

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

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Form Approved OMB
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 01/10/2026
NAME OF PROVIDER OR SUPPLIER Othello Post Acute		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 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** Based on observation, interview and record review, the facility failed to ensure care plans were updated timely for 3 of 3 sampled residents (Residents 6, 7 and 47), reviewed for individualized plans of care. This failure created the potential for resident needs to go unaddressed, and potential related adverse events. Findings included. <Resident 6> A quarterly assessment dated [DATE] documented Resident 6 had diagnoses that included low back pain and infection of the bone of the right foot and ankle. Resident 6 was able to make their needs known, occasionally experienced pain they rated as moderate intensity, and received regularly scheduled and as needed opioid (narcotic) pain medications daily. During an interview on 01/07/2026 at 9:52 AM, Resident 6 was observed to be visibly uncomfortable; their brow was furrowed, and they made a face when moving in their bed. Resident 6 stated they had a long history of lower back pain. The resident stated they had a pain pump (a device implanted under the skin that delivers a steady dose of pain medication) and the medication in the pump was now morphine (an opioid pain medication), a change from fentanyl (an opioid pain medication). Resident 6 stated they also received pain pills that could be given every 4 hours. The 08/18/2025 care plan documented Resident 6 had potential and actual pain. Staff were to administer medications as ordered, and complete a pain assessment on admission, quarterly, and with new complaints of pain. On 10/14/2025, the care plan was updated for staff to encourage different pain-relieving methods, such as positioning or relaxation, observe and report changes in usual routine, monitor/record and report to the nurse complaints of pain or requests for pain treatments, observe for side effects of pain medication and report occurrences to the provider. The care plan had no goals, interventions, or monitoring developed regarding the resident's use of a pain pump. The 08/08/2025 admission physician assistant progress note documented Resident 6 previously managed their pain using a pain pump; the pump was not in use, and the resident's pain was to be managed with oral pain medication given as needed. The 12/16/2025 physician progress note documented Resident 6 was to be seen at the nearby pain clinic and their pain pump was to be refilled. There were no provider notes in Resident 6's record that detailed the pain clinic visit or any instructions regarding the use of the pain pump. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of provider orders documented Resident 6 could receive 5 milligrams (mg) of oxycodone, an opioid pain medication, every 4 hours as needed for moderate pain and 10 mg. every 4 hours for severe pain. Resident 6 could also take 650 mg. of acetaminophen every 6 hours as needed for pain. Staff were to assess the resident's pain every shift. There were no provider orders regarding the pain pump, what medication and dose were infusing, or what management of the pump was indicated. During an interview on 01/09/2026 at 1:33 PM, Staff K, Physician Assistant, stated Resident 6 was seen by the provider at the pain clinic on 12/16/2025, but Staff K was unable to see a provider note from that visit in the resident's record. Staff K stated they requested a copy from the pain clinic provider. Staff K stated the pain clinic would manage the resident's pain pump and the clinic would likely see the resident at least quarterly. During an interview on 01/10/2026 at 8:38 AM, Staff B, Director of Nursing, (DON), stated if there are new interventions needed in a plan of care, the care plan was to be updated within 24-28 hours. Staff B stated they were aware Resident 6 had been to the pain clinic and had their pain pump refilled in December 2025 and the care plan should have been updated to address the pump. Staff B stated the resident was at risk for being over sedated if staff were unaware the resident had a pain pump in use. Staff B stated they were waiting for notes from the provider at the pain clinic to add to the resident's record. <Resident 7> The 12/11/2025 significant change assessment documented Resident 7 had diagnoses that included traumatic brain injury (brain injury as a result of an external trauma), difficulty swallowing, and gastroparesis (delayed movement of food from the stomach to the small intestine). Resident 6 was severely cognitively impaired, was dependent on staff for all aspects of their care and received their nutrition through a feeding tube (a tube inserted through the abdomen into the intestine that bypassed the mouth, esophagus and stomach). On 01/06/2026 at 2:54 PM, Resident 7 was observed positioned in a tilting-style wheelchair. The resident was extremely thin; their cheekbones and collar bones protruded, and their arms and legs were thin with no visible muscle mass or tone. The resident was unable to follow any commands with purpose and had a very moist, harsh cough. Suction equipment to clear the resident's oral cavity of any secretions was present in the room for use as needed. A review of Resident 7's provider orders showed that on 05/30/2025, Resident 7 was to have nothing by mouth. Further review of the record