and 11:43 AM, 10/10/2024 at 7:44 AM and 1:29 PM, and 10/11/2024 at 7:12 AM. In an interview on 10/11/2024 at 9:16 AM, Staff B, Director of Nursing, stated showers were to be given twice weekly and this was important for hygiene and to promote health. Staff B added the staff were hesitant to give Resident 2 a shower because they had involuntary spastic movements of their limbs and should have assessed Resident 2 for a different type of bath chair so they could have showers. Reference: WAC 388-97-1060 (2)(c)		

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NAME OF PROVIDER OR SUPPLIER Othello Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 495 North Thirteenth Street Othello, WA 99344	
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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. 47328 Based on interview and record review, the facility failed to repeatedly implement the bowel management protocol when indicated for 2 of 5 sampled residents (Resident 7 and 16), reviewed for bowel management. This failure placed residents at risk of medical complications, unmet care needs, and diminished quality of life. Findings included . Review of the facility policy titled, Management of Constipation revised November 2023, defined constipation as three or more days without a bowel movement (BM) characterized by a decrease in frequency and/or passage of hard, dry stools. The policy showed BMs would be documented and monitored in the electronic medical record. When a resident was identified with no/small BM documented for 64 hours the nurse would assess the resident and determine if the bowel protocol would be initiated. The policy further showed the standard bowel protocol to relieve constipation with a provider order may include administration of 1) Milk of Magnesia (MOM, liquid laxative) after eight shifts of no BM, 2) Bisacodyl (stimulant laxative) suppository, if no results from MOM, and 3) Fleets enema (liquid laxative inserted rectally), if no results from the suppository. <Resident 7> Review of the quarterly assessment, dated 07/11/2024, showed Resident 7 had a diagnosis of neurogenic bladder (nerves and muscles of bladder do not work together). The assessment further showed Resident 7 experienced constipation and bowel continence was not rated because the resident did not have a BM during the seven-day assessment observation period. Review of the nutrition risk care plan implemented 09/14/2022 showed Resident 7 experienced constipation and instructed staff to monitor BMs and follow provider orders for bowel interventions. The 07/13/2024 self-deficit care plan showed Resident 7 required extensive assistance of 2 staff for toilet use. Review of provider orders showed Resident 7 was to take an opioid pain medication routinely three times daily, was not on routine bowel medications, and had active orders for: - 02/27/2024 Docusate to be given every 12 hours as needed for constipation - 02/27/2024 MOM to be given as needed for constipation if no BM after three days. - 02/27/2024 Bisacodyl suppository to be given every 24 hours as needed for constipation, if no results from MOM after 12 hours. - 02/27/2024 Fleet enema to be given every 24 hours as needed for constipation, if no results from suppository after four to six hours. The provider was to be notified if no results from the enema. Review of Resident 7's July 2024 through October 2024 bowel record showed: (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- July: 07/07/2024 large (after 6 days without a BM), 07/13/2024 extra-large (after 5 days without a BM), 07/24/2024 large and small (after 4 days without a BM) - August: 08/08/2024 medium (after 7 days without a BM), 08/11/2024 extra-large (after 3 days without a BM), 08/16/2024 extra-large (after 5 days without a BM), 08/20/2024 large (after 4 days without a BM), 08/23/2024 extra-large (after 3 days without a BM), 08/27/2024 large (after 4 days without a BM), 08/30/2024 extra-large (after 3 days without a BM) - September: 09/06/2024 extra-large (after 7 days without a BM), 09/11/2024 large (after 5 days without a BM), 09/16/2024 large (after 5 days without a BM), 09/28/2024 small - October: 10/02/2024 large (after 4 days without a BM), 10/04/2024 large, no BM documented through October 9th (5 days without a BM) Review of Resident 7's July 2024 through October 2024 Medication Administration Record showed: - July: MOM was administered on 07/12/2024 with effective results and 07/23/2024 with results documented as unknown. - August: MOM was administered on 08/19/2024, 08/27/2024, and 08/30/2024 with all results documented as unknown. - September: MOM was administered on 09/10/2024 with unknown results and on 09/17/2024 with effective results - October: MOM was administered on 10/09/2024 Review of July 2024 through October 2024 nursing progress notes showed Resident 7 took routine opioid pain medication possibly affecting bowel regularity. The notes showed no documentation the provider was notified of Resident 7's history of recurrent constipation. <Resident 16> Review of the 08/11/2024 quarterly assessment documented Resident 16 had diagnoses including kidney disease and depression. Resident 16 was cognitively impaired, required moderate assistance of staff for toileting, was occasionally incontinent of bowels, and had constipation. The 05/04/2023 care plan showed Resident 16 had an alteration in bowel elimination; staff were instructed to assist with periods of incontinence and provide pericare after each incontinence episode. Resident 16 had the following provider orders: -09/12/2024 Senna 8.6 milligrams (mg) one tablet twice daily for constipation, -08/01/2023 MOM 30 milliliters (ml) as needed for constipation, give at bedtime if no bowel movement on day 3, (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-08/01/2023 Dulcolax suppository once every 24 hours as needed for constipation if no results from MOM after 12 hours, -08/20/2024 Fleet enema 7-19 grams (gm) /118 ml once every 24 hours as needed if no results from Dulcolax in 4-6 hours. If no results from enema notify provider. A Physician Assistant progress note written on 09/11/2024 documented Resident 16 was seen at the request of nursing for constipation, going two to five days between bowel movements. The plan was to increase the Senna from once daily to twice daily and they would continue to monitor this. A nursing progress note written on 09/17/2024 documented Resident 16 complained of constipation. Review of the September 2024 MAR showed the Senna was increased and given twice daily, and the resident was given MOM on 09/17/2024 for no bowel movement. Review of the October 2024 MAR showed the Senna was given twice daily with no omissions, and there were no administrations of the as needed MOM, Dulcolax, or Fleet enema. A review of the 30 day look back of Nursing Assistant Bowel documentation from 09/11/2024 to 10/09/2024 showed the following: - From 09/11/2024 to 09/16/2024, Resident 16 had no bowel movement, a period of 6 days. -On 09/17/2024, the resident had one small and one medium bowel movement after administration of MOM. -From 09/22/2024 to 09/29/2024, the resident had no bowel movement, a period of 7 days. Resident 16 had received no as needed medications to relieve their constipation. -From 10/06/2024 to 10/09/2024 the resident had no bowel movement, a period of 3 days, and received no as needed medications to relieve their constipation. In an interview on 10/10/2024 at 11:28 AM, Staff E, Nursing Assistant, stated BMs were documented in the resident's electronic medical record and an alert would pop up if/when a resident did not have a BM documented for three days. Staff E further stated the typical bowel protocol consisted of oral laxative administration if no BM after three days, a suppository if no results, then an enema if no results from the suppository. Staff E stated potential complications from unresolved constipation could include a bowel obstruction that could require surgical intervention. Staff E acknowledged Resident 7 suffered from routine constipation for a while and would have rock hard stools after receiving as needed bowel medications. In an interview on 10/10/2024 at 11:58 AM, Staff B, Director of Nursing, stated BMs were documented in the electronic health record. Staff B explained the facility bowel protocol consisted of administration of MOM if no BM for three days, administration of suppository on day 4, then administration of an enema on day five, and the provider was to be notified if there were no results from the enema or if a resident experienced routine constipation issues. Staff B acknowledged Resident 7 had an extensive constipation history, routinely went five to seven days without having a BM, and stated the residents did not have the bowel protocol implemented when indicated. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference WAC 388-97- 1060 (1) This is a repeat citation from 03/27/2024 46033		

