STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505280	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renton Health & Rehabilitation	80 Southwest Second Street Renton, WA 98057

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 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** 29644 Based on interview and record review, the facility failed to ensure a Physician Order for Life Sustaining Treatment (POLST - a form indicating the resident's wishes when found not breathing and without a pulse) to initiate Cardio-Pulmonary Resuscitation (CPR - an emergency procedure consisting of chest compressions combined with giving breaths of air/Full Code) or not during medical emergency for 2 of 8 residents (Residents 3 & 4) reviewed for Advance Directives. The failure to ensure a copy of the POLST form was available in the medical records and accessible to staff (Resident 3) and to fully complete the POLST form (Resident 4) placed residents at risk of losing their right to have their stated preferences/decisions honored regarding medical treatment and end-of-life care, not receiving CPR when indicated, and potentially death. Findings included . <Resident 3> According to the [DATE] Discharge Minimum Data Set (MDS - an assessment tool), Resident 3 had medical conditions including unstable blood sugar levels, respiratory failure, and muscle weakness. The MDS showed Resident 3 sustained a fall with major injury in the facility. A [DATE] nursing progress note indicated Resident 3 was sent to the hospital for further evaluation after the staff found the resident on the floor with their left leg shorter than the right and was rotated outwards indicative of a possible fracture. Review of a [DATE] Order Audit Report provided by Staff D (Resource Nurse) showed a [DATE] order indicating Resident 3 was a Full Code and wanted CPR. Review of Resident 3's medical records did not show a POLST form was accessible to the staff. The facility was not able to provide documentation to support Resident 3 had a POLST form in place. In an interview on [DATE] at 4:08 PM, Staff D confirmed Resident 3's medical records did not show a POLST form was available or accessible to staff and stated, [POLST form] must have been sent out with the resident to the hospital .I will check and get back to you. Staff D stated it was important for residents to have a POLST form in place so the staff would know what to do in case of a medical emergency based on the resident's wishes. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2024
NAME OF PROVIDER OR SUPPLIER Renton Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 80 Southwest Second Street Renton, WA 98057	

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 4:56 PM, Staff A (Administrator) stated they were unable to locate Resident 3's POLST form. <Resident 4> According to the [DATE] 5-day MDS, Resident 4 had clear speech, understood others during communication, and had medical conditions including kidney failure, unstable blood sugar levels, and respiratory failure. Review of the MDS schedule showed a [DATE] Death in Facility assessment was completed for Resident 4. Review of Resident 4's progress notes showed a [DATE] note indicating Resident 4 experienced shortness of breath (at rest and with activity) after missing three dialysis (a treatment that cleaned the blood when the kidneys could not) sessions in a row. A [DATE] note showed Resident 4 refused to be sent out to the hospital for further evaluation. A [DATE] note showed Resident 4 was found unresponsive by staff and CPR was performed. Review of the medical records showed Resident 4's POLST form was initiated and signed by the resident on [DATE]. The form did not show the contents of the POLST form and was not signed by the facility provider to show the information was discussed with Resident 4 and/or their representative. In an interview on [DATE] at 4:56 PM, Staff A confirmed Resident 4's POLST form was incomplete and stated the form was never signed by the physician until Resident 4 died . REFERENCE: WAC [DATE](3)(c)(i-ii). 46471

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident’s advance directives.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 29644

Based on observation, interview, and record review, the facility failed to have a system in place that ensured basic life support was initiated immediately, as directed in the facility policy, including Cardio-Pulmonary Resuscitation (CPR - an emergency procedure consisting of chest compressions combined with giving breaths of air) when 2 of 3 residents (Residents 1 & 2) were reviewed for unexpected death in the facility. This failed practice placed 35 additional residents (Residents 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, & 39), who had current physician orders to receive CPR, at serious risk for adverse outcome including death and constituted an Immediate Jeopardy (IJ).

On [DATE] at 3:58 PM, the facility was notified of an IJ in F678. The facility removed the immediacy on [DATE] after they audited the records of all residents, audited the Physician Order for Life Sustaining Treatment (POLST - a form indicating the resident's wishes to have or not have CPR) binders, educated staff on the facility's Medical Emergency Response Policy and Code Blue Emergency Recorder process during CPR, performed CPR drills, and implemented a plan of correction to sustain ongoing compliance.

Findings included .

