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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505265	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Care	209 North Ahtanum Avenue Wapato, WA 98951

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on observation, interview and record review, the facility failed to ensure that residents who had an indwelling urinary catheter (IUC, a tube placed in the bladder which drains urine out into a collection bag) received care and services to prevent urinary tract infections (UTI, a condition were bacteria enter through the urinary meatus [a passage or opening leading to the interior of the body] and infect the kidneys or bladder) for 1 of 3 residents (Resident 7), reviewed for urinary catheter care. This failure placed the residents at risk of developing medical complications, secondary to an infection in the bladder. Findings included . Review of the facility's policy titled, Indwelling catheter Insertion and Care, dated January 2025 showed that it was the policy of the facility to .provide for the use of indwelling catheters per physician orders . Review of the facility's policy titled, Catheter Management, revised 08/13/2019, showed IUC were .only changed as necessary (i.e., when it becomes occluded, contaminated, or the integrity of the catheter or the system is compromised). <Resident 7> Review of the resident's medical record showed that they were admitted on [DATE] with a recent readmission from the hospital on 11/20/2024 for diagnoses including UTI and dementia (a progressive disease that destroys the memory and other important mental functions). Review of the 11/21/2024 comprehensive assessment showed the resident had a severely impaired cognition and had a IUC for bladder elimination. Review of Resident 7's hospital records, dated 11/19/2024 showed the resident admitted due to septic shock (a life-threatening medical condition that occurs in the body when faced with a widespread infection that can lead to organ failure and extremely low blood pressure) after/resulting from a complicated UTI. The record showed a physician order to .continue foley (another name for an IUC) on discharge for suspected neurogenic bladder (a urinary bladder problem due to disease or injury to the body nervous system that controls when/how the bladder empties); change every four weeks, placed 11/10/2024, and to follow-up with a urologist (a specialist physician for urinary tract issues). (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 7's facility provider note, dated 11/25/2024 showed orders to changed r/c (retention catheter or IUC) and obtain urine, send for urinalysis (a laboratory test that examines the urine), culture and sensitivity (identification of the germs causing the infection and what antibiotic would be best to treat the infection identified) Review of Resident 7's November 2024 facility provider orders showed that on 11/25/2024 orders to changed IUC and obtain urinalysis (a laboratory test that examines the urine), one time, was completed for the resident. No other orders on the type/size of the IUC, frequency for changing the IUC/drainage collection bag nor if nursing staff were monitoring signs/symptoms (indications of illness, injury or condition) of complications/infection regarding Resident 7's IUC. Review of Resident 7's facility provider note, dated 12/05/2024 showed orders for nursing staff to follow the plan of care per urology. Review of Resident 7's urologist provider visit, dated 12/06/2024 showed the resident a neurogenic bladder with urinary retention (a condition where the body is unable to empty the bladder), recommended a long term IUC. Additionally, the urologist ordered, please change foley catheter every four weeks. (Resident 7) is due for change now. Review of Resident 7's December 2024 provider orders showed the orders for the resident IUC to be changed every four weeks and to have the IUC changed after the urologist appointment were not put in nor completed for the resident. During a concurrent observation and interview on 01/28/2025 at 11:29 AM, Resident 7 was lying in bed, with their half full catheter bag resting on the floor, below the resident bed, pulling downwards, putting tension at the clear/plastic drainage tube to rubber catheter tube junction point. The resident IUC junction point did not have a seal (a plastic wrapping around the junction point where the two-tubing meet and an indicator of an intact, closed, non-compromised drainage system) in place and the tension on the junction was pulling the tubing apart. Resident 7 stated the IUC had been changed before a while ago, can't really remember, maybe at the hospital. Review of Resident 7's provider orders, dated 01/29/2025 showed that orders