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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** 46033 Based on observation, interview and record review, the facility failed to develop treatment goals and care-planned interventions after a resident developed a pressure ulcer for 1 of 3 sampled residents (Resident 1) reviewed for pressure ulcers. This failure placed the resident at risk for further deterioration of their skin, unintended health consequences and decreased quality of life. Findings included . Edsberg, L. E., Black, J. M., [NAME], M., [NAME], L., [NAME], L., & Sieggreen, M. (2016). Revised National Pressure Ulcer Advisory Panel Pressure Injury Staging System; Journal of Wound Ostomy Continence Nurs, 43(6), 585-597 retrieved 10/21/2024 from https://npiap.com/page/PressureInjuryStages defined a stage 2 pressure injury as a partial-thickness skin loss, the wound bed is pink or red, moist and may also present as an intact or ruptured serum-filled blister. A review of the quarterly assessment dated [DATE] documented Resident 1 had diagnoses including complete quadriplegia-paralysis of the body from the neck down. Resident 1 was cognitively intact, was dependent on staff for all their activities of daily living (ADLs) and was at risk for pressure ulcers. The care plan revised 05/21/2024 documented Resident 1 had potential for alteration in their skin integrity related to quadriplegia; interventions included to perform weekly skin checks, identify/document potential causative factors and eliminate/resolve where possible, and to notify the charge nurse immediately if any skin breakdown was noted during care. A weekly skin evaluation dated 09/26/2024 showed no skin concerns were identified for Resident 1. A Physician Assistant (PA) progress note dated 10/02/2024 documented Resident 1 complained of a blister to the outer aspect of their right fifth finger (the pinky finger), had never had this before and was unsure how it happened. The note further documented nursing had provided wound care with padding and tape to keep the area safe and appeared to be related to pressure from their hand resting on the wheelchair. The PA determined the pressure injury was unavoidable due to Resident 1's quadriplegia that resulted in decreased movement and sensation. Further record review showed there were no orders or interventions added to Resident 1's treatment plan regarding the pressure ulcer that had developed on their pinky finger. Weekly skin checks completed on 10/03/2024 and 10/10/2024 showed no skin concerns were identified for Resident 1. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/07/2024 at 2:37 PM, Resident 1 was observed in their room seated in their electric wheelchair. A blister similar in size to a fingerprint was observed on the outer upper portion of the resident's right pinky finger. The top part of the blister near the fingertip contained fluid, and the lower portion was collapsed but intact. When the resident's hand was in a resting position on the arm support, the same area of their finger rested against the side of the armrest. The armrest was constructed of a firm black material and had no additional padding on it. Resident 1 stated they had no sensation in their fingers and they had not had any bandages or treatments regarding their finger. On 10/09/2024 at 11:49 AM and 10/10/2024 at 10:09 AM, the resident's pressure sore was observed. The fluid in the upper portion had decreased in size, and the skin remained intact, but appeared dried without elasticity. During an interview on 10/11/2024 at 12:09 PM, Staff B, Director of Nursing, stated Resident 1 was high risk for skin breakdown. Staff B stated skin checks were completed weekly at night so the resident's hands may not have been looked at closely. Staff B stated that when providers visited the residents, they did not always know who was seen or if there were any new findings that needed to be followed up on. Staff B stated interventions needed to be put in place so that Resident 1's pressure sore did not get worse. Reference: WAC 388-97-1060(3)(b)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 47328 Based on observation, interview, and record review the facility failed to implement interventions to prevent reduced range of motion (ROM) and/or prevent further decrease in ROM for 1 of 3 sampled residents (Resident 12), reviewed for limited ROM. This failure placed residents at risk of contracture (permanent tightening of muscles, tendons, ligaments, or skin that limits movement in a joint or body part) development, unmet care needs, and diminished quality of life. Findings included . Review of the facility undated procedure titled, Contracture Program showed it was used to determine if a resident would benefit from, or required contracture prevention or management which may include passive range of motion (PROM), active range of motion (AROM), positioning, splint and/or brace assistance through the restorative nursing program. The procedure referred staff to a nursing assistant textbook for AROM and/or PROM procedure guidance. Review of the facility policy titled, Restorative Nursing dated December 2022, showed the facility's restorative nursing program enabled residents to attain or maintain their highest practicable level of physical, mental, and psychosocial functioning. The restorative nursing program consisted of two options, restorative improvement and restorative maintenance. Restorative improvement was based on a reasonable expectation of improvement in function, restorative maintenance was based on the achievement of highest functional level and prevention of functional decline. Resident would be assessed for restorative services upon discontinuation of therapy services, quarterly, with significant changes and/or as needed. The policy instructed staff to determine a resident's willingness and ability to participate in a restorative nursing program, document refusals in the resident medical record, and re-evaluate at least quarterly. If a restorative program was initiated, it was to be documented in the electronic medical record, daily participation documented, progress reviewed with the interdisciplinary team and during care conferences, program and/interventions revised as needed based on individual resident needs. Review of the quarterly assessment, dated 09/16/2024, showed Resident 12 had diagnoses including dementia. Resident 12 was dependent on staff to complete all of their activities of daily living (ADL's). The assessment further showed Resident 12 had range of motion impairment to both upper extremities and did not receive AROM, PROM or require splint or brace assistance. Resident 12 had severe cognitive impairment. Review of the care plan initiated 06/14/2022 showed Resident 12 had limited physical mobility related to dementia and instructed staff to monitor, document, and report signs and/or symptoms of contracture