STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505276	A. Building B. Wing	04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Frontier Rehab & Extended Care	1500 3rd Avenue Longview, WA 98632

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36368 Based on interview and record review, the facility failed to ensure adequate care planned supervision was provided, for an out of the facility appointment, to prevent accidents for 1 of 3 sampled residents (Resident 1) reviewed for accident hazards and supervision to prevent accidents. Resident 1; who was assessed with moderate cognitive impairment, poor safety awareness and required maximum assistance with transfer and mobility; experienced harm when left unattended at an out of the facility medical appointment and fell while attempting a toilet transfer/stand from a seated position in the bathroom, required transfer to the hospital and experienced a pelvic bone fracture. This failure placed residents at risk for falls with injury, pain and a diminished quality of life. Findings included . Resident 1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease (a progressive brain disorder affecting memory, thinking and behavioral skills), Osteoarthritis (a degenerative joint disease where cartilage breaks down over time causing pain, stiffness and reduced mobility), and presence of bilateral artificial hips. Resident 1's Minimum Data Set (MDS) assessment, dated 12/03/2024, documented the resident had moderate cognitive impairment and required assistance with activities of daily living including transfers and mobility. Resident 1's care plan, dated 03/24/2024, documented Resident 1 was a high risk for falls related to a history of falls with right hip fracture, left humeral fracture, confusion, de-conditioning, weakness, gait/balance problems, incontinence, pain, medications, cognitive impairment, and impulsive with poor safety awareness. Resident 1's care plan, updated 10/09/2024, documented Resident 1 was an elopement risk due to poor safety awareness/dementia, would not leave the facility unattended and had been provided with a wander guard (a device worn by the resident that triggers alarms or locks doors preventing residents from leaving facilities unattended). Resident 1's care plan, updated 02/21/2025, documented Resident 1 required two person maximal assistance for toilet transfers and sitting to standing as well as one to two person maximal/substantial assistance for transfers. An Accident/Incident/Injury/Property Damage Report from the local clinic had the following written statements: (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	--Dated 02/13/2025 at 12:30 PM, showed, [A clinic staff] came to get nursing staff for help with patient [Resident 1] in bathroom . Once door was opened we found patient on floor head facing toilet. --Dated 02/13/2025 at 12:30 PM to 12:40 PM, documented, When patient was done with [appointment] with [clinic doctor], [a clinic staff] took [Resident 1] out to the waiting room so her [facility ride] could pick her up. [The clinic staff] walked back into the office. [Resident 1's facility ride] from the [facility] arrived and patient was not in waiting room where [the clinic staff] left her. [The clinic staff] then go to check the bathrooms . When knocked on the door, [Resident 1] had locked herself in the bathroom. [Clinic staff] asked if she fell . [Resident 1] said yes . Patient was on the floor . --Dated 02/13/2025 at around 12:30 PM, documented, [Clinic staff] came back and said someone fell in the bathroom . Patient was on the floor, feet near the toilet and head near the sink/wall. Wheelchair was also in the bathroom. When asked how she fell , [Resident 1]said she pulled herself up at the sink and fell before she could get to the toilet. [Nursing staff] came in to evaluate patient and [they] decided it would be best to call 911 so [Resident 1] could be evaluated at the [emergency department]. [Clinic doctor] also came in to evaluate patient . [Clinic staff] talked with the patient . and it was unclear if she goes to the bathroom by herself at the nursing facility. [Clinic staff was] not sure if anyone helped [Resident 1] to the bathroom or how she got in there . --Undated, documented, Patient finished an appointment with [clinic doctor] for a distal humerus fracture . [Resident 1 was waiting in the waiting room for a ride. She went to the bathroom alone unknown to staff. Ride could not find her; door locked to the restroom. Could hear her yelling for help. The door was unlocked with a key. Unwitnessed fall. [Resident 1] was found lying on her back, alert and oriented, some baseline confusion. Complaining of right hip pain. No cuts or abrasions . Did not think she passed out. [Resident 1] is on a blood thinner. Had a history of right hip replacement. [Clinic doctor] evaluated . Called 911 to assist with transport to the hospital . A facility incident report, dated 02/13/2025, documented Resident 1 was out of the facility at a doctor's appointment and fell while using the bathroom resulting in hip pain. Clinic staff called 911 and Resident 1 was