<Facility Policy>

Review of the facility policy, Medical Emergency Response, revised ,d+[DATE], showed the employee who first witnessed or was first on the site of a medical emergency, that were trained, would initiate immediate action, including CPR as appropriate, .and summon for assistance. CPR would continue unless there was a DNR (Do Not Resuscitate) order in place .The RN (Registered Nurse) supervisor or Charge Nurse of the unit would take the Emergency Cart to the code site, and ensure accurate documentation of the event.

Review of the 2020 American Heart Association Advanced Cardiovascular Life Support Provider Manual showed the passage of time drove all aspects of emergency cardiovascular care. The final outcomes were determined by the intervals between collapse or onset of the emergency and the delivery of basic and advanced interventions. The manual showed the probability of survival declined sharply with each passing minute of cardiopulmonary compromise. Some interventions, like basic CPR, slow the rate at which this decline in probability occured. CPR made this contribution by supplying some blood flow to the heart and brain. Some single interventions, such as tracheal intubation (insertion of a tube through the mouth or nose and into the airway/windpipe), clearing an obstructed airway, or defibrillating a heart (administering a controlled electric shock to restore the heart's normal rhythm), were sufficient alone to restore a beating heart. For all of these interventions, independently sufficient or simply contributory, the longer it took to administer these therapies, the lower the chances of survival.

<Resident 1>

(continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Resident 1's POLST showed it was signed by the Resident or Legal Surrogate on [DATE] and signed by the Nurse Practitioner on [DATE]. The form showed Resident 1 wanted CPR if they were not breathing and had no pulse. The form showed Resident 1 wanted full treatment to prolong life by all medically effective means including transfer to the hospital and intensive care (Full Code). Review of Resident 1's medical records showed Resident 1 was designated as a Full Code. Review of the Advanced Directives Care Plan (CP), revised [DATE], showed Resident 1's POLST indicated the resident was a Full Code. Review of the Minimum Data Set (MDS - an assessment tool) showed a [DATE] Death in Facility MDS was completed for Resident 1. Review of a nursing note documented by Staff F (Registered Nurse) showed on [DATE], Resident 1's family member (CC1) came out of the resident's room and went to Collectible Court hallway (A-Hall) to tell Staff F that Resident 1 was cold. Staff F notified the nurse assigned-Staff E (Licensed Practical Nurse - LPN) at Garden Way hallway (B-Hall), who was at the time in another resident room, that attention was needed in Resident 1's room. A Certified Nursing Assistant (CNA) then came out with CC1 needing help. Staff F went to Resident 1's room, noticed that Resident 1 was unresponsive and not breathing, and warmth still present in their arms and chest. Staff F told a CNA to notify another nurse of the situation and to call 911. The CNA and Staff F moved Resident 1 from the bed to the ground, and started doing chest compressions until the air bag was available to do CPR. CPR continued until EMS (Emergency Medical Services) arrived. Review of a nursing note, documented by Staff E on [DATE], showed while they were in the different room administering medications, a nurse called them to attend to Resident 1's room. Staff E found Resident 1 unresponsive. Resident 1 was cold around the neck but warm on the chest and legs. Staff E yelled out to get more people to lower resident down and start CPR. 911 was called and CPR continued until help arrived. Review of a statement in the facility investigation written by Staff E, dated [DATE], showed Staff E and a CNA responded to Resident 1 and stated, we were unable to lower resident down by ourselves to start CPR, therefore I asked a CNA to call everyone while I called 911. Review of an undated statement in the facility investigation written by Staff G (CNA) showed they saw Resident 1's family member (CC2) worried and calling out for help so they went to find the nurse, Staff E, who was in another room. Staff E and Staff G went in to Resident 1's room, and the resident was unresponsive. During an interview on [DATE] at 5:45 PM, Staff G, stated , we went in, we couldn't do CPR. Staff G stated they went out to get Staff F to pull the resident from the bed. Staff G stated they put Resident 1 on the floor, Staff F started CPR, and Staff E called 911. Review of the facility investigation, dated [DATE], showed it was noted in the visitor log that CC2 arrived to the facility at around 7:07 PM finding the resident unresponsive. Per Staff F, the incident occurred between 7:00 PM to 7:12 PM, when they were called and performed CPR, while Staff E called 911, which was at 7:14 PM. 911 arrived at 7:18 PM and took over CPR until around 7:56 PM. Attempts to resuscitate Resident 1 were unsuccessful. Resident 1 passed away between 7:45 PM - 8:00 PM. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on [DATE] at 3:02 PM, Staff C (Director of Nursing - Interim) stated the staff involved could not recall specific times. Staff C confirmed CC2 signed in at 7:07 PM, 911 was called at 7:13 PM, and CPR was in process when the medics arrived. Review of the facility investigation dated [DATE] showed there was no timeline or actual documentation of the sequence of events. On [DATE] 3:15 PM, the back hall crash cart was observed with a clipboard and a Code Blue Emergency Recorder (Time Line) form was on the clipboard. The front hall crash cart was observed with a clipboard, but there was no Code Blue Emergency Recorder form on the clipboard or the cart. During an interview at that time, when asked if the Emergency Recorder form was completed for Resident 1's code, Staff C stated no, they did not have one in the investigation. Staff C looked at the nurse's station and other places within the facility and was unable to locate a form documenting the sequence of events. On [DATE] at 2:27 PM, an Automated External Defibrillator (AED - a lightweight, portable device that delivers an electric shock through the chest to the heart when it detects an abnormal rhythm and changes the rhythm back to normal) was observed in the facility, mounted on the wall. During an interview on [DATE] at 4:48 PM, Staff B (Director of Nursing) stated it was not a requirement to use the AED during CPR. During an interview on [DATE] at 5:10 PM, Staff A (Administrator) was unable to provide staff training in the use of an AED and stated the facility did not have a policy or procedure regarding the use of the AED. During an interview on [DATE] at 3:02 PM regarding the investigative findings, Staff D (Resource Nurse) stated CC2 came out, Staff F went to the room, and initiated CPR. Both Staff C and Staff D thought Staff F was the first on the scene to identify the resident had no pulse and no respiration. During an interview on [DATE] at 11:19 AM, CC2 stated, after exiting Resident 1's room, they ran down the hallway, saw a nurse and yelled It's an emergency, hey we need help, [Resident 1] is in trouble! CC2 stated they told a nurse who went and told another nurse. During an interview on [DATE] at 11:38 AM, CC1 stated they stayed in the room while CC2 went to find staff, trying to find staff took a while. They said they were looking for [Resident 1's] nurse. CC1 stated ,I started screaming, then they [staff] came in. During an interview on [DATE] at 10:03 AM, Staff H (Corporate Consultant) stated they re-interviewed the staff involved and determined that Staff G was the first in the room, summoned Staff E, who told Staff G to get Staff F. When asked why Staff G did not initiate CPR, Staff H stated that a licensed nurse needed to verify the code status, the POLST, and then make the decision to do CPR or not. <Resident 2> (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Renton Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 80 Southwest Second Street Renton, WA 98057	