development or worsening and refer to therapy as needed. Review of the quarterly assessment, dated 03/16/2024, showed Resident 12 had no range of motion impairment to either upper extremity and did not receive AROM, PROM or require splint or brace assistance. (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 03/26/2024 quarterly nursing evaluation showed Resident 12 had no impairment to either upper extremity but was dependent on staff assistance to complete their ADLs. Review of the 06/13/2024 quarterly nursing evaluation showed Resident 12 had impairment to both upper extremities and had begun to curl into themselves at wrists and hands. Review of the annual assessment, dated 06/16/2024, showed Resident 12 had range of motion impairment to both upper extremities and did not receive AROM, PROM or require splint or brace assistance. Review of the 06/25/2024 provider progress note showed Resident 12 had a contracture to their left upper extremity and was only able to move their hand slightly. During an observation on 10/07/2024 at 2:38 PM, Resident 12 had their right hand clamped shut in a fist with no rolled up washcloth, palm protector, splint or brace in place. Similar observations were made on 10/08/2024 at 8:46 AM, 2:23 PM, and 3:46 PM. In an interview on 10/07/2024 at 3:34 PM, Resident 12's family member stated Resident 12 typically did not have a rolled-up washcloth, palm protector, splint or brace in place and was unsure if staff assisted Resident 12 with hand stretching exercises. In an interview on 10/11/2024 at 8:03 AM, Staff F, Nursing Assistant, stated Resident 12 had not been able to open their hands for a while and did not have or use any type of palm protector or hand splints. In an interview on 10/11/2024 at 8:14 AM, Staff D, Licensed Practical Nurse, acknowledged Resident 12 had hand contractures that had progressed over time and was dependent on staff assist to perform their ADLs. Staff D further stated Resident 12 did not have or use any hand splints or braces. In an interview on 10/11/2024 at 10:05 AM, Staff G, Director of Therapy, reviewed Resident 12's therapy records. Staff G stated Resident 12 was last seen by therapy in April 2024 for wheelchair positioning. Staff G was unsure if Resident 12 had hand contractures and acknowledged therapy had not worked with Resident 12 on contracture prevention or management. Staff G further stated a ROM restorative nursing program could have prevented contractures. In an interview on 10/11/2024 at 11:07 AM, Staff B, Director of Nursing, stated if a resident had contractures, they would involve therapy so a plan of care could be developed to prevent further contracture development or worsening. Staff B acknowledged Resident 12's hands have been clamped shut for at least six months. In an interview on 10/11/2024 at 1:53 PM, Staff A, Administrator, stated they would submit a therapy referral if a ROM issue was observed. Reference WAC 388-97- 1060 (3)(d), (j)(ix) See F676 for additional information.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46115 Based on interview and record review, the facility failed to consistently implement appropriate interventions to reduce fall hazards and monitor for intervention effectiveness for 1 of 3 sampled residents (Resident 4), reviewed for falls. This failure resulted in Resident 4 sustaining repeated falls and placed residents at risk for avoidable accidents, significant injury, and diminished quality of life. Findings included . Review of the facility policy titled, Fall and Injury Prevention and Management Care Plan revised 01/2023, showed the facility would revise a resident's care plan and/or center practices to attempt to determine causal factors that may have led to a fall, to prevent future occurrences and reduce the likelihood of another fall. The facility was to assess risk factors and hazards to identify potential interventions to implement. Review of the facility policy titled, Fall Injury Management- Post Fall or Injury revised 01/30/2023, documented proper action following a fall included: assessing for injury, determining potential cause, or contributing factors, addressing potential contributing factors, revising the care plan and/or center practices to reduce the likelihood of another fall, and communicating a fall to the physician and the resident representative in a timely manner. The policy instructed staff to initiate and complete a fall incident report, complete a fall risk assessment, determine potential causes to the fall, review and revise fall interventions, and communicate changes and/or interventions to staff. Per the 09/21/2024 admission assessment, Resident 18 admitted on [DATE], had diagnoses which included chronic obstructive lung disease (COPD, a group of lung diseases that make it difficult to breathe), kidney disease and diabetes, was cognitively intact and made needs known. The assessment documented Resident 18 had sustained a non injury fall since their admission to the facility. The assessment additionally documented resident was on Hospice (end of life care) related to end stage COPD. Per the 09/23/2024 care plan, Resident 18 was at risk for falls related to anxiety and deconditioning secondary to end stage respiratory failure. The nursing staff was instructed to encourage the resident to use their call light and ensure it was within reach, keep needed items within reach, ensure resident was wearing non-skid socks or shoes when ambulating or mobilizing in wheelchair, and to offer to assist resident to the bathroom prior to bed. Review of the 10/07/2024 fall risk assessment documented Resident 18 was at high risk for falls because they had a history of falling and overestimated/forgot their limitations. Review of September 2024 through October 2024 accident and incident log and nursing progress notes documented Resident 18 sustained 9 falls in 23 days on: 09/21/2024 at 7:30 PM, 09/30/2024 at 11:29 PM, 10/02/2024 at 10:33 AM, 10/02/2024 at 5:15 PM, 10/05/2024 at 6:30 AM, 10/05/2024 at 7:03 PM, 10/06/2024 at 12:15 AM, 10/07/2024 at 10:58 AM and 10/08/2024 at 4:15 AM. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility incident report for the unwitnessed fall that occurred on 09/30/2024 at 11:29 AM documented Resident 18 was found on the floor next to their bed, was not wearing their oxygen, had a skin tear on their right forearm, bruising and swelling to left hand and knee. Resident 18's oxygen saturation was checked, and it was 50% (the normal oxygen saturation for someone with COPD is 88-92%). The 09/30/2024 progress note at 11:51 AM, documented Resident 18 was on Hospice, ambulated without waiting or calling for assistance and did not have their oxygen on. An intervention was added to the care plan on 10/01/2024 to place a sign in Resident 18's room to remind them to call for assistance. Review of the facility incident report for the unwitnessed fall that occurred on 10/02/2024 at 10:30 AM documented Resident 18 was found on the floor in front of their bed, was not wearing their oxygen, had a skin tear on their left forearm, very confused, and unable to answer questions appropriately. Resident 18's oxygen saturation was checked, and it was 70%. The fall was related to attempting to get out of bed to ambulate, anxiety, and unawareness of their limitations. Per the incident report the resident admitted to the facility, was alert, oriented, able to make needs known, wore oxygen and their saturations stayed in the 90's. Since their admission, Resident 18 had a significant change in condition, increased confusion, anxiety, unable to answer questions appropriately and make needs known and the resident had several falls over the last weeks. Fall mats were placed on each side of the bed to decrease risk of injury if another fall occurred. Review of the facility incident report for the unwitnessed fall that occurred on 10/02/2024 at 5:15 PM documented Resident 18 was found on the floor in front