STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505269	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vancouver Specialty and Rehab Care	1015 North Garrison Road Vancouver, WA 98664

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51254 Based on interviews and record review, the facility failed to ensure the resident was informed about the risk and benefits and could provide an informed consent prior to administration of psychotropic medications for 1 of 5 sampled residents (332) reviewed for informed consent of psychotropic medications. This failure placed residents as risk for not being informed prior to receiving psychotropic medication and a decreased quality of life. Findings included . Resident 332 was admitted to the facility on [DATE]. The 5-day Minimum Data Set assessment, dated 12/31/2024, documented Resident 332 was alert and oriented and had no signs and symptoms of depression. Resident 332's electronic health record (EHR) showed the resident started on Trazadone for depression on 01/03/2025. The EHR did not show an informed consent including the risks and benefits was completed for the Trazadone. On 01/08/2025 at 9:09 AM, Staff D, Licensed Practical Nurse, said usually the Resident Care Managers obtain the medication consents for psychotropic medications. Staff D said psychotropic consents should be done prior to starting psychotropic medications. At 9:44 AM, Staff E, Assistant Director of Nursing Services and Registered Nurse, said Resident 332 was on Trazadone for insomnia. When asked about obtaining a consent for psychotropic medications, Staff E said usually the nurse managers obtained consents from residents or the decision makers. When asked about the resident's informed consent for Trazadone, Staff E was unable to find documentation of an informed consent for the Trazadone for Resident 332. Reference WAC 388-97-0300 (3)(a), -0260, -1020 (4)(a)(b)

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934 Based on interview and record review, the facility failed to ensure residents and/or their representatives were offered the opportunity to participate in care conferences for 1 of 3 sampled residents (13) reviewed for right to participate in planning care. This failure placed residents at risk of not being involved in decisions about their long-term care needs and a diminished quality of life. Findings included . Resident 13 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set assessment, dated 11/28/2024, showed the resident was moderately cognitively impaired. The electronic health records (EHR) showed a care conference was conducted on 04/16/2024. The EHR showed the next care conference was conducted on 12/04/2024, almost eight months after the 04/16/2024 care conference. On 01/08/2025 at 1:39 PM, Staff I, Social Services, said care conferences for long-term residents were done quarterly or as needed. Staff I said Resident 13 had a care conference on 12/04/2024. When asked if there was a care conference prior to the 12/04/2024 care conference, Staff I said Resident 13 had a care conference on 04/16/2024. At 3:32 PM, Staff A, Administrator, said care conferences should be completed quarterly. Reference WAC 388-97-1020 (2)(e)(f)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934 Based on interview and record review, the facility failed to provide and/or have procedures in place to assist with completing advance directives (AD), and obtaining and maintaining Power of Attorney documentation for 1 of 12 sampled residents (13) reviewed for ADs. This failure place residents at risk for losing their right to have their healthcare preferences and/or decisions honored. Findings included . Resident 13 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set assessment, dated 11/28/2024, showed the resident was moderately cognitively impaired. Resident 13's electronic medical record did not have an ADs or documentation that ADs were reviewed since March 2024. On 01/08/2025 at 1:39 PM, Staff I, Social Services, said ADs were reviewed every quarter during the care conference with long term care residents. Staff I said if the resident did not have an AD, they reviewed the AD with the resident and helped the resident complete one if needed. Staff I said Resident 13 was her own decision maker. Staff I said Resident 13 had a POLST (Physician Orders for Life-Sustaining Treatment), but no AD, Power of Attorney or guardian. At 3:32 PM, Staff A, Administrator, said ADs should be reviewed with residents upon admissions and quarterly if the resident did not have one in place. Refer to F-553 Reference WAC 388-97-0280(3)(c)(i)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51254 Based on