for the residents IUC were placed. The orders showed change IUC as needed for blockage and other signs/symptoms, change IUC drainage bag every two weeks and as needed, change as necessary for blockages or to obtain a urinalysis and irrigate (flushing fluid through the IUC to prevent a blockage) the IUC for obstruction prior to replacing (these orders were placed 70 days after the resident's readmission with a IUC in place and 54 days after their urology visit). During an interview on 01/31/2025 at 3:14 PM, Staff S, Treatment Nurse, stated the process for IUC orders was to have them placed in a resident's chart after a IUC was inserted or if a resident had one place in the hospital. The orders included IUC change frequency, drainage bag change frequency and/or irrigation of the IUC if it was needed. Staff S stated they did not see orders for Resident 7's IUC until they were notified of the needed for IUC orders, which they had placed on 01/29/2025. Staff S stated the resident's IUC was changed on 01/30/2025. Additionally, Staff S stated that the correct process was not followed regarding Resident 7' IUC care/management and put the resident at an increased risk for further UTI's. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/31/2025 at 3:51 PM, Staff T, Licensed Practical Nurse, stated that Resident 7's orders for their IUC should have been placed in the resident chart back in November 2024. Staff T stated the resident IUC was not changed due to no orders to replace the resident's IUC and the correct process was not followed. During an interview on 02/03/2025 at 11:06 AM, Staff H, Registered Nurse/Resident care Manager, stated that orders for IUC were placed by either Staff H or Staff S and must have slipped through both of our hands. Staff H stated the IUC orders were normally put on the resident orders to help with care maintenance and prevent further IUC infections for the residents. During an interview on 02/03/2025 at 1:49 PM, Staff C, Assistant Director of Nursing Services/Infection Preventionist, stated the correct process was not followed regarding Resident 7's physician orders the day the resident returned from the hospital. Reference: WAC 388-97-1060 (3)(c)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 30528 Based on observation, interview and record review the facility failed to secure all medication in 1of 1 locked medication room and to limit access to authorized personal consistent with professional practice. This failure allowed one unauthorized staff member (Staff E) to access medication in the medication storage room and increasing the risk for diversion of controlled (narcotic) medication. Findings included Record review of the facility's policy titled, Storage of Medications, dated, 07/2021showed that the medication was accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Medication rooms were locked when not attended by persons with authorized access. During a concurrent observation and interview on 01/29/2025 at 1:20 PM, Staff H, Registered Nurse/Resident Care Manager (RN/RCM), used their key to open the medication room. Staff H stated that only nursing staff had keys to the medication room and there were no controlled medications stored in the room. On 01/29/2025 at 1:30 PM, during medication storage observation with Staff H, Staff E, Maintenance Director, used a key to open the locked door to the medication room to let the State Fire Marshal into the medication room. During an interview on 01/29/2025 at 2:29 PM, Staff I, Licensed Practical Nurse, stated nurses had keys to the medication room. If housekeeping needed in the medication room to clean, a nurse would let them in and stayed while thousekeeping cleaned. Staff I stated maybe Staff E had a key in case of emergencies; however, was not sure. During an interview on 01/29/2025 at 3:12 PM, Staff E stated they had a key to the medication storage room and got it from the previous Maintenance Director. Staff E stated they were not aware they should not have a key and had used it monthly to check the air conditioner unit. During an interview on 01/29/2025 at 3:20 PM, Staff A, Administrator, stated they were not aware Staff E had a key to the medication storage room, and they should not have key access to that room. Reference: WAC 388-97-2340(4)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 45642 Based on observation, interview, and record review, the facility failed to ensure expired foods were discarded for 1 of 1 dry storage area and failed to consistently monitor refrigerator temperatures for 2 of 3 refrigerators (the kitchen snack refrigerator and a small black refrigerator), reviewed for food safety. These failures placed residents at an increased risk for food-borne illnesses. Findings include . Review