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Resident 2's POLST showed it was signed by the resident (undated) and signed by the physician on [DATE]. The form showed Resident 2 wanted CPR if they were not breathing and had no pulse. The form showed Resident 2 wanted full treatment to prolong life by all medically effective means including transfer to the hospital and intensive care. Review of Resident 2's electronic medical record showed Resident 2 was designated as a Full Code. Review of the Advance Directives CP, revised [DATE], showed Resident 2's POLST indicated the resident was a Full Code. Review of the MDS showed a [DATE] Death in Facility assessment was completed for Resident 2. Review of a [DATE] nursing progress note time stamped at 12:22 AM showed on [DATE], Resident 2 complained of stomach upset and the physician came, assessed Resident 2's discomfort, and ordered medications for the resident. The note showed, at 8:30 PM, Staff F saw Resident 2 watching television in bed while holding a bucket (in case of vomiting). At 9:10 PM, Staff F found Resident 2 unresponsive and their breathing and pulse were present but weak. The note showed Staff F notified a nursing aide to obtain Resident 2's vital signs, went and told another nurse of Resident 2's condition, and called 911. Review of the [DATE] facility investigation showed no emergency response timeline or documentation of the sequence of events was included in the report to support the facility initiated CPR timely as required. A [DATE] investigation note showed, on Staff F's way to call 911, Staff F alerted Staff I (LPN) about what was going on with Resident 2, and by the time Staff I got to the room, Resident 2 had stopped breathing. A [DATE] testimony (staff interview/statement) by Staff I showed, when Staff F told them of Resident 2's condition, they went to the resident's room and assessed the resident while Staff F called 911. The testimony showed it was not until Staff F came back (after making the 911 call) and multiple staff were present in the room when Resident 2 was pulled on the floor to initiate CPR. The testimony showed Staff I called a Code Blue at 9:20 PM. Review of an undated statement in the facility investigation by Staff J (CNA) showed they participated in bringing Resident 2 down on the floor to do CPR at 9:15 PM. In an interview on [DATE] at 1:51 PM, Staff H confirmed there was no timeline completed for Resident 2's emergency response. Staff H stated the staff should have initiated the Code Blue Emergency Recorder form as part of the facility's process, but did not. Review of the facility provided Timeline of [Resident 2] CPR event document on [DATE] (created after the incident) showed when Staff F called 911, Resident 2 was unresponsive but was still alive, breathing and with a pulse. The document showed Staff F told Staff I that Resident 2 was unresponsive as they were running to a phone to call 911 and at 9:13 PM, the 911 dispatcher was updated by Staff F (while they were still on the phone) that Resident 2 had coded (stopped breathing and without a pulse). (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	The document showed Staff F initiated the CPR after completing the 911 call and moving Resident 2 down on the floor with Staff J until the EMS (Emergency Response Services) arrived at 9:16 PM and took over the resuscitation efforts. The document showed Staff I told the investigative staff the time (9:20 PM) they provided in their testimony was a guesstimate. The document did not show if/when Staff I performed CPR on Resident 2 after they assessed the resident was unresponsive and called the Code Blue. In an interview on [DATE] at 11:12 AM, when Staff H was asked who was in Resident 2's room when the resident coded at 9:13 PM, Staff H stated Staff I was, and that Staff I did not move Resident 2 down on the floor to initiate CPR because the staff had a back injury. Staff H stated it was Staff F who initiated the CPR (and not Staff I) and confirmed it was a similar situation (where the first CPR-trained staff member who was on scene did not initiate CPR) as with the case of Resident 1. A review of the electronic medical records on [DATE] showed 35 residents (Residents 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, & 39) had current physician orders to receive CPR according to the facility policy. These 35 residents all resided in the facility on [DATE]. REFERENCE: WAC [DATE](1). 46471

