| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505260 | A. Building<br>B. Wing | 04/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Hudson Bay Health and Rehabilitation | 8507 Northeast 8th Way<br>Vancouver, WA 98664 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47518<br><br>Based on observation, interview and record review, the facility failed to develop a comprehensive care plan for 1 of 4 sampled residents (Resident 38) reviewed for mood and behavior. This failure placed residents at risk for unmet care needs and a diminished quality of life.<br><br>Findings Included .<br><br>Resident 38 was admitted to the facility on [DATE] with diagnosis to include Post Traumatic Stress Disorder (PTSD, a mental health condition that can develop after someone experiences or witnesses a traumatic event). The Quarterly Minimum Data Set assessment, an assessment tool, dated 03/22/2025, documented Resident 38 was alert and oriented, had a diagnosis of PTSD, and was taking antipsychotic medication.<br><br>Review of Resident 38's Comprehensive Care Plan, on 04/24/2025, did not show a Focus, Goal, or Interventions/Tasks related to PTSD.<br><br>On 04/24/2025 at 10:38 AM, Staff F, Social Services Director, said if a resident had a diagnosis of PTSD, they should have a care plan in place. Staff F said she did not find a PTSD care plan and trauma informed care evaluation done for Resident 38 and there should have been.<br><br>At 10:52 AM, Staff B, Chief Nursing Officer and Registered Nurse, said she expected PTSD care plans were in place for residents with a diagnosis of PTSD. After looking at Resident 38's electronic health record, Staff B said she did not see a PTSD care plan and there should have been one.<br><br>Reference WAC 388-97-1020(1), (2)(a)(c) |



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

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934<br><br>Based on observation, interview and record review, the facility failed to document/monitor targeted behaviors for 1 of 5 residents (Resident 48) reviewed for behavior-emotions. This failure to monitor targeted behaviors placed residents at risk for unmet psychosocial needs and a decreased quality of life.<br><br>Findings included .<br><br>Resident 48 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set assessment, an assessment tool, dated 02/13/2025, indicated Resident 48 was moderately cognitively impaired.<br><br>Review of Resident 48's care plan, dated 05/20/2024, showed a focus area, Psychosocial/Mood/Behavior related to [Resident 48] has mood problem r/t schizophrenia, Depression, Visual Hallucinations, Auditory Hallucinations, Uncontrollable crying/tearfulness, Delusional thoughts, Agitation . 3. Behavioral supports Monitor for symptoms of anxiety, depression, or psychosis as evidenced by irritability, agitation, fidgeting, tearfulness, diminished sleep, worry and overall mood presentation. Document changes when observed and update care plans as needed.<br><br>On 04/21/2025 at 3:18 PM, Resident 48, while interviewing cried several times during the interview in the initial pool process, when talking about her living situation, a fall, and activities.<br><br>At 3:34 PM, Staff I, Licensed Practical Nurse, was alerted to Resident 48's crying episodes, upon completion of the interview.<br><br>On 04/23/2025 at 9:14 PM, review of Resident 48's progress notes showed no mention of the above crying episodes on 04/21/2025.<br><br>On 04/24/2025 at 9:28 AM, Staff I, when asked what she did with the information she was given regarding Resident 48's crying episodes, Staff I said she told Staff D, Resident Care Manager.<br><br>At 1:59 PM, Staff D, said Resident 48's crying episodes should have been documented even if the episode was witnessed by another person. Staff D said monitoring helped with deterring and providing interventions for Resident 48.<br><br>At 2:04 PM, Staff B, Chief Nursing Officer and Registered Nurse, said staff should document target behaviors by the end of their shifts. Staff B said documentation helped to track the behavior.<br><br>Reference WAC 388-97-1060 (1) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47518<br><br>Based on observation, interview, and record review, the facility failed to ensure medications were administered by professional standards of practice for 1 of 4 sample residents (Resident 38) reviewed for medication administration. This failure placed residents at risk for medication errors, negative outcomes, and a diminished quality of life.<br><br>Findings Included .<br><br>Review of the facility's policy entitled, Oral Medication Administration, dated 01/01/2018, documented, . Administration .6.e. Observe the resident ingest the medication.<br><br>Resident 38 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set assessment, an assessment tool, dated 03/22/2025, documented Resident 38 was alert and oriented.<br><br>On 04/23/2025 at 11:03 AM, Resident 38 was observed lying in bed with no staff present in the room. A white oval pill was observed on Resident 38's overbed table lying on a napkin. Resident 38 picked up the pill off the table and swallowed the pill with no nurse present in the room. When asked about the pill she just swallowed, Resident 38 said she took about 13 pills. Resident 38 said the nurse didn't stay with her while she took the pills because she had only 1 or 2 left. Staff G, Licensed Practical Nurse, entered the room and asked Resident 38 if she could take her blood sugar. When asked Staff G about the pill Resident 38 just took while unattended, Staff G stated, I'm sorry, I thought she was taking them when I walked away.<br><br>Review of Resident 38's electronic health record did not show a self-medication administration evaluation had been completed.<br><br>At 12:00 PM, Staff D, Resident Care Manager and Registered Nurse (RN), said medications are not supposed to be left at the bedside. Staff D said medications are supposed to be watched the entire time until they are swallowed. Staff D said Resident 38 did not have approval for self-administration of medications.<br><br>At 12:13 PM, Staff B, Chief Nursing Officer and RN, said it was her expectation nurses observed residents take all their medication and not leave any at the bedside.<br><br>Reference WAC 388-97-1300 (1)(b)(i), (3)(a) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>37934<br><br>Based on observation and interview, the facility failed to ensure food was served hot at a safe temperature. This failure to serve foods at proper temperatures placed resident at risk for decreased nutritional intake, food borne illness and a decreased quality of life.<br><br>Findings included .<br><br>The Center of Disease Control (CDC) indicated, Listeria infection (Listeriosis) are bacteria (germs) that can contaminate many foods including hot dogs. People who eat those foods can get infected with the bacteria . Listeria infection can be especially harmful for some people, including adults aged 65 or older, and people with weakened immune systems.<br><br>The United States Department of Agrigulture (USDA), Food Safety and Inspection Service indicated, hot food should be held at 140 degrees or warmer.<br><br>On 04/21/2025 at 11:43 AM, Resident 27 said her food was usually warm but not hot.<br><br>On 04/24/2025 at 11:40 AM, hot dogs were removed from the cooking process and placed on the service line. The temperature of the hot dogs measured 160+ degrees Fahrenheit. The hot dogs were covered with a cookie sheet pan.<br><br>At 12:37 PM, the remaining hot dogs', after the service line was completed, temperatures measured about 100 degrees Fahrenheit. Staff J, Culinary Manager, said the hot dogs were not warm enough.<br><br>Reference WAC 388-97-1100 (1), (2) |