of the undated policy titled, Receiving, Inventory and Storage, Food Storage showed food items should be received and handled in accordance with good sanitary practice. The dry foods would be rotated, labeled, dated, and discarded on the expiration date. The facility ' s policy further showed a temperature record was to be kept of all refrigerated items. <Expired Foods> During an observation on [DATE] at 8:16 AM, the initial kitchen tour with Staff K, Cook, showed the dry storage area contained the following expired foods: one box of spinach wraps; expiration date of [DATE]. two boxes of white corn tortillas; expiration date of [DATE]. seven packs of flour tortillas; expiration date of [DATE]. During an interview on [DATE] at 8:10 AM, Staff K, confirmed that the flour tortillas were served during the lunch meal on [DATE]. Staff K stated they mistakenly assumed that the tortillas were fresh. Staff K stated that the Dietary Manager disposed of them on [DATE]. <Refrigerator Temperatures> During an observation on [DATE] at 8:26 AM, the kitchen snack refrigerator did not have a temperature log of recorded temperatures. Staff K stated, We don't have a temperature log for that refrigerator right now. Staff K stated that the refrigerator held salads, snacks, juices, and milk for the residents. During an observation on [DATE] at 8:32 AM, a small black refrigerator contained more than 10 Mighty Health Shakes (a nutritional shake that can add protein and calories to a diet). The temperature log had one temperature recorded for [DATE] on [DATE] at 3:00 PM. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 8:54 AM, Staff L, Dietary Manager, stated upon a food delivery, it was the responsibility of the staff to organize the items. The process included moving the older food items to the front and placing the new items at the back to ensure proper food rotation. Staff L emphasized the importance of staff checking the expiration dates prior to usage. Staff L stated that the small black refrigerator, which had previously been designated for the nurses ' medication cart, was currently not in use. Additionally, Staff L acknowledged the temperature log had not been completed for the month of [DATE]. During an interview on [DATE] at 10:54 AM, Staff A, Administrator, stated there was an expectation for the dietary staff to rotate food items and ensure that any expired food was properly discarded. Staff A stated they were aware of the temperatures not being documented on the refrigerator temperature logs and indicated that the small black refrigerator would be removed. Reference: WAC [DATE] (3)

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on interview and record review, the facility failed to ensure the Director of Nursing Services (DNS) had an active nursing license while providing care to residents in the facility for 1 of 6 staff (Staff R) reviewed for staff qualifications. This failure placed residents at risk of receiving care from an unlicensed staff health professional and unmet care needs. Findings included . Review of the facility's undated document titled, Director of Nursing Job Description, dated 2023, showed that Staff B, DNS, had acknowledged/signed on as the responsible DNS of the facility. The document showed the required qualifications of the DNS was to have a current unrestricted license as a Registered Nurse (RN) . and to abide by all standards, polices, regulations and guidelines of the facility and the state and federal governing agencies .at all times. <Staff R> Review of Staff R's personnel records showed their professional RN license was no longer active and had expired on [DATE]. Review of Staff R's DNS schedule of days worked in the facility for [DATE] and [DATE] showed, that Staff R had worked a total of 17 days after their RN licensure had expired. During an interview on [DATE] at 3:34 PM, Staff A, Administrator, stated that Staff R had informed them that the staff members professional RN license was renewed prior to the expiration date but had then found out on [DATE] that it was expired. Staff A stated that Staff R should not have worked those 17 days after the staff members nursing license had expired and would not be working until a renewal of the professional RN license. Reference: WAC [DATE](10)(b)