documented Resident 7 had multiple hospitalizations beginning 06/12/2025 related to self-removal of their feeding tube, vomiting of bloody emesis, nausea, continued vomiting, aspiration pneumonia and bleeding in the intestines. A review of the care plan documented the following active care areas: -11/05/2024 Activities of daily living (ADL) self-care deficit; for EATING: the resident is totally dependent with eating at meals and snacks. Position upright at 90 degrees while seated in chair, make sure the resident swallows 2 times after every bite or given a drink with a spoon and is to (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	remain upright for 30 minutes minimum after eating or drinking. -06/17/2025 The resident was at high risk for aspiration (when food entered the lungs instead of being swallowed) related to decreased cognitive status and tube feeding; staff were to encourage fluid intake and follow aspiration precautions such as head of bed elevated and upright position when eating. -06/18/2025 The resident was at nutritional risk related to gastroparesis and difficult swallowing; the resident was to have nothing by mouth, monitor and record food and fluid intake. During an interview on 01/10/2026 at 9:48 AM, Staff B, Director of Nursing reviewed Resident 7's record and stated Resident 7 was not safe to swallow and went to strict nothing by mouth (NPO) status when their feeding tube was inserted. Staff B acknowledged references to eating and drinking should have been resolved in the resident's care plan when the resident was determined to be strict NPO. Staff B stated there was a risk for a mistake to be made if those references remained on the resident's care plan. <Resident 47> The 12/18/2025 admission assessment documented Resident 47 had diagnoses including bilateral knee fractures and had surgical repair. The resident was cognitively intact and made their needs known. The 12/26/2025 physician order documented Resident 47 had been prescribed enoxaparin (a blood thinning medication, anticoagulant, used to prevent and treat serious blood clots after surgery) daily for prophylaxis. Review of the care plan showed no documentation Resident 47 was prescribed a blood thinning medication and possible adverse effects to monitor for such as bruising and bleeding. Further record review showed there were no side effect monitors in the medication administration or treatment administration records (MAR/TAR). In an interview on 01/09/2026 at 2:10 PM, Staff J, Nursing Assistant, stated they knew what care to provide the residents with by reading their care plan. Staff J stated if a resident was at risk for bleeding/bruising it would say on the care plan. In an interview on 01/09/2026 at 1:57 PM, Staff C, Registered Nurse, stated when a resident received anticoagulant medication there was a monitor in the MAR or TAR for bruising and bleeding. Staff C stated the medication needed to be on the resident's care plan in the event of an injury that caused bleeding. In an interview on 01/09/2026 at 3:10 PM, Staff B, Director of Nursing, stated Resident 47's anticoagulant medication should have been on their care plan, and it was important because nursing staff needed to be aware of what to monitor them for as they might have bleeding. Reference: WAC 388-97-1020(2)(c)(d)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards for food service safety. Specifically, food was not covered, labeled, dated or discarded when expired for 2 of 3 refrigerators. The facility failed to perform hand hygiene when indicated during the meal service and did not maintain food at acceptable temperatures for service. These failures placed residents at risk for foodborne illnesses. Findings included . <Expired/undated/uncovered food>During an initial tour of the kitchen on 01/06/2026 at 10:33 AM, the main refrigerator in the kitchen contained nine bowls of cooked apples with cinnamon that were uncovered and had no date. An observation on 01/06/2026 at 10:48 AM of the refrigerator in the employee lounge that held the resident's food revealed a bowl of food for Resident 18 that was to be used by 12/20/2025, and another bowl without a date. There were also seven ice cream bars in the freezer for Resident 18 that had no date. Resident 35 had a bag of tamales that were dated 12/28/2025, and a pizza pocket with no date. In an interview on 01/06/2026 at 10:33 AM, Staff H, Dietary Manager, stated food that was in the refrigerator had to have a date and be covered for food safety. In an interview on 01/06/2026 at 10:48 AM, Staff H stated when food was brought in from family members it was taken to the kitchen, dated and placed in the refrigerator. Staff H stated it was important to date the food to prevent illness. <Food Temperatures>During an observation of the lunch meal service on 01/26/2026 at 10:36 AM, Staff Y, Cook, had checked the temperatures of the cold items. The milk was 48 degrees Fahrenheit (F), coleslaw 44.3 degrees F, and the peaches were 42 degrees F, all above the recommended food temperature of 41 degrees. Staff H instructed staff to discard the coleslaw, while they removed the milk from the resident trays. There were four glasses of milk left on the trays. At 11:44 AM, the cart with the milk was ready to be served to the residents. When Staff H was asked about the milk, they pulled the milk from the resident trays and stated it did not meet the required temperature. A plain piece of fish was prepared for a resident, and the temperature was 141 degrees F, not 145 degrees