of their bed, was not wearing their oxygen, very confused, and unable to answer questions appropriately. Resident 18's oxygen saturation was checked, and it was in the 70's. The fall was related to attempting to get out of bed to ambulate, anxiety secondary to air hunger and decreased oxygen saturations and unawareness of their limitations. Review of the facility incident report for the fall that occurred on 10/05/2024 at 6:30 AM documented Resident 18 was found on their knees on the floor next to their bed. Family was in the room and had attempted to transfer the resident into their wheelchair. Resident 18 received a large bruise on their left knee and a skin tear on their left forearm. On 10/08/2024, the family was educated that Resident 18 was to be transferred by staff using a hooyer lift (a device that lifts the resident). Review of the facility incident report for the fall that occurred on 10/06/2024 at 12:15 AM documented Resident 18 was found sitting on their wheelchair foot pedals, very confused and anxious secondary to respiratory distress and low oxygen saturations. Resident 18 had attempted to stand unassisted from their wheelchair, staff member reacted quickly but was unable to keep the resident in their chair and had to assist them to a seated position on the floor. A self-releasing seatbelt was added to Resident 18's wheelchair. Review of the facility incident report for the unwitnessed fall that occurred on 10/07/2024 at 10:58 AM documented Resident 18 was found lying on the floor next to the bed, was not wearing oxygen, confused, and had a skin tear to their right forearm. Resident 18's oxygen saturation was checked, and it was 81%. The resident was placed in their wheelchair and placed in front of the nurse's station for increased supervision and a medication review was completed. The fall was related to Resident 18 had attempted to ambulate, poor safety awareness and unawareness of limitations. A sign was added to remind resident to call for assistance. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility incident report for the unwitnessed fall that occurred on 10/08/2024 at 4:15 AM documented Resident 18 was found lying on the floor near the end of the bed. Resident 18 was placed back in their wheelchair and brought to the nurse's station for better supervision. Resident 18's care plan was updated to place resident in activities or at the nurse's station to provide interaction and closer supervision when awake. During an observation on 10/07/2024 at 2:35 PM, Resident 18 was tilted back in their wheelchair, very fidgety, calling out, confused, and their family kept telling them they needed to stay in their wheelchair. Resident 18 observed multiple times trying to get out of their wheelchair unassisted. Resident 18's family spoke to the nurse and the nurse had explained how the resident continued to try to get out of their chair and bed. In an observation and interview on 10/07/2024 at 3:15 PM, Resident 18 was sitting in their wheelchair, had purple and green bruising over their arms and their entire left hand was covered in bruises. Resident 18's family stated some of the bruises were from a dog where she used to live but had fallen twice the day before and fell about every other day. Resident 18's family stated the facility did not have 1:1 supervision for the resident when they were not there. During an observation on 10/07/2024 at 3:49 PM, Resident 18 had a fall mat on the right side of their bed only, not the left side also as care planned. In an observation on 10/08/2024 at 10:10 AM, Resident 18 was sitting on the edge of the bed with no oxygen on and stated they needed to put their make up on. A staff member entered the room and stated they were going to go get help and left. Resident 18 stood up and began walking, very unsteadily, surveyor yelled to staff that Resident 18 was going to fall. Staff B, Director of Nursing and an unnamed staff member ran down the hall. Resident 18 had grabbed onto their wheelchair and leaned over it. The staff arrived in the resident's room and stated they needed more help. The surveyor went and got a nurse, and the resident was assisted into their wheelchair. During an observation on 10/09/2024 at 1:20 PM, Resident 18 was in their room tilted back in their wheelchair. There was no supervision provided as care planned. In an observation on 10/10/2024 at 7:54 AM, Resident 18 was sitting in the hall near the nurse's station, had pulled their oxygen off, and was attempting to get out of the wheelchair. There was no staff at or near the nurse's station to provide supervision. At 8:00 AM, two nursing assistants arrived and picked Resident 18's nasal cannula off the floor. The resident was anxious and kept trying to get out of their wheelchair. At 8:03 AM, Resident 18 was wheeled to their room without oxygen on. At 8:06 AM, Staff B, Director of Nursing, stated the resident was restless and was waiting for the nurse to get them a mask for oxygenation and pain medication. At 8:09 AM, Staff C, Registered Nurse, entered the room and Resident 18's oxygen saturation was 44-45% on room air. At 8:12 AM, the nurse placed the oxygen mask on the resident. During an observation on 10/10/2024 at 1:27 PM, Resident 18 was asleep in bed with only one prong of their nasal cannula in their nose, no supervision was being provided. The bed was not in low position and the fall mat was not on the left side of the bed on the floor. At 2:55 PM, the same observation of the bed and fall mat were made. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 10/11/2024 at 7:10 AM, Resident was lying in bed asleep, no supervision was being provided. The resident was not wearing oxygen, and the bed was not in low position. In an interview on 10/11/2024 at 8:41 AM, Staff E, Nursing Assistant, stated high fall risk residents would have floor mats, be placed at the nurse's station for increased supervision or have 1:1 supervision. Staff E added that Resident 18 was a high fall risk, and they were able to provide safety for them when they had 1:1 supervision. During an interview on 10/11/2024 at 9:01 AM, Staff D, Licensed Practical Nurse, stated they checked the residents during rounds to ensure their oxygen was being worn and they educated the residents on risks of not doing so. Staff D stated if oxygen saturations were too low it could lead to hypoxia (a deficiency in the amount of oxygen reaching the body's tissues) which could lead to shortness of breath and death. Staff D stated increased supervision or 1:1 supervision was provided for residents that have repeated falls. Staff D stated Resident 18 would have benefited from having 1:1 supervision related to confusion, depression and end of life status and they had mentioned it to the hospice nurse two days ago and they were looking into that. Staff D stated some of Resident 18's fall possibly could have been prevented with 1:1 supervision. Staff D added that some of Resident 18's falls could have occurred from low oxygen saturation and the resident was educated but confused. In an interview on 10/11/2024 at 9:22 AM, Staff B stated checks were completed to ensure residents were wearing their oxygen and low oxygen saturations could lead to respiratory issues. Staff B stated the cause of Resident 18's falls were related to increased anxiety, restlessness and end of life status. Staff B stated Resident 18's bed should have been kept in the lowest position and fall mats on each side of the bed. Staff B added Resident 18 would have benefited from 1:1 supervision, and it possibly could have prevented some of their falls and injuries and would have also helped with Resident 18 wearing their oxygen. Reference WAC: 388-97-1060 (3)(g)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46033 Based on observation, interview and record review, the facility failed to maintain respiratory equipment in a clean manner for 2 of 2 sampled residents (Residents 8 and 18) reviewed