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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** 30528 Based on observation, interview and record review the facility failed to provide correct implementation of infection control practices for indwelling urinary catheter (a hollow, partially flexible tube that collects urine from the bladder and leads to a drainage bag) equipment for 2 of 4 residents (Resident 29 and Resident 52) reviewed for use of urinary catheters. This failure placed residents with catheter bags at risk for infections and a diminished quality of life. Finding included Review of recommendations from the Centers of Disease Control, Guideline for Prevention of Catheter-Associated Urinary Tract Infections (2009), located at www.cdc.gov, showed a strong recommendation to maintain unobstructive urine flow and to not rest the catheter bag (a urine collection bag attached to the catheter) on the floor. Review of the Lippincott Manual of Nursing Practice 10th Ed. ([NAME], 2014) showed infectious organisms could move into the bladder along the outside of any urinary catheter, and the catheter bag should be kept off the floor (and other unclean surfaces), to prevent bacteria from entering the bladder (pg. 781-782). Record review of a facility policy titled Catheter Management dated 08/13/2019, showed that the retention catheter bag should never touch the floor. <Resident 29> Review of Resident 29's medical recorded showed they were a long-term resident with diagnoses to include diabetes mellites (damaged cells don't respond normally to insulin which cause high levels of glucose), dementia (a loss of mental ability severe enough to interfere with normal activities of daily living), and obstructive uropathy (a condition where urine cannot flow normally through the urinary tract). The 12/18/2024 comprehensive assessment showed Resident 29 was cognitively impaired, had an indwelling urinary catheter and required a wheelchair for mobility. Record review of the resident's catheter care plan dated 01/08/2025 showed staff should keep the urinary catheter bag below the resident's bladder, cover for privacy and not to allow the bag to touch the floor. The resident had a history of urinary tract infections (UTI, infection of any part of the urinary system) with the last one dated 04/21/2024. During an observation on 01/30/2025 at 9:26 AM, Resident 29 was seated in their wheelchair and their urinary catheter bag and tubing was dragging on the floor as the resident was wheeled by Staff P, Nursing Assistant, from the room sink to their bed. During an observation on 01/30/2025 at 1:17 PM, Resident 29 was lying in bed with their eyes closed. Their catheter bag was attached to the left side of the bed frame with the bottom on the bag touching the floor. (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 01/31/2025 at 8:37 AM, Resident 29 was seated in their wheelchair across from the nurse's station with their urinary catheter bag and tubing hanging under the wheelchair seat and touching the floor. During a concurrent observation and interview on 02/03/2025 at 12:15 PM, Staff Q, Registered Nurse, pushed Resident 29 in their wheelchair from the front lobby back to their room. The resident's catheter bag and tubing was dragging on the floor under the wheelchair. When brought to Staff Q's attention, they stated the bag and tubing should not be touching the floor, the tubing could get caught and it was an infection risk. <Resident 52> Review of Resident 52's medical recorded showed they were a long-term resident with diagnoses to include diabetes mellites, heart failure (a progressive heart disease that affects pumping action of the heart muscles) and obstructive uropathy. Record review of the 12/16/2024 comprehensive assessment showed Resident 52 was cognitively intact, had an indwelling urinary catheter and required a wheelchair for mobility. Review of the 01/10/2025 catheter care plan showed staff should monitor and report signs of a UTI such as foul-smelling urine, fever, and altered mental status. Review of Resident 52's physician orders showed they were treated for UTIs with antibiotics on 08/31/2024, 10/14/2024 and 11/14/2024. During an observation on 01/31/2025 at 7:30 AM, Resident 52 was seated in their wheelchair across from the nurse's station with their catheter bag touching the floor under their wheelchair and they were holding the catheter tubing in their right hand. During an observation on 02/03/2025 at 12:18 PM, Resident 52 was observed seated in their wheelchair across from the nurse's station with their catheter bag touching the floor under their wheelchair. During a concurrent observation and interview on 02/04/2025 at 11:05 AM, Resident 52 was seated in their wheelchair across from the nurse's station with their catheter bag touching the floor under their wheelchair and they were holding the catheter tubing in their hand. Resident 52 stated they held the tubing, so it did not pull or drag on the floor. During an interview on 02/04/2025 at 12:16 PM, Staff C, Licensed Practical Nurse and Infection Preventionist, stated that residents' catheter bags and tubing should not be touching or dragging on the floor. Reference: WAC 388-97-1320(1)(a), (2)(a)