STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505283	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clarkston Health and Rehab of Cascadia	1242 Eleventh Street Clarkston, WA 99403

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to inform the Resident Representative (RR) of changes to the resident's weight, treatments, wound status, medication changes, refusals of treatments, and changes in condition for one (1) of 4 residents reviewed for the right to be informed of care for a span of five months. This failure precluded the RR from the opportunity to contribute to help Resident 1 make an informed decision related to medication and treatment changes and move forward with the treatment options being proposed. Findings included . Review of an 11/28/2017 facility policy titled Resident Change in Condition, described a change in condition as a change from the resident's normal status or whenever there was a change in the resident's medical condition. Some of the examples of a change in condition included, new or increasing confusion, newly identified incontinence, weight loss of more than 5 % (percent) of body weight, behavior changes, and potentially life-threatening conditions due to a change in the resident's chronic disease and medical condition. The policy instructed the staff to notify the resident representative (consistent with their authority), family member, or responsible party, when there was a significant change or a deterioration in the resident's physical, mental or psychosocial status in health, life-threatening conditions or clinical complications, a need to change treatment significantly, the decision to transfer the resident from the facility, and/or when there is a change in room or roommate assignment. Additionally, the policy instructed the staff to document in the resident's medical record all attempts to notify the resident's family member or responsible party of the change in condition. <Resident 1> Review of a 09/17/2024 assessment showed Resident 1 readmitted to the facility on [DATE] with medically complex conditions. This assessment showed the staff identified Resident 1 had moderate cognitive impairment and the family participated in the assessment and goal setting. Record review showed the resident admitted to the facility with a chronic wound and a history of falls. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record showed Resident 1 had two designated Power-of-Attorneys (POA) for health care decision-making. A POA has the privilege, in the event of an unfortunate medical condition, to make health-related decisions for the resident. The medical record also showed designated Emergency Contacts and in what order staff should contact them, like Emergency Contact # [number] 1. Review of the medical record also showed physician orders that read, Patient is aware of patient's medical condition(s), Resident is capable of making his/her own health decisions, and Resident is incapable of making his/her own health decisions. Record review showed supporting POA documents were available to the staff in the electronic medical record since on 04/02/2024. A 04/02/2024 progress note showed the resident, has family for support and that their son is POA and a source of support to [the resident]. Review of the progress notes showed Resident 1 experienced events that met the definition of a change in condition, but no documentation to show the staff notified the RR as instructed: 04/12/2024 - Resident lethargic and very confused. awaiting lab results. will place note in Provider's box for review and Received signed lab results from [provider]. Received orders for referral to nephrology [kidney specialist]. 04/25/2024 - Rec'd [Received] call from infectious disease stating resident's WBC's [white blood cell count] are low and gave the following new orders to discontinue one antibiotic and start another. 04/26/2024 - Resident came out of room with visible 2cm [centimeter - a unit of measurement] x 2cm bump to his right eye brown [sic]. Purple bruising already present and Lung have rhonchi [wheezing breaths] throughout . Due to change in respiratory assessment and new injury to eyebrow, Dr. [NAME] was notified. RN [Registered Nurse] advised to start neuro [neurological] checks to monitor patient and put an order in for the AM [morning] for a 2-view chest xray. 5/17/2024 - RT [Resident] tested positive for COVID at this time 06/06/2024 - Provider reviewed pharmacy recommendation to discontinue sliding scale (insulin dose based on your blood sugar level just before your meal), order signed and discontinued by provider. 06/06/2024 - Review of a 06/07/2024 Notice of Room-to- Room Transfer showed no documentation the facility adequately informed Resident 1 or their representative. There were no resident or RR signatures, and page 2 of the notice was entirely blank. Page 2 required the date the notice was issued, the room Resident 1 was being transferred to, that they were informed of their rights to transfer, to include the rationale for the transfer. 