for respiratory care. This failure placed the residents at risk for illness and decreased quality of life. Findings included . <Resident 8> A review of the 08/28/2024 five day assessment documented Resident 8 had diagnoses including heart failure (the heart pumps ineffectively so does not meet the needs of the body) and pneumonia. The resident was moderately impaired cognitively and was dependent on supplemental oxygen. Provider orders instructed staff to wash the oxygen concentrator (the machine that delivers oxygen) filter if recommended by the manufacturer every Wednesday on night shift. A review of the September and October 2024 Medication Administration Records (MARs) documented the filter on the oxygen concentrator had been cleaned every Wednesday, with no omissions. On 10/07/2024 at 3:29 PM, Resident 8 was observed in their room, seated in an easy chair. Resident 8 was wearing oxygen and stated they had to wear it all the time. An oxygen concentrator was observed on the floor by the bed. The mesh filter on the side of the concentrator was covered in layers of lint and dust. The color of the filter was unable to be seen because the dust covered it so thickly. On 10/08/2024 at 9:07 AM, the concentrator filter was observed and had been cleaned. During an interview on 10/11/2024 at 3:00 PM, Staff A, Administrator, stated they had seen how dirty the filter on Resident 8's oxygen concentrator was and had cleaned it themselves. They were surprised to learn the MAR showed the filter had been cleaned weekly. Staff A expected staff to clean the filters as ordered. <Resident 18> According to the 09/21/2024 admission assessment, Resident 18 had diagnoses including chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe), was cognitively intact and wore oxygen. The 09/16/2024 comprehensive care plan documented Resident 18 had chronic respiratory failure related to COPD and received oxygen as ordered by the physician. A review of Resident 18's record revealed there were no orders to clean the oxygen filter. The October 2024 MAR documented the oxygen filter was to be changed every six months. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/07/2024 at 3:43 PM, Resident 18 was observed sitting in their wheelchair. The back of the oxygen concentrator had an air filter that was covered in a thick layer of dust and debris. In an interview on 10/11/2024 at 9:01 AM, Staff D, Licensed Practical Nurse, stated the oxygen filters were checked weekly and changed if they needed to be. In an interview on 10/11/2024 at 9:22 AM, Staff B, Director of Nursing, stated the oxygen filters were to be cleaned weekly and as needed. Staff B added this was important because unclean filters could cause respiratory issues. Reference: WAC 388-97-1060(3)(j)(vi) 46115		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 46115 Based on observation, interview, and record review, the facility failed to have the practitioner reevaluate the continued use of antipsychotic medication (a type of medication used to treat symptoms of psychosis) as required after 14 days of use for 1 of 5 sampled residents (Resident 18) reviewed for unnecessary medications. These failures placed the residents at risk for unintended medication side effects and a decreased quality of life. Findings included . According to the 09/21/2024 admission assessment, Resident 18 had diagnoses which included chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe), respiratory failure and diabetes, was cognitively intact, able to make their needs known and received Hospice services. A review of the 09/2024 physician's orders documented Resident 18 was prescribed haloperidol lactate (an antipsychotic medication) as needed (PRN) for agitation. The 09/27/2024 comprehensive care plan had the following care areas: -Hospice Care/End of life needs; interventions were to provide end of life care as needed to meet the needs of the resident and alert the provider with changes in resident's status. -the resident had a psychosocial well-being problem related to anxiety; interventions were to provide the resident assistance/supervision/support to identify precipitating factors/stressors, provide opportunities for resident and family to participate in care, and when conflict arose, remove resident to a calm safe environment that allowed them to vent/share feelings. A review of the resident's medication administration records (MAR) for 09/2024 and 10/2024 documented the resident received haloperidol lactate on 09/22/2024, 10/02/2024, 10/04/2024, 10/05/2024, 10/06/2024, 10/07/2024, 10/08/2024 and 10/09/2024. Resident 18's records did not include progress notes or assessments from the resident's providers for 09/2024 or 10/2024 for the continued use of the haloperidol lactate for more than 14 days. In an interview on 10/11/2024 at 9:01 AM, Staff D, Licensed Practical Nurse, stated PRN psychotropic medications needed to be reassessed by the providers after 14 days. During an interview on 10/11/2024 at 9:22 AM, Staff B, Director of Nursing, was not able to provide documentation that Resident 18 had been reassessed for the continued use of the PRN haloperidol lactate after 14 days. Staff B added it was important that the resident be reassessed to know if the resident still needed it and whether it was beneficial to them. Reference: WAC 388-97-1060 (3)(k)(i)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 47328 Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than five percent. Three medication errors were identified for 2 of 10 sampled residents (Residents 23 and 176), observed during 30 medication administration opportunities that resulted in an error rate of 10%. This failure placed residents at risk of receiving subtherapeutic effects of their medications, possible adverse side effects, and diminished quality of life. Findings included . Review of the undated facility policy titled, Medication Administration showed staff would check for the right medication, right dose, right dosage form, right route, right resident, and right time prior to administering medication. Staff were to perform hand hygiene, gather appropriate equipment for medication administration, perform necessary assessments as needed prior to medication administration, and read the medication administration record (MAR) for the ordered medication, dose, dosage form, route, and time. If there was a discrepancy between the medication label and the MAR, staff were not to administer medications and check with the provider for clarification. The policy further instructed staff to follow the MAR and document medications administered into the MAR as soon as medications were given. Review of the facility policy titled, Physician's Orders revised February 2023, showed clinicians could take verbal, telephone, and electronic orders from a provider. The policy explained the required components of an order and instructed staff to transcribe verified ordered into the electronic health record, leaving them in a queue for a second licensed nurse to review for accuracy. <Resident 176> During a medication administration observation on 10/10/2024 at 7:18 AM, Staff C, Registered Nurse (RN), prepared, dispensed, and administered numerous oral medications to Resident 176 including Aspirin (over the counter medication that reduces pain, fever, inflammation, and blood clotting) safety coated (prevents stomach upset) and Geri-Mox regular strength liquid antacid. Review of the 10/01/2024 provider orders documented Resident 176 was to be given chewable, not safety coated aspirin daily for heart health. There was no provider order for the resident to receive Geri-Mox liquid antacid. In an interview on 10/10/2024 at 10:29 AM, Staff C stated they administered Geri-Mox to Resident 176 because the resident had reported stomach pain earlier. Staff C was informed an order for Geri-Mox or liquid antacid was not seen in Resident 176's medical record. Staff C stated