as required. At 12:00 PM, the fish was placed on the cart to be served to the resident. When Staff I, Cook, was asked about the fish, they stated the temperature needed to be 145 degrees. In an interview on 01/09/2026 at 1:40 PM, Staff H stated food needed to be served at the appropriate temperatures to prevent the growth of bacteria. <Hygiene>In an observation on 01/09/2026 at 12:08 PM, Staff I, with gloved hands, pushed the meal cart that other staff members had touched through the door to the dining room. Staff I put a piece of fish on a plate and touched it with the same gloved hands to prevent it from falling off the plate. Staff I then grabbed a hamburger bun with the same gloved hands and placed a slice of cheese on it. At 12:10 PM Staff I removed their gloves, no hand hygiene was performed, and they checked the temperature of a glass of milk. Staff I then put on a new pair of gloves without hand hygiene being performed. In an interview on 01/09/2026 at 1:36 PM, Staff I stated they should have removed their gloves after touching the meal cart, washed their hands and put on new gloves prior to touching the food and it was important to prevent cross contamination. Staff I added they should have also washed their hands and put on new gloves after checking the temperature of the milk, prior to going back to the meal service. In an interview on 01/09/2026 at 1:40 PM, Staff H stated hand hygiene needed to be performed after touching things and new gloves were to be worn to prevent cross contamination. Reference: WAC 388-97-1100 (3), 2980		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to obtain consent for psychotropic medications (medications that affect the mind, mood, and emotions) prior to administration of the first dose, as required, for 1 of 5 sampled residents (Resident 47), reviewed for unnecessary medications. This failure placed the resident and representative at risk of not being fully informed of the risks and benefits of medications and making a fully informed choice about their medical care. Findings included .A 12/18/2025 admission assessment documented Resident 47 had diagnoses including depression and anxiety. Resident 47 was cognitively intact and took medication for depression. The 12/12/2025 nutritional care plan documented Resident 47 had depression. There were no instructions to nursing staff regarding the antidepressant medication. On 12/12/2025, a provider order was given to administer mirtazapine (a medication used to treat depression) daily.A review of Resident 47's medical record showed no informed consent was completed for their mirtazapine. Per the December 2025 medication administration record, Resident 47 received their first dose of mirtazapine on 12/26/2025.In an interview on 01/09/2026 at 1:57 PM, Staff C, Registered Nurse, stated the consent for psychotropic medications needed to be obtained within three to five days of administering the medication. When asked why it was important to obtain consent prior to administering the medication, Staff C was unsure. In an interview on 01/09/2026 at 2:26 PM, Staff D, Registered Nurse, stated psychotropic medication consents needed to be obtained prior to the first dose. During an interview on 01/09/2026 at 3:10 PM, Staff B, Director of Nursing, stated the consent should have been signed prior to the administration of the medication and this was important because the resident needed to be informed of the risks and benefits so they could make an informed decision. Reference WAC 388-97-0300(3)(a), -0260, -1020(4)(a-b).		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Pre-admission Screening and Resident Review (PASRR, an assessment done to identify if potential nursing facility residents required services to support any behavioral health needs once admitted to the nursing facility) was completed after a 30-day hospital exempted stay expired for 2 of 5 sampled residents (Residents 6 and 34), reviewed. This failure placed the residents at risk for inappropriate placement, and/or not receiving timely and necessary services to meet their behavioral health needs. Findings included . The Medicaid.gov Preadmission Screening and Resident Review retrieved at https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/preadmission-screening documented the PASRR process required that all applicants to Medicaid-certified nursing facilities be given a preliminary assessment called a Level I screen prior to facility admission to determine whether they might have severe mental illness (SMI) or intellectual disability (ID). Those individuals who tested positive at Level I were then evaluated in depth, called a Level II PASRR. The results of this evaluation determined need for behavioral health services, appropriate setting, and recommendations for services to inform the individual's plan of care. <Resident 6> Review of the record showed Resident 6 was admitted to the facility on [DATE] and had diagnoses that included depression and post-traumatic stress disorder (PTSD, a mental health condition caused by experiencing an extremely stressful event that caused emotional distress or physical reactions). A PASRR Level I screen completed on [DATE] documented Resident 6 screened positive for severe mental illness; however, the Level II evaluation was not indicated at that time related to an exempted hospital discharge (when the resident was expected to reside at the facility for less than 30 days). The form documented the additional assessments were to be completed if the resident remained at the