06/17/2024 - The resident complained to the staff of left ring finger pain and that it had been hurting for two weeks. the resident requested an xray. On 06/19/2924, the staff, Received new orders from provider for X-ray to L hand r/t [related to] pain. X-ray tech [technician] here now to do exam. X-ray results back, conclusion possible avulsion [a bone fragment is pulled away from its main body by soft tissue that is attached to it] fx [fracture] of base of the L 4th proximal [finger]. Placed in provider box for review. Resident stated to this LN [Licensed Nurse] finger has been this way for over a month and a half. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	06/24/2024 - Resident 1 told the staff they felt like, an abscess on [their] upper gum area where one of [their] teeth were removed. Upon inspection, the area is slightly red and swollen. [Resident] said it is painful and would like to have an order for a dental appt [appointment] as well as something for the pain besides prn [as needed] Tylenol. 06/26/2024 - Provider in and assessed Resident 1's mouth due to redness, swelling along with c/o [complaints of] pain. New order received for [antibiotic twice a day for 10 days] r/t peridontal [sic] abscess [a pocket of infection that starts in your gums]. 07/12/2024 - The progress note showed the Resident 1 returned from the dental clinic who referred the resident to an oral surgeon for impacted wisdom teeth and extraction was recommended. The resident was prescribed antibiotics and a prescription mouthwash. 07/22/2024 - Orders received by the staff for stronger analgesics and another dentist referral secondary to Resident 1's complaints of pain. 07/26/2024 - Resident gum swelling increased, seen by Dr. [NAME] this [morning] who gives the following new order: [antibiotic twice a day for 10 days]. 07/27/2024 - The staff identified Resident 1 had a 1cm x 1cm palpable mass to upper right jaw. 08/14/2024 - Resident continues to have increased pain and swelling to left side of face. Area is also noted to be very firm and orders for antibiotics for 30 days and a narcotic analgesic were received. 09/01/2024 - Tooth abscess has grown. Last week this RN could palpate mass to upper left jaw, measuring about 1 cm x 1 cm. It now is felt on his face measuring 2cm x 2cm and is visible and, Left cheek is notably swollen and warm to touch. The affected area on gums is creamy/yellow. Surrounding gum tissue is swollen and red. 09/04/2024 - Resident with new orders to continue antibiotic and an additional antibiotic was added by the Infectious Disease clinic. Review of the progress notes showed that on 09/06/2024, the facility received a call from Resident 1's RR who expressed concern that he was not being kept up and informed on resident's condition, new orders, especially related to resident's left foot lesion and the plan to resolve the infection in it. This author apologized to [them] for the lack of communication and stated would inform nursing staff to remember to contact [the POA] for any changes, new orders, etc.[etcetera]. Short discussion regarding resident's new antibiotic orders, upcoming repeat [lab work], and the consideration for IV [intravenous - by vein] antibiotics. Record review showed no documentation the facility informed or updated the RR of the oral/dental status/concerns. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/08/2024 - The progress notes showed the resident continued to complain about the abscess to the upper left jaw and staff described a palpable area measured the previous week to be at 4cm diameter, now increased in size to 4cm x 8cm, extending clear back to [the resident's] left ear and red, scabbed rash to both arms and legs. The notes also showed they assessed Resident 1's left foot wound with increased drainage that required additional dressing changes and with redness that spread to the top of the foot. The drainage was described as copious. While the staff notified the provider, who in turn gave treatment orders, it showed no documentation the staff informed the RR. 09/9/2024 - The progress note showed a chronology of events about the abscess to the resident's upper left jaw, completed/pending/incomplete dental appointments and referral to an oral surgeon. It showed no documentation the facility shared this information with the RR. Review of 09/10/2024 and 09/18/2024 provider notes showed the staff acknowledged Resident 1 was chronically refusing their dressing changes to the left foot wound to include becoming combative with staff at times and not allowing the staff to change the dressings. It showed no documentation the facility shared this information with the RR. 09/20/2024 - The nurses reported to the provider that Resident 1 stated that they experienced shooting pains in their mouth and also has four new sores. 09/21/2024 - The progress note showed the staff assessed Resident 1 had, Foul smelling, copious amount of drainage to the foot wound. The staff described the entire foot is macerated and raw with thick layers of dead skin. Open area is measuring 5 x 5 cm, center is dark purple. Patient has redness and warmth extending 6 inches up calf. 09/22/2024 - Staff reported, episodes of confusion over the last 2-3 days. Patient frequently taking [their] pants off and urinating on the floor and that Resident 1 acted like they didn't know how to put [their] pants back on. Review of the medical record showed Resident 1 weighed 283 # (pounds) on 03/29/2024. The record showed that on 04/28/2024, the resident experienced a loss of 14 pounds (268.2), a significant weight loss of 5.23% in a 30-day period. On 07/01/2024, the resident weighed 259.2, or a significant weight loss in 90 days of 8.41%. On 9/30/2024, Resident 1 weighed 235 pounds, or a 16.96% significant weight loss at 180 days. Resident 1 lost 48 pounds in six months. Record review showed no documentation the staff informed Resident 1's representative of the continued and significant weight loss or plans to address it. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/03/2024 at 12:35 PM, the POA stated that when Resident 1 was in room [ROOM NUMBER], one of the staff told them, They did not know the resident had a POA or a medical proxy. The POA stated that the staff did not inform them of Resident 1's changes in mentation, referral to specialists, refusal of cares, medication changes, bruise and bump to the right eyebrow, a possible fracture to the left fourth finger, or status of the wound throughout the resident's stay, until they called to complain to the facility about the lack of communication early September. I had no knowledge of the dental issues until the Spokane appointment in September. I never heard of an oral surgeon. The POA stated that they never heard someone talking specifically about a significant weight loss. I've never had a conversation like that. The POA stated that when they brought up the lack of care concerns to the facility, the staff told them Resident 1 was refusing care and being disgruntled. They never contacted me about [the refusals]. They haven't been telling me [Resident 1] was argumentative or refusing. I am the POA, maybe they should have called me at least to let me know of any issues [Resident 1] has been giving them. The above information was shared with Staff A, Director of Nursing, on 10/4/2024 at 10:40 AM. Staff A stated, I agree to the communication [with the POA] was lacking and managed poorly and that the staff, Yes, should have called POA. Reference WAC 388-97-0300(3)(a), -0260, -1020(4)(a-b).

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to ensure 1 of 4 residents (Resident 1) reviewed for dental services received adequate pain management and timely dental services for an impacted wisdom tooth and abscess. This failure placed residents at increased risk of pain, unmet dental needs, and a diminished quality of life. Findings included . Review of an 11/28/2017 facility policy titled Dental Services showed the facility provided the assistance needed or requested to obtain dental services and if a referral did not occur within 3 business days, the facility would ensure the resident would drink and eat adequately while awaiting dental services. The policy defined emergency dental services as services needed to treat an episode of acute pain in teeth, gums, or palate, broken or otherwise damaged teeth, or any other problem of the oral cavity that required immediate attention by a dentist. <Resident 1> Review of a 09/17/2024 assessment showed Resident 1 readmitted to the facility on [DATE] with medically complex conditions. This assessment showed the staff identified Resident 1 had moderate cognitive impairment and had no oral or dental issues. Review of a 06/24/2024 progress note showed Resident 1 told the staff that they felt like they had an abscess to their upper gum area where one of [the Resident's] teeth were removed. Upon inspection, the area is slightly red and swollen. The resident reported to the staff that it was painful and would like to have an order for a dental appointment, as well as something for the pain besides Tylenol as needed. The staff gave the resident Orajel, an over-the-counter topical gel analgesic, the resident applied it to their gumline. Progress notes showed the facility medical provider (Provider) referred the resident to a dentist on 06/25/2024 . On 06/26/2024 the provider assessed Resident 1's mouth related to redness, swelling along with c/o [complaints of] pain. The provider prescribed an antibiotic twice a day for 10 days for the diagnosis of periodontal abscess (pocket of infection that forms in the gums and the associated pain can be severe, constant, throbbing, can spread to the jawbone, neck or ear, and cause pain or discomfort with the pressure of chewing or biting). Review of the June 2024 Medication Administration Record (MAR) showed no documention of non-pharmacological interventions. Review of a 07/05/2024 progress note, 10 days after the facility received an order to refer Resident 1 to a dentist, showed the resident told the staff that they felt the tooth abscess is not getting better. There was no documentation to show the staff updated the provider of the resident's oral status, to include an assessment of the mouth. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a 07/08/2024 progress note showed Resident 1 requested of the staff to get an order to apply Oragel to possible dental abscess site until resident is seen by dentist. The 07/09/2024 progress note showed the provider agreed to the Oragel [sic] application up to four times a day. Record review showed no [Oragel] orders were scheduled routinely or as needed in the July 2024 MAR. Review of the July 2024 Medication Administration Record (MAR) showed no documention of non-pharmacological interventions. Review of a 07/09/2024 progress note, 14 days after the facility received an order to refer Resident 1 to a dentist, showed the resident complained of bleeding to the right upper gum and wants to see provider about this, also requesting to see the Dentist. The note showed the nurse already informed the resident they had an appointment in August. The nurse assessed Resident 1's mouth, saw no bleeding but confirmed dry blood around the lips, and provided [the resident] a washcloth. Review of the medical record showed the provider responded the following day on 07/10/2024 with a second request for a dentist referral. Review of the medical record showed Resident 1 was seen at the dentist office on 07/12/2024. The 07/12/2024 dental clinic notes showed the resident required oral surgery due to a partially erupting and impacted wisdom tooth. The dental clinic prescribed another antibiotic and a prescription mouthwash. Review of a 07/19/2024 progress note showed Resident 1 requested stronger pain medication than the as needed Tylenol. The staff described the pain was related to the resident's tooth, caused moderate pain, and that Resident 1 stated that the pain is worse than what Tylenol can manage. The staff informed the provider and requested a stronger analgesic. Review of the July 2024 MAR showed staff did not deliver non-pharmacological interventions to help manage Resident 1's oral/dental pain. Record review showed no Orajel orders were scheduled routinely or as needed in the July 2024 MAR. Review of the medical record showed that on 07/23/2024, four days after the nurse notified the provider of Resident 1's need for stronger pain medication due to dental pain, the facility received an order from the provider for a stronger analgesic and the instruction to, Patient needs to follow up with dentist if having this much pain. In an interview on 10/04/2024 at 11:21 AM, Staff A, Director of Nursing, was asked when they expect a complaint of unrelieved pain to be addressed. Staff A stated, It was addressed originally with the Oragel. This is just a continuation of the same situation. The nurses assessed the resident, and they notified the provider right away. I'm not a provider so I can't say what that process looks like. Staff A acknowledged that a response time of 4 days to address increased pain, seems a little longer than it normally takes but I don't know the reason for that. Review of a 07/26/2024 progress note showed staff assessed Resident 1 who was experiencing increased swelling to their gums, and Resident 1 was seen by the provider in the morning who prescribed an antibiotic for 10 days. Review of the 07/26/2024 associated provider notes showed the resident was seen for Tooth concerns, that the resident is scheduled with oral surgery in September, and had a left upper gum abscess present today. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a 07/27/2024 progress note showed that staff assessed Resident 1 had a 1cm [centimeter, a unit of measurement] x 1cm palpable mass to upper right jaw. Record review showed no documentation the staff notified the provider of this finding. No documentation was provided by the facility when requested on 10/04/2024 at 11:28 AM. Review of 07/29/2024 progress notes showed, Resident 1 stated the pain comes and goes. Another later note dated 07/29/2024 showed Resident 1 complained their jaw is painful at this time, instead of just the gumline area. Left side of face is possibly slightly swollen, though difficult to discern due to [their] beard. PRN [as needed] Tramadol (Pain medication) is partially effective. Record review showed no documentation of how the staff addressed the partially effective analgesic. Review of a 07/30/2024 progress note, 38 days after Resident 1's initial dental complaints, showed a detailed account where a nurse notified the provider and informed them that Resident 1, has ongoing left upper palate, gumline and now jaw pain from an impacted wisdom tooth. [The resident] is receiving [analgesic], which is only partially effective. Background/Data: Impacted left upper wisdom tooth; he has an appointment for excision, but it is not until sometime in September. The nurse told the provider that the resident's level of pain is approximately 5-6, or moderate, that the frequency of the analgesic is every 6 hours as needed, and that the resident seemed, to be having end-dose failure (medication wears off before the next analgesic dose is due) after about 3 or 4 hours. Additionally, the nurse informed the provider that Resident 1's left side of the face is becoming swollen, and the resident began to ask for soft foods only, to minimize irritation. The nurse asked the provider to consider increasing the frequency or the dose of the analgesic being considered, or both. The nurse suggested that possibly a different narcotic analgesic may be more helpful. The nurse ended the communication with the provider by stating that they and the resident are concerned that [the resident] is going to have to wait at least another month before being able to have the tooth taken out. The following day the provider answered, Please notify dentist of situation. Record review showed no documentation the facility followed through with the provider's order to notify the dentist or address Resident's 1 oral/dental pain. On 10/04/2024 at 11:35 AM, Staff A was asked if the