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47518<br><br>Based on observation, interview and record review, the facility failed to ensure bed rails were securely fastened to the bed for 1 of 2 sampled residents (Resident 49) reviewed for accident hazards. This failure placed residents at risk for injury and/or entrapment.<br><br>Findings included .<br><br>Review of the facility's policy entitled, Restraints, revised 03/01/2024, documented, .Bedrails/Side Rails . 3. If the bedrail/side rail is used, the facility ensures correct installation, use, and maintenance of the rail(s) .<br><br>Resident 49 was admitted to the facility on [DATE]. The Admission/Medicare - 5 day Minimum Data Set assessment, an assessment tool, dated 04/05/2025, documented Resident 49 was alert and oriented.<br><br>On 04/21/2025 at 2:46 PM, Resident 49's bed was observed with a quarter length bed rail on the left side of the upper bed. The bed rail was observed to be loose with about four to five inches of movement up and down and five to six inches of movement back and forth. Resident 49 said her bed rail was loose. Resident 49 said she told the staff three or four times, but they have not fixed it. Resident 49 said a CNA (Certified Nursing Assistant) told her they put in a request on the computer for maintenance to fix it, but they still had not.<br><br>On 04/23/2025 at 12:05 PM, Resident 49's bed was observed with a quarter length bed rail on the left side of the upper bed. The bed rail was observed to be leaning out from the bed and loose, with about four to five inches of movement up and down and five to six inches of movement back and forth. The bracket attaching the bed rail to the frame of the bed was observed to be loose, wiggling about one inch around the bolt attached to the bed frame.<br><br>At 3:10 PM, Resident 49 was observed lying in bed with the left side bed rail loose. Resident 49 said her bed rail was still loose and she has told staff three to four times, but it had not been fixed.<br><br>At 3:16 PM, Staff H, CNA, said if there was equipment like bed rails, hoyer lifts, or anything that was broken or needed to be fixed, they would report it through TELS (an electronic work order system) and verbally tell maintenance.<br><br>At 3:20 PM, Staff B, Chief Nursing Officer and Registered Nurse, said bed rails were installed by maintenance. Staff B said if a bed rail needed to be fixed or repaired, the staff would use TELS to report it to maintenance. Staff B went to Resident 49's room to look at the bed rail. Staff B said the bed rail was looser than it should have been and needed to be tightened.<br><br>On 04/24/2025 at 11:05 AM, Staff B said a TELS work order was put in by a CNA on 04/15/2025 for the loose bed rail, but it had not been fixed yet. Staff B said she expected anything safety related, such as bed rails, were addressed right away and indicated it should have been fixed sooner.<br><br>(continued on next page) |

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reference WAC 388-97-2100 (1) |