facility after the 30-day exemption expired. Further record review showed Resident 6 did not discharge from the facility after 30 days expired and still resided at the facility. Resident 6's record had no documentation that a Level II PASRR was completed after the 30-day hospital exemption expired. <Resident 34> Review of the record showed Resident 34 admitted to the facility on [DATE] and had diagnoses which included depression and anxiety. The [DATE] Level I PASRR screen for Resident 34 was positive for severe mental illness. The Level II PASRR was not indicated at that time due to meeting the guidelines for an exempted hospital stay. The form documented the additional assessments were to be completed if the resident remained at the facility after the 30-day exemption expired. Further record review showed Resident 34 did not discharge from the facility within 30 days or less as expected and was currently still a resident at the facility. Resident 34's medical record had no documentation that a Level II PASRR was completed after the 30-day hospital exemption expired. During an interview on [DATE] at 3:52 PM, Staff E, Social Service Director, stated they were (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible for the PASRR process at the facility. They acknowledged Residents 6 and 34 should have been referred for Level II PASRR evaluations after their exempted hospital stay was completed. Staff E stated the evaluations were important so recommendations for the residents' mental health needs could be implemented. Reference: WAC 388-97-1915(1)(2)(a-c)		

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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. Based on observation, interview, and record review, the facility failed to ensure oxygen and nebulizer delivery equipment was maintained as ordered and oxygen was administered per provider orders for 1 of 2 sampled residents (Resident 34), reviewed for respiratory care. These failures placed the residents at risk for respiratory complications and infection. Findings included .Per the 10/29/2025 admission assessment, Resident 34 had diagnoses which included chronic obstructive pulmonary disease (COPD, a progressive lung disease that blocked airflow and made it hard to breathe), and respiratory failure. In an observation on 01/06/2025 at 11:52 AM, Resident 34 was lying in bed asleep. The resident wore oxygen that was set at 4 liters (L) and the tubing was dated 12/17/2025. The 10/23/2025 physician order documented Resident 34 had been prescribed oxygen at 3L continuously for shortness of breath and the tubing was to be changed weekly. The December 2025 medication administrator record (MAR) and January 2026 MAR showed nursing staff initialed weekly that the oxygen tubing had been changed and Resident 34 received 3L of oxygen daily. Subsequent observations of Resident 34's oxygen tubing dated 12/17/2025 were made on 01/06/2025 at 1:41 PM. On 01/07/2026 at 8:54 AM the oxygen tubing was dated 01/06/2026. Subsequent observations on 01/09/2026 at 9:29 AM and 1:44 PM, and 01/10/2026 at 8:24 AM showed Resident 34 was on 4L of oxygen, not 3L as ordered. In an observation on 01/06/2026 at 1:41 PM, Resident 34 was lying in bed asleep. On their tray table was a small volume nebulizer (SVN, turns liquid medication into a fine, breathable mist for people with lung conditions such as COPD) and the tubing and equipment was dated 11/25/2025. The 10/23/2025 physician order instructed nursing to administer Ipratropium-Albuterol (DuoNeb, opens airways during times of difficult breathing) three milliliters via inhalation every six hours as needed for shortness of breath. The December 2025 and January 2026 MAR's showed Resident 34 received the Albuterol-Ipratropium via SVN on a consistent basis. Subsequent observations of Resident 34's SVN equipment dated 11/25/2025 were made on 01/07/2026 at 8:54 AM, 12:39 PM, and 2:45 PM, 01/08/2026 at 8:57 AM, 01/09/2026 at 9:29 AM and 1:44 PM, and 1/10/2026 at 8:24 AM. Review of Resident 34's medical record showed no documentation to clean or change the nebulizer equipment. In an interview on 01/09/2026 at 4:03 PM, Staff F, Registered Nurse, stated oxygen tubing was changed weekly, and they did not think there was a monitor for the SVN equipment. Staff F stated it was important to change the oxygen tubing and SVN equipment to prevent bacterial growth as it was a direct path into the lungs. In an interview on 01/10/2026 at 8:46 AM, Staff G, Licensed Practical Nurse, stated it was important to follow provider orders for oxygen because the residents could retain too much carbon dioxide. When Staff G was asked how many L's of oxygen Resident 34 was prescribed, they stated 3L. Staff G entered Resident 34's room and verified the resident was on 4L of oxygen and the SVN tubing was dated 11/25/2025. Staff G exited Resident 34's room without correcting the oxygen flow rate. In an interview on 01/10/2025 at 9:08 AM, Staff B, Director of Nursing, stated SVN equipment and oxygen tubing was changed weekly and documented on the MAR. Staff B stated it was important to change the SVN equipment and oxygen tubing to prevent bacteria. Staff B stated if the equipment and tubing were not changed it could possibly lead to a respiratory infection. Staff B stated Resident 34 should have received 3L of oxygen and it was important for their respiratory status and to follow the provider's orders. Staff B acknowledged there were no orders to maintain the SVN equipment. Reference: WAC 388-97-1060 (3)(j)(vi)		