sent to the ER for evaluation. Predisposing physiological factors were documented as confused, gait balance, history of self-transfer, and impaired memory. Predisposing situation factor was documented as ambulating without assistance during transfer. The facility incident report documented Resident 1 had limited safety awareness and required assistance for safety in transfers. The facility investigation, dated 02/13/2025, documented, [Staff Member] from [local] orthopedic clinic states that the driver showed up to pick up [Resident 1] and she was no longer sitting in the lobby where the MA [medical assistant] had left her. Staff went looking for [the resident] and found her laying on the floor of the bathroom in front of the sink, WC [wheelchair] behind her. [Resident 1] was laying on her right side, but [Resident 1] reports landing on her bottom first. Resident was then assessed by nursing and the MD [doctor at Ortho clinic]. MD ordered to send [Resident 1] to hospital for possible fracture. A computed tomography (CT) scan of Resident 1's pelvis, dated 02/13/2025, showed Resident 1 had an acute fracture of the right inferior pubic ramus (a bone located in the pelvis). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 03/11/2025 at 1:20 PM, Staff D, Administrator, said there were problems with how the transport form had been filled out for Resident 1. The person who filled it out did not put in for caregiver assist. Staff D said the person who filled out the form did not put their name on it, so they were not able to address the issue with that staff member. At 1:40 PM, Resident 1 said she remembered having a fall while out at an appointment, and believed she was trying to wash her hands at the time. On 04/02/2025 at 3:39 PM, Staff B, Social Services Assistant, said when residents needed to be scheduled for out-of-facility appointments, nurses would notify her of where residents needed to go and if they needed a staff assist (staff would go with the resident to the appointment). Residents that were either cognitively impaired or unable to self-propel in wheelchair would get a staff assist for their appointment. At 3:44 PM, Staff C, Licensed Practical Nurse, said nurses would let social work know who needed to be scheduled for transportation and they would plan from there. At 4:00 PM, Staff A, Director of Nursing Services and Registered Nurse (RN), said outgoing appointments were discussed during morning stand up every morning. Which residents required staff assistance was decided by the group at that time. Staff A said she did not recall what had been discussed for Resident 1's transportation needs. Staff A said she would have thought Resident 1 would have been safe after the facility driver got Resident 1 to the appointment. On 04/10/2025 at 2:57 PM, Staff E, Facility Transportation Driver, said he was strictly a driver for the facility. Staff E said he brought Resident 1 to the clinic, checked her in and left her in the lobby. Staff E said if residents needed to have staff assistant to be with them, the facility would send one with them. Or residents may have a family member to go with them, which Resident 1 normally did. Staff E said this was the first time he had taken Resident 1 to an appointment that her daughter was not with her. On 04/11/2025 at 12:06 PM, Collateral Contact (CC), Clinic RN, said after Resident 1's appointment, the medical assistant wheeled Resident 1 out to the lobby and told her the driver would be here shortly. CC said about 10-15 minutes later, the medical assistant noticed Staff E was in the lobby, but Resident 1 was not where she parked her. CC said the medical assistant heard someone yelling for help from the bathroom and knocked on the door. Resident 1 said she had fallen. CC said the medical assistant was unable to get in the bathroom because Resident 1 had locked it from the inside. Clinic staff got the key and got the door open. Resident 1 expressed pain and 911 was called. CC said no clinic staff were waiting with Resident 1 after she was taken to the lobby. CC said normally if the driver was not there after an appointment, residents would wait in the lobby until the driver got there to pick them up. CC said if residents come from a facility and need assistance, then someone from the facility should come with them. CC said clinic staff were not responsible for patients waiting in the lobby. CC said when they have patients come from facilities that are not cognitively intact, they have a caregiver or family member sit with them. CC said Resident 1 appeared confused. On 04/14/2025 at 11:40 AM, Staff G, Certified Nurses Assistant, said prior to Resident 1's pelvic fracture, she required assistance for transfers and sitting to standing. Staff G said Resident 1 was not able to perform either activity safely without assistance, but had a history of attempting self transfers without assistance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	At 11:40 AM, Staff A said prior to Resident 1's pelvis fracture, the resident was not safe to transfer or sit to stand without assistance. Reference WAC 388-97-1060 (3)(g)