Geri-Mox was part of the provider standing orders but should be entered into the resident's record so staff could follow up on the medication effectiveness and prevent potential double dosing the medication. (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility undated standing order protocol showed standing orders were a guide for nurses and providers. The standing orders could be implemented following an appropriate nursing assessment of the resident and transcription into the electronic health record. For heartburn/bloating/stomachache staff could initiate orders to administer one over the counter chewable antacid tablet every eight hours as needed, if no relief after one day staff could give liquid antacid four times daily as needed. Further review of Resident 176's provider orders showed no order for over the counter chewable antacid tablets, as per the standing order protocol guidance. <Resident 23> During a medication administration observation on 10/10/2024 at 7:27 AM, Staff C prepared, dispensed, and administered numerous oral medications and gave an insulin injection to Resident 23. No topical patches for pain relief were dispensed, applied or offered to Resident 23. Review of the 09/17/2024 provider orders documented Resident 23 was to have a Lidocaine patch applied daily for pain. In an interview on 10/10/2024 at 10:27 AM, Staff C, when asked, stated they had not applied a lidocaine patch to Resident 23. Staff C stated Resident 23 frequently refused the Lidocaine patch but was unsure if the provider was notified so the order could be discontinued. In an interview on 10/10/2024 at 10:56 AM, Staff B, Director of Nursing, stated the facility standing order protocol was a guide and orders needed to be transcribed into the resident's electronic health record. Staff B stated they expected staff to document medications as administered in the MAR. In a follow-up interview on 10/10/2024 at 11:43 AM, Staff B stated they expected staff to administer medications as ordered by the providers. Reference WAC 388-97-1060 (3)(k)(ii)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46115 Based on observation, interview, and record review, the facility failed to ensure expired medications were disposed of timely, in accordance with currently accepted professional standards, in 1 of 1 medication storage rooms. The facility further failed to maintain temperatures to ensure medications were properly stored. This failure placed residents at risk for receiving compromised or ineffective medication. Findings included . During an observation of the medication room on 10/10/2024 at 7:18 AM, with Staff I, Registered Nurse, revealed a vial of hepatitis vaccine that had expired on 08/24/2024. The refrigerator in the medication room was 50 degrees and contained Covid-19 and Prevnar (a vaccine that protects against pneumonia) vaccines and a vial of Tubersol (medication injected under the skin to determine exposure to Tuberculosis). The temperature log posted on the wall stated the temperature should be between 36-46 degrees. Review of the refrigerator temperature logs documented the temperature had not been monitored since July 2024 and was monitored nine times that month. In an interview on 10/10/2024 at 7:18 AM, Staff I stated the temperature of the vaccines should be monitored to ensure the temperature was appropriate to maintain viability of the vaccines. During an interview on 10/10/2024 at 7:35 PM, Staff B, Director of Nursing, confirmed the temperature of the refrigerator should have been monitored to ensure the viability of the vaccines and the hepatitis vaccine should have been discarded. Reference: WAC 388-97-1300 (2)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46115 Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards for food service safety. Failure to ensure expired foods were discarded for 2 of 2 refrigerators, 1 of 1 dry storage areas and opened dates were placed on food items in the freezer. These failures placed residents served from the kitchen and snacks out of the refrigerator at risk for consuming expired food and food-borne illnesses. Findings included . During an initial tour of the kitchen on [DATE] at 8:49 AM, the pantry revealed five boxes of grits that had expired on [DATE], a banana cake mix that had expired on [DATE], cheddar garlic biscuit mix that had expired on [DATE], pizza crust mix that had expired on [DATE], can of sliced peaches that had expired on [DATE], three boxes of oatmeal that had expired on [DATE], package of shredded seasoned pork that had expired on [DATE], a bag of powdered sugar that had expired on ,d+[DATE], can of strawberry pie filling that had expired on [DATE], cupcake sprinkles that had expired on [DATE], a bag of corn tortillas that had no open or expiration date, two bags of Chile peppers that had no open or expiration date, bag of cinnamon that had no open or expiration date and six containers of cupcake sprinkles that had no open or expiration date. The refrigerator in the kitchen contained three stalks of celery that were brown and wilted an were received on [DATE], cabbage that was brown and was received on [DATE], five heads of lettuce, one head was dated [DATE] and the other four heads were dated [DATE]. The refrigerator in the conference room contained a yogurt and rice pudding that had expired on [DATE], a bag of spinach that had expired on [DATE], and a container of tossed salad dated [DATE]. The freezer contained opened packages of [NAME] fillets, chicken strips, sausage and bacon that had no open or expiration date. In an interview on [DATE] at 10:32 AM, Staff M, Dietary Manager, stated the dry storage was assessed weekly and it was important to discard expired foods to ensure contaminated food was not served to the residents, which could cause illness and open dates needed to be placed on the food so the staff would know when the food expired. During an interview on [DATE] at 11:03 AM, Staff M stated the kitchen was responsible for cleaning the conference room refrigerators. Reference: WAC [DATE](3), 2980		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 47328 Based on interview and record review, the facility failed to explain the arbitration agreement (a procedure used to settle a dispute using an independent person mutually agreed upon by both parties) in a manner and language the resident and/or their legal representative understood for 1 of 3 sampled residents (Resident 22), reviewed for arbitration agreement. This failure placed residents at risk of losing legal protection, forfeiture (loss or giving up of something) of the right to a jury or court, lack of understanding of the legal document signed, and a diminished quality of life. Findings included . Review of the facility policy titled, Voluntary Arbitration Agreement dated August 2022, showed the agreement was voluntary to resolve any dispute related to any admission by binding arbitration. The policy specified the arbitration agreement was found in the admission agreement, the admission agreements were to be reviewed with every resident and/or representative upon admission. The policy showed no further details of the arbitration agreement process. Review of the quarterly assessment, dated 08/31/2024, showed Resident 22 had diagnoses including stroke and aphasia (inability to form spoken words). Resident 22 had severe cognitive impairment, no speech, was rarely understood, and sometimes understood others. The assessment further showed Resident 22's preferred language was Spanish, and they needed or wanted an interpreter to communicate with a doctor or healthcare staff. Review of the 05/26/2024 advanced directive (a document that appoints a representative to make decisions on behalf of a resident if they become unable to do so) care plan showed Resident 22 did not have advanced directives, was unable to formulate advanced directives due to their cognitive status, and Resident 22's spouse was their next of kin (closest living relative). Review of the volunteer arbitration agreement showed the agreement was written in English and not signed by Resident 22's spouse, who was the designated next of kin, but was signed by a different family member. Review of May 2024 through June 2024 nursing progress notes showed Resident 22 did not have a power of attorney (POA, legal document that allowed a person to appoint someone to make decisions on their behalf when unable to do so) and their spouse only spoke Spanish. No documentation was found to show the binding arbitration agreement was explained in a form, manner, and language Resident 22 or their Spouse, next of kin, understood. In an interview on 10/07/2024 at 8:58 AM, Staff A, Administrator, stated the facility chose to enter into binding arbitration agreements, they were reviewed upon admission, and Staff H, Social Service Director (SSD), was the staff responsible for the binding arbitration agreements. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Othello Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 495 North Thirteenth Street Othello, WA 99344	