interviews and record review, the facility failed to ensure preparations were made for a safe orderly discharge for 1 of 2 sampled residents (186) reviewed for discharge planning. This failure placed residents at risk for an unsafe discharge into the community and a diminished quality of life. Findings included . Resident 186 was admitted to the facility on [DATE] with diagnoses including diabetes [chronic disease that occurs when the body cannot produce or use insulin properly resulting in high blood sugar levels]. The Quarterly Minimum Data Set assessment, dated 09/26/2024, indicated Resident 186 had moderate cognitive impairment. Discharge care conference, dated 10/25/2024, indicated Resident 186 would be discharging home with spouse (also a resident at the facility). The care conference documentation did not show diabetic monitoring or management was discussed during the meeting. The electronic health record showed Resident 186 discharged home on 11/16/2024. On 01/08/2025 at 9:09 AM, Staff I, Social Services Director, said Resident 186 would have been given a glucometer from the facility to use after discharge. Staff I was unable to provide documentation showing Resident 186 had received a glucometer or had been trained on its use. Staff I said nursing staff would be the ones to document resident training on use of equipment for diabetes monitoring. Staff I said she would look for any documentation to see if teaching and training was completed. Staff I was unable to provide additional documentation of glucometer training. At 9:44 AM, Staff E, Assistant Director of Nursing Services and Registered Nurse (RN), said Resident 186 should have been given a glucometer and should have been shown how to use the glucometer prior to discharge. Staff E was unable to provide documentation of the issuance of a glucometer or training on its use. At 9:50 AM, Staff B, Director of Nursing Services and RN, said she would expect the resident would have been trained on glucometer use, and there should be documentation in the electronic health record. Staff B was unable to provide documentation of the issuance of a glucometer or training on its use. Reference WAC 388-97-0120 (3)(a)

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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** 51254 Based on interviews and and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR) was completed for 1 of 6 sampled residents (76) reviewed for Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. This failure placed residents at risk for unidentified mental health needs, unmet mental health needs and a diminished quality of life. Findings included . Per facility policy, entitled Resident Assessment Coordination with PASARR Program, revised 09/30/2024, documented, This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs . The facility will only admit individuals with a mental disorder or intellectual disability who the State mental health or intellectual disability authority has determined as appropriate for admission. Resident 76 was admitted to the facility on [DATE] with diagnoses including anxiety and depression. The 5-day Minimum Data Set assessment, dated 12/22/2024, indicated Resident 76 was alert and oriented. The Level I PASARR (initial screening) was completed by the discharging hospital on 12/21/2024, and showed the resident did not require a Level II evaluation (in-depth evaluation by the state designated authority to determine the need for specialized services for the resident). The medical records showed Resident 76 had a history of anxiety and depression prior to admitting to the facility on [DATE]. On 01/06/2025 at 11:30 AM, Resident 76 was observed to be tearful and extremely anxious when the resident attempted to physically grab the surveyor's arm and requested anxiety medication from the facility staff. Resident 76 said staff had found a bag of knives that he was giving to female staff for personal protection, and now he was fearful of retaliation by staff. On 01/08/2025 at 9:20 AM, Staff H, Social Services Director, said the PASARR was generally reviewed for accuracy, after the resident was admitted . Staff H said if the PASARR was found to be inaccurate, the assessment would be completed immediately that day and sent in for PASARR Level II evaluation. Staff H said the PASARR was not found to be inaccurate until 01/07/2025. Staff H said she was unable to determine why Resident 76's PASARR was not corrected upon admission. At 2:17 PM, Staff A, Administrator, said the facility followed their policy for PASARR reviews. Staff A was unable to provide documentation to support the admission PASARR Level I had been reviewed by facility for accuracy. Reference WAC 388-97-1975

