

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/07/2024
NAME OF PROVIDER OR SUPPLIER Hudson Bay Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 8507 Northeast 8th Way Vancouver, WA 98664	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>50416</p> <p>Based on observation, interview and record review, the facility failed to develop and implement a person-centered care plan addressing limited mobility for 1 of 6 sampled residents (40) reviewed for comprehensive care plan related to mobility. This failure placed residents at risk for unmet care needs and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 40's comprehensive care plan, dated 05/20/2024, did not address a plan of care for contractures to the left arm.</p> <p>On 06/03/2024 at 11:47 AM, Resident 40 was observed with a contracted left arm that had decreased range of motion. When asked about the resident's ability to use his arm, Resident 40 said his contracture had gotten worse.</p> <p>On 06/05/2024 at 9:12 AM, Staff C, Licensed Practical Nurse, said there were no interventions in place to care for Resident 40's contracted left arm.</p> <p>On 06/06/24 at 10:36 AM, Staff B, Chief Nursing Officer and Registered Nurse, said there was nothing in the resident's care plan that reflected a plan to care for Resident 40's contractures.</p> <p>Reference WAC 388-97-1020 (1), (2)(a)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934</p> <p>Based on observation, interview and record review, the facility failed to ensure food preferences were honored for 1 of 3 sample residents (114) reviewed for food preferences. This failure placed residents at risk for not having their food preferences honored and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 114 was admitted to the facility on [DATE]. The admissions Minimum Data Set assessment, dated 05/24/2024, indicated Resident 114 was cognitively intact.</p> <p>The Diet History & Preferences, dated 06/03/2024, indicated Resident 114 had cereal dislikes: Cream of Wheat, Grits, Malt-O-Meal and Oatmeal.</p> <p>On 06/03/2024 at 12:12 PM, Resident 114 was observed receiving her lunch and stated, Gross.</p> <p>At 3:27 PM, Resident 114 said her lunch had vegetables on it that she did not like. Resident 114 said she had spoken with the dietician, the dietary manager, and had told the aids; but they kept giving her food she disliked.</p> <p>On 06/07/2024 at 9:18 AM, Staff F, Dietary Manager, said they tried to serve residents their preferences but if they did not get a menu from the nursing staff for that resident, they would serve the resident the main meal. Resident 114 was observed showing Staff F the hot cereal. Staff F said it was oatmeal. After reviewing the resident's preferences, Staff F said she would be sure this did not happen again.</p> <p>Reference WAC 388-97-1120 (3)(a)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>37934</p> <p>Based on observation and interview, the facility failed to maintain the cleanliness of the vent covers in 1 of 1 facility kitchen. This failure placed residents at risk to consume food not prepared in a sanitary manner and a diminished quality of life.</p> <p>kitchen vent covers reviewed for kitchen. These failures had the potential to affect all residents who consumed food and may cause a diminished quality of life.</p> <p>Findings included .</p> <p>On 06/06/2024 at 10:05 AM, the overhead vent covers (located over the food prep areas) were observed with lint trapped between the grilles. The stove hood filters appeared to be greasy and had some lint between the grilles.</p> <p>At 2:07 PM, when asked what was in the overhead vents above the food prep area, Staff F, Dietary Manager, said it looked like lint. After looking at the slats of the hood filters over the stove, Staff F said it looked like lint and the slats were not put in correctly. Staff F said maintenance was responsible for cleaning the overhead vent covers. Staff F said they contracted the cleaning for the hood filters, and they come out about every six months.</p> <p>Reference WAC 388-97-1100 (3)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>37934</p> <p>Based on observation and interview, the facility failed to ensure the floor was inspected where medication was found in 1 of 3 resident hallways (East) reviewed for safe environment. This failure placed residents at risk for an unsafe living environment and a diminished quality of life.</p> <p>Findings included .</p> <p>On 06/05/2024 at 1:51 PM, an unidentified resident was observed saying loudly, to an unidentified staff, there was a pill on the floor. The pill was picked up by the unidentified staff. Staff D, Registered Nurse, told the unidentified staff to hand her the pill and she would take care of it. Staff D looked at the pill and stated, It's Zoloft [an antidepressant].</p> <p>At 2:52 PM, a partial blue colored pill was observed on the floor by the nurse's station along the edge of the carpet and floor of the dayroom.</p> <p>At 2:54 PM, when asked what was on the floor, Staff E, Resident Care Manager and Licensed Practical Nurse, said it looked like a pill. Staff E said he could not tell what it was because it did not have a marker. Staff E said he would have expected staff to search the area and made sure no other pills were on the floor.</p> <p>At 3:01 PM, Staff B, Chief Nursing Officer and Registered Nurse, said if a pill was found on the floor, she would expect staff to look around the area to ensure nothing else was around there.</p> <p>Reference WAC 388-97-3220 (1)</p> <p>.</p>