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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/11/2024 at 12:18 PM, Staff H, SSD, stated they had only seen the arbitration agreement in English, no other language. Staff H explained they reviewed the English arbitration agreement with residents, verbally explained it in Spanish if needed, and had the resident or their representative sign the English arbitration agreement. Staff H was asked how residents or their representative knew what they were signing if the form was not in a language, format, font size, or literacy level they understood. Staff H again stated they attempted to translate and explain the arbitration agreement to the best of their ability. Staff H further stated they requested arbitration agreements in different languages, including Spanish because the facility had a high population of Spanish speaking residents, but Staff H only had access to arbitration agreements in English. Staff H acknowledged they did not document when they reviewed and explained the arbitration agreement or that the resident and/or representative understood. In an interview on 10/11/2024 at 12:38 PM, Staff B, Director of Nursing, acknowledged the facility had a high population of Spanish speaking residents but had only seen arbitration agreements written in English. Staff B was unsure how a Spanish speaking resident and/or their representative knew what they were signing if the arbitration agreement was not in a language they understood. In a follow-up interview on 10/11/2024 at 12:55 PM, Staff A, Administrator, was unsure if the facility had arbitration agreements in languages other than English. No associated WAC.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on observation, interview, and record review, the facility failed to implement enhanced barrier precautions (EBP) for 1 of 3 sampled residents (Resident 13), reviewed for isolation precautions. In addition, the facility failed to perform hand hygiene when indicated during medication administration. These failures placed residents at risk of development of multi-drug-resistant organisms (MDROs), contracting communicable diseases, and diminished quality of life. Findings included . Review of the facility policy titled, Enhanced Barrier Precautions revised August 2023, showed EBP expanded the use of personal protective equipment (PPE) and referred to the use of gown and gloves during high-contact resident care activities that provided opportunities for transfer of MDROs to staff hands and clothing. Nursing home residents with wounds and indwelling medical devices were at higher risk of both acquisition of and colonization with MDROs. The policy included examples of high-contact care activities that required use of gown and gloves as dressing, bathing/showering, transferring, providing hygiene, changing linens, assisting with toileting, device and wound care. The policy instructed staff to post the appropriate EBP signage on the resident's door with PPE readily available and accessible. Staff were to document precautions implemented in the resident's care plan. Review of the undated facility policy titled, Handwashing/Hand Hygiene showed hand hygiene was the primary means to prevent the spread of infections. The policy instructed staff to follow hand hygiene procedures and included the following examples of when hand hygiene was indicated: before and after direct contact with resident, before preparing and handling medications, before and after handling an invasive medical device, before moving from a contaminated body site to a clean body site during resident care, after contact with a resident's intact skin, after contact with objects in the immediate vicinity of a resident, after glove removal, before and after entering an isolation precaution setting. The policy further showed the use of gloves did not replace hand hygiene. <Enhanced Barrier Precautions> Per the comprehensive assessment dated [DATE], Resident 13 had diagnoses including Parkinson's disease and neuromuscular dysfunction of the bladder (loss of bladder control due to brain, spinal cord, or nerve damage), requiring the use of an indwelling catheter (a catheter that is left in the bladder). Resident 13 had moderate cognitive impairment and required substantial/maximal assistance for most ADLs (activities of daily living) and mobility. The 06/22/2022 care plan, revised on 06/02/2024, documented Resident 13 had an alteration in urinary elimination due to their indwelling catheter. Staff were instructed to follow EBP's attributed to the resident's catheter. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/09/2024 at 1:36 PM, Staff K, Nursing Assistant, entered Resident 13's room to answer their call light. At 1:39 PM, Staff L, Nursing Assistant, entered the resident's room and provided Resident 13 with a drink. The resident then requested to get out of bed. Staff K put on Resident 13's shoes and Staff L applied a gait belt around their waist. Staff L and Staff K assisted the resident with transferring them from their bed to their wheelchair and did not put on PPE (gloves and gown) throughout this process. There was an EBP sign posted on Resident 13's door. PPE was also contained in a plastic drawer organizer directly outside of the resident's room. During an observation on 10/10/2024 at 8:46 AM, Staff K, entered Resident 13's room and put on gloves. Staff K wore gloves when they began to assist the resident with transferring them from their wheelchair to their bed. The resident stood up from their wheelchair. The resident decided they wanted to go to the bathroom before getting into bed. Staff K told the resident to sit back down in their chair and wheeled them into the bathroom. Staff K did not put on a gown throughout this process. The EBP sign was still posted on Resident 13's door and PPE remained contained in a plastic drawer organizer directly outside of the resident's room. In an interview on 10/10/2024 at 2:09 PM, Staff K confirmed that they should have worn PPE when they transferred Resident 13. During an interview on 10/11/2024 at 12:13 PM, Staff L stated that staff wears PPE for precautions with residents that have catheters and wounds informed by a sign that is posted on residents' doors. Staff L confirmed they should have worn the PPE required when they transferred Resident 13. In an interview on 10/11/2024 at 1:17 PM, Staff D, Licensed Practical Nurse, stated staff were informed by the nurse and signage was on the resident's door that notified staff when they needed to wear PPE for EBP's. In an interview on 10/11/2024 at 1:36 PM, Staff B, Director of Nursing/Infection Preventionist, confirmed that staff were to wear gloves and gowns when they transferred a resident that required EBP's to prevent the spread of harmful bacteria to other