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51254 Based on interview and record review, the facility failed to consistently assess and implement interventions for bowel management for 3 of 4 sampled residents (76, 332 & 72) reviewed for quality of care related to constipation. This failure placed residents at risk of increased discomfort and negative health outcomes. Findings included . Review of facility policy, entitled, House Bowel P&P [Policy and Procedures], revised 10/23/2023, documented: 1. Day shift nurse run bowel report upon start of shift. 2. Day shift nurse to start bowel protocol in AM with morning med pass, document in EMAR [electronic Medication Administration Record (MAR)], place on alert charting to monitor BT/BM [bowel movement]. 3. Day shift nurse to follow up after 6 hours for effectiveness, if no results complete a bowel assessment and document in progress notes, then proceed to step 2 of house protocol prior to end of shift. 4. Day shift nurses to give report to NOC [night] shift nurses on who needs an Enema. 5. Noc shift nurses to run bowel report upon start of shift, initiate step 3 of bowel protocol at the end of the shift, document on bowel monitor, EMAR, and progress note, then pass off to Day shift via verbal report and Day shift to follow up if no BM with MD [Medical Director]. 6. All Nurses must chart on PRN [as needed] MAR that meds were given and chart the results, must make nursing progress note R/T [related to] ABD [abdomen] assessments . 7. If resident refuses bowel protocol, notify MD, place on alert charting, complete bowel assessment and document. 1) Resident 76 was admitted to the facility on [DATE]. The Admission Minimum Data Set (MDS) assessment, dated 12/04/2024, documented Resident 76 was alert and oriented. Review of Resident 76's electronic medical records (EHR) indicated Resident 76 had no documented BMs for 7 days, from 12/30/2024 day shift until 01/06/2025 on the night shift. On 01/06/2025 at 11:30 AM, Resident 76 said he had been constipated for several days making his appetite poor. Resident 76 said he had reported these concerns to staff. 2) Resident 332 was admitted to the facility on [DATE]. The 5-Day MDS assessment, dated 12/31/2024, documented Resident 322 was alert and oriented. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 332's EHR indicated no documented BMs for 12 shifts with no initiation of bowel protocol from 12/28/2024 until 01/01/2025 on the evening shift. On 01/06/2025 at 11:30 AM, Resident 332 said he was not eating well due to constipation. Resident 332 said he did not want to keep putting things in from the top when he was not moving on the bottom. 46751 3) Resident 72 was admitted to the facility on [DATE]. The Admission MDS assessment, dated 12/04/2024, documented Resident 72 was alert and oriented. On 01/07/2025 at 8:25 AM, Resident 72 said he was frequently constipated and in discomfort as a result of insufficient bowel management. Resident 72 stated, The morphine makes me constipated. What they give me every day doesn't help. The December 2024 Bowel and Bladder Elimination task sheet documented Resident 72 had a BM on 12/12/2024 at 4:24 AM and did not have another BM until 12/16/2024 at 1:59 PM, over 105 hours between BMs (over four days and 9 hours). Review of Resident 72's EHR indicated no documented BMs for over 105 hours (as indicated above) with no initiation of bowel protocol from 12/12/2024 to 12/16/2024. Review of Resident 72's EHR indicated no documented BMs for over 77 hours (over three days and five hours) no initiation of bowel protocol from 12/16/2024 to 12/19/2024. Review of Resident 72's EHR indicated no documented BMs for over 86 hours (over three days and 14 hours) with no initiation of bowel protocol from 12/28/2024 to 01/01/2025. On 01/08/2025 at 9:09 AM, Staff D, Licensed Practical Nurse, said if a resident did not have a BM by Day 3, senna (bowel stimulant) would be given. If no results, a Bisacodyl suppository; if still no results, an enema would be given to promote a BM. A bowel assessment would also be completed, and if no results the Provider would be notified. All refusal would be documented on the MAR or in a progress note. At 9:44 AM, after reviewing Resident 72's records to determine if the bowel protocol was initiated and followed, Staff E, Assistant Director of Nursing Services and Registered Nurse (RN), said the resident was given Senna on 01/03/2025, 01/06/2025, and 01/07/2025, with no progression to Step 2 of the bowel protocol. Staff E was unable to provide documentation of BMs or medication refusals. At 10:00 AM, Staff B, Director of Nursing Services and RN, said the bowel program should be initiated on Shift 9 at the start of the shift, and if no bowel movement by end of day shift, a suppository should be given. An Enema would be following the end of the night shift following the day when the bowel protocol was initiated. Staff B said she would expect a MD notification if no bowel movements were recorded. On 01/09/2025 at 9:16 AM, Staff D was unable to provide documentation of the BM protocol being initiated for Resident 72. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 1:33 PM, Staff A, Administrator, said she would expect the BM protocol to be started and documented as outlined in the policy. Staff A was unable to provide additional documentation showing Resident 72 received bowel protocol interventions. Reference WAC 388-97-1060 (1)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 37934 Based on interview and record review, the facility failed to provide at least eight hours of Registered Nurse (RN) coverage and supervision for 3 of 30 days reviewed. This failure placed residents at risk for not receiving needed care and supervision. Findings included . The facility's daily nurse staff postings and the Staffing Coordinator's working schedule for the 30 days prior to entry into the facility (12/06/2024 to 01/05/2025) showed the facility did not have 24 hours of RN coverage on all reviewed days. On 01/09/2024 at 1:19 PM, Staff A, Administrator, said they did not have a waiver for RN coverage. Staff A said they were recruiting for RNs and offering bonuses. Staff A said they offered incentives for staff retention. Reference WAC 388-97-1080 (3)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 37934 Based on interview and record review, the facility failed to complete performance evaluation reviews for 1 of 2 sampled nursing assistants (Staff J) reviewed for nurse aide performance reviews. This failure placed residents at risk for receiving care from unskilled staff and a diminished quality of life. Finding included . Staff J, NA, was hired on 05/11/2021. Staff J's personnel records did not have a Performance Evaluation for the previous year. On 01/09/2025 at 1:19 PM, Staff B, Director of Nursing Services and Registered Nurse, said performance evaluations were done annually or when they saw a need for additional trainings. Reference WAC 388-97-1680 (2)(b)(I)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46751 Based on interview and record review, the facility failed to monitor residents on psychotropic medications for target behaviors and interventions for 2 of 5 sampled residents (36 & 332) reviewed for unnecessary psychotropic medications. This failure placed residents as risk for decreased mental health well-being and a decreased quality of life. Findings included . 1) Resident 36 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS) assessment, dated 12/02/2024, indicated the resident was alert and oriented and with no symptoms of depression. Review of Resident 36's Electronic Health Records (EHR), did not show behavior monitoring for symptoms and/or signs of depression. On 01/08/2025 at 9:09 AM, Staff D, Licensed Practical Nurse, said each shift was to record behaviors in the EHR. Staff D said if a behavior was new, then they would document that behavior and monitor the resident on alert status. The nurse documented when behaviors were present, and interventions were used. At 9:44 AM, Staff E, Assistant Director of Nursing Services and Registered Nurse (RN), said the target behaviors for the medications were recorded in the electronic Medication Administration Record (EMAR). When asked to locate where they were recording target behaviors and interventions for Resident 36, Staff E was unable to locate them. Staff E said they usually do have them on the EMAR for purposes of monitoring. 2) Resident 332 was admitted to the facility on [DATE]. The 5-day MDS assessment, dated 12/31/2024, documented Resident 332 was alert and oriented and had no signs and symptoms of depression. Resident 332's EHR showed the resident started on Trazadone for depression on 01/03/2025. The EHR did not show monitoring of target behaviors and/or interventions were completed for use of the psychotropic medication. On 01/08/2025 at 9:09 AM, Staff D, Licensed Practical Nurse, said Resident 332 was on Trazadone for insomnia. At 9:44 AM, Staff E, Assistant Director of Nursing Services and Registered Nurse, said Resident 332 was on Trazadone for insomnia. When asked about behavior monitoring for Trazadone, the January 2025 Medication Administration Record was reviewed and showed no monitoring for the psychotropic use of Trazadone for insomnia. Reference WAC 388-97-0620 (1)(a)