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29644 Based on observation, interview, and record review, the facility failed to develop, implement and maintain an in-service training program that ensured 3 of 3 Nursing Assistants (Staff's L, M, & N) reviewed for training and competency, had the required 12 hours per year of in-service training and education. This failure placed residents at risk of less than competent care and services from staff. Findings included . Review of the Facility Assessment, revised [DATE], showed required in-service training for nurse aides must be sufficient to ensure the continuing competence of nurse aids and must be no less than 12 hours per year, including dementia (a memory impairment) management training. Additional staff training identified included communication training, resident rights and facility responsibilities, cultural competency, identification of resident changes in condition, including how to determine if symptoms represent problems in need of intervention. On [DATE] at 2:27 PM, an Automated External Defibrillator (AED - a lightweight, portable device that delivers an electric shock through the chest to the heart when it detects an abnormal rhythm and changes the rhythm back to normal) was observed in the facility, mounted on the wall. During an interview on [DATE] at 5:10 PM, Staff A (Administrator) was unable to provide documentation of staff training regarding the use of the AED. In addition, the facility was unable to provide documentation to show staff were educated on the facility's Medical Emergency Response policy, and the Code Blue Emergency Recorder process during CPR. Review of Staff L's (Certified Nursing Assistant - CNA) employee file showed their date of hire was [DATE]. Review of Staff M's (CNA) employee file showed their date of hire was [DATE]. Review of Staff N's (CNA) employee file showed their date of hire was [DATE]. The facility was unable to provide requested documentation to support Staff's L, M, and/or N received no less than 12 hours of in-service education annually (based on employment date) as required. During an interview on [DATE] at 4:16 PM, Staff H (Corporate Consultant) stated the facility had an in-service training calendar, but the previous Staff Development Coordinator did not follow it. During an interview on [DATE] at 4:24 PM, Staff O (Vice President of Operations) stated they were able to find records of in-service training/education provided to staff, but there was currently not a system in place to ensure the required in-service training was provided, for the minimum 12 hours, to each nursing aide. Refer to F678- Cardio-Pulmonary Resuscitation. REFERENCE: WAC [DATE] (2)(a-c).