residents. <Hand Hygiene> During an observation on 10/10/2024 at 7:05 AM, Staff C, Registered Nurse, did not perform hand hygiene prior to dispensing medications for Resident 7. Staff C proceeded to enter Resident 7's room without performing hand hygiene, used the bed control to elevate the head of the bed, while leaning against the bed, touched Resident 7's blanket and assisted them to sit up in bed. Staff C placed the medications into their hand to look at them, put the medications back into the paper medication cup then placed them in Resident 7's mouth, and assisted them to drink water from a cup that was at bedside. Staff C used alcohol based-hand rub (ABHR) as they exited the room. During an observation on 10/10/2024 at 7:27 AM, Staff C, did not perform hand hygiene prior to dispensing medications for Resident 23. Staff C entered Resident 23's room, placed a blood pressure machine on the bedside table, placed the blood pressure cuff on Resident 23's left arm, Staff C put on a pair of gloves without performing hand hygiene, obtained a drop of blood to check Resident 23's blood sugar, walked back to their medication cart wearing the pair of gloves, disinfected the blood sugar machine, removed gloves, then used ABHR. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Refer to WAC 388-97-1320(2)(b), (1)(c) 46033		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on observation and interview the facility failed to ensure rooms containing sharps, chemicals, and tools were secured in 3 of 4 shower rooms and 1 of 22 resident rooms (room [ROOM NUMBER]), and failed to ensure a wheelchair and seatbelt were maintained in a clean manner for Resident 2 reviewed for physical environment. This failure placed residents at risk of potentially avoidable accidents, lack of dignity and diminished quality of life. Findings included . <Shower Rooms> During observation on 10/07/2024 at 10:35 AM, the shower room at the end of the hall between room [ROOM NUMBER] and room [ROOM NUMBER] was unlocked. The shower room had 2 unlocked cabinets that were at eye level. One cabinet contained a gallon of pink shampoo. The second cabinet contained a multi-purpose cleanser in a spray bottle and a small box containing 14 disposable razors. A similar observation was made at 12:39 PM, the same day. In an interview on 10/07/2024 at 12:46 PM, Staff L, Nursing Assistant (NA), stated the facility did not lock the shower rooms but the cabinets were supposed to be locked. Staff L was shown the unlocked cabinets in the shower room and acknowledged the shampoo and multi-purpose cleanser should have been locked up. Staff L further stated disposable razors were not to be stored in the shower room. During an inspection of the nursing units on 10/07/2024 at 9:56 AM, the shower room next to resident room [ROOM NUMBER] was observed. Signage on the door showed the room was in use, however, after knocking, the door was not locked and was opened. The room was mostly bare, except for a large bathtub, and a large black tool chest was positioned against the wall. The tool chest drawers were unlocked and contained power tools, screwdrivers, drill bits, nails, screws, and other sharp objects. There were no residents wandering near or trying to enter the shower room. On 10/07/2024 at 10:14 AM, the door to the shower room remained unlocked; there were no residents or staff in the hall. On 10/07/2024 at 10:15 AM, Staff J, Maintenance Manager, was observed entering the shower room. When interviewed, they stated staff and residents no longer used the shower room, they had been using it for the last 6 months to store their tools. The drawer contents and small sharp objects were observed, and Staff J stated they could see where leaving the shower room and the tool chest unlocked could present a risk for the residents if they got into the tools. Staff J locked the tool chest at that time. (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/07/2024 at 9:31 AM, the shower room towards the end of the hall between the nurse's station and room [ROOM NUMBER] was open, and accessible to residents and the public. The shower room had two plastic cabinets secured to walls on opposite sides of the room. One cabinet was without a lock and freely opened, and the other cabinet had a lock in place with a key attached to it. The cabinet without a lock contained the following items: an opened 10 pack of disposable razors, used bar of soap, hair shampoo, body wash, antiseptic skin cleanser, roll of plastic bags, and two boxes of gloves. The same observation was made at 12:33 PM. In an interview on 10/07/2024 at 10:32 AM, Staff F, Nursing Assistant, stated that the shower room was used to shower residents and the facility stored items such as disposable razors, shower chairs and disinfectants. Staff F also stated that the shower room should be locked. In an interview and observation on 10/07/2024 at 12:42 PM, Staff D, Licensed Practical Nurse, observed the opened shower room door and disposable razors in the unlocked cabinet. Staff D stated they were not aware that the razors were in the cabinet, and the cabinet should have been locked. Staff D confirmed that the shower room should be locked because residents could get into it. At this time it was observed the cabinet that had the lock and key was now opened and contained a bottle of peroxide disinfectant. Staff D stated chemicals should have been locked up. < room [ROOM NUMBER]> During observation on 10/07/2024 at 10:15 AM, a project work being done sign was observed on the room door. The door was closed but unlocked, no staff were in the room. Upon entering the room, a closed can of paint approximately 1/4 full was sitting on a bedside table to the right near the room entrance. On the bathroom floor there was a caulking gun with a tube of caulk, two [NAME] spatulas, a tape measure, and a blue folded item that looked like a pocketknife. In an interview on 10/07/2024 at 10:17 AM, Staff J, Maintenance Manager, stated painting and repairs were being done in room [ROOM NUMBER]. Staff J was shown the blue folded item that looked like a pocketknife. Staff J identified the item as a folded-up box cutting knife and acknowledged it should not have been left in the room unsecured or unattended. Staff J further stated they could not lock room [ROOM NUMBER] when work was being done related to safety issues. In an interview on 10/10/2024 at 11:55 AM, Staff B, Director of Nursing, stated chemicals, razors, tools and potentially dangerous items should be secured for resident safety. In an interview on 10/11/2024 at 12:53 AM, Staff A, Administrator, acknowledged chemicals, razors, and tools should have been locked up for resident safety. <Resident 2> Per the 08/07/2024 quarterly assessment, Resident 2 had diagnoses which included a traumatic brain injury and quadriplegia, had severe cognitive impairments and was dependent for all cares. Review of a 02/20/2024 comprehensive care plan documented Resident 2 was wheelchair bound, at risk for falls and wore a lap belt related to poor trunk control and spasticity. (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 10/08/2024 at 9:38 AM, Resident 2 was observed in their room sitting in their wheelchair. The wheelchair and lap belt was unclear with food debris on it. Subsequent observations of the wheelchair and lap belt with food debris were made on 10/08/2024 at 2:02 PM, 10/10/2024 at 7:44 AM, and 10/11/2024 at 7:12 AM. During an interview on 10/11/2024 at 7:13 AM, Staff F, Nursing Assistant, stated night shift was responsible for cleaning the wheelchairs and it was important for hygiene and dignity. In an interview on 10/11/2024 at 9:16 AM, Staff B, Director of Nursing, stated the nursing assistants were responsible for cleaning the wheelchairs and lap belts weekly and as needed. Staff B added this was important because of bacteria and to maintain the resident's dignity. Reference WAC 388-97- 3220 (1) 46033 46115 50027		