facility coordinated the dentist referral or considered other treatment option. Staff A stated, We got his dental appointment bumped up to August 16 [2024]. Review of an 08/04/2024 progress note showed Resident 1 asked about the follow-up appointment with the dentist and that the Resident complained of pain, tenderness, reports oral pain medication not effective. An 08/05/2024 progress note showed that even though the resident completed their course of antibiotics, The swelling and pain from tooth abscess [sic] does not appear have gotten any better. This note showed the staff asked the provider if a stronger antibiotic should be considered to prepare for their upcoming appointment with the dentist. Review of a 08/05/2024 progress note showed Resident 1 continued to complain of upper left gumline and jaw pain. An 08/06/2024 progress note showed the resident still complaints [sic] pain to area. Review of an 08/07/2024 progress note showed the staff received a signed note by the provider, two days after the staff notified the provider of Resident 1's ineffective dental pain management, that showed, Need to call dentist office to see what they recommend. The nurse called the dental clinic, and an appointment was scheduled for Resident 1 on 08/08/2024. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an 08/09/2024 progress note, 46 days after Resident 1's initial dental complaints, showed the dental clinic requested of Resident 1 to complete a Release of Information form. Review of an 08/09/2024 provider note showed Resident 1 was seen for pain - 2 week follow up. The note showed the provider assessed Resident 1 continues with increased pain and that the facility was trying to get an appointment with the dental clinic moved up. The provider assessed Resident 1 experienced pain 8 out of 10 today [or severe] and that, we will continue to monitor this area for further concerns. Review of an 08/14/2024 progress note showed the staff notified the dental clinic that the oral surgeon's appointment was canceled due to the resident's insurance not being accepted. The nurse requested an oral surgeon referral to a city two-plus hours away by car. Additionally, the nurse notified the provider that Resident 1 continued to, have increased pain and swelling to left side of face. Area is also noted to be very firm. The provider gave an order four days later, on 08/18/2024, for an antibiotic for 30 days and a narcotic analgesic. Review of an 08/21/2024 provider note showed Resident 1was seen for chronic conditions review, and assessed the resident as stable on treatment interventions, no changes needed at this time, no concerns at this time per patient or nursing staff, and Referral in place to oral surgeon - scheduled in September. Review of an 08/25/2024 progress note showed the staff assessed Resident 1 had a small abscess area to right upper jaw still palpable externally and hardened nodule felt left upper jaw. A week later, on 09/01/2024, the staff documented that Resident 1's, Tooth abscess has grown. That the prior week the nurse could feel the mass to the upper left jaw, measuring about 1 cm x 1 cm, but now was 2cm x 2cm and visible. The nurse went to describe, Left cheek is notably swollen and warm to touch. The affected area on gums is creamy/yellow. Surrounding gum tissue is swollen and red. The nurse wrote that the Orajel was administered twice on their shift with somewhat effective results. Resident states it takes the pain away enough to be tolerable. Resident states narcotic pain medication does not alleviate [their] tooth pain at all. Record review showed no documentation the staff notified the provider of the new or worsening oral/dental symptoms. Review of a 09/08/2024 progress note showed Resident 1 continued to complain to the staff about abscess to upper left jaw. The staff described the abscess grew to a palpable size of 4cm x 8cm, extending clear back to [the resident's] left ear'. The nurse informed the provider of these findings. No instructions were received by the staff to address the growing abscess. A subsequent note showed Resident 1 reported to the staff a pain level of 10, the most severe pain level on a scale of 1 to 10, and discomfort to tooth abscess. The resident informed the staff that the as needed narcotic analgesic does not alleviate pain at all. Expresses frustrations in not being able to eat because of [their] pain, and that the Oragel [sic] to affected area with ineffective results. The notes showed the provider was to see the resident in person this week per the Medical Director. Staff A acknowledged that a change in the treatment plan to address the resident's severe oral/dental pain and a growing abscess was not evident in the medical record. Review of a 09/10/2024 provider notes showed the provider saw Resident 1 for Chronic wound. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 09/20/2024 progress note showed the staff notified the provider that Resident 1 experienced shooting pains in their mouth and developed four new sores inside his mouth. The staff requested of the provider to, please evaluate for recommendations. A 09/24/2024 follow-up provider note showed the provider responded four days later and asked the facility if the resident had a follow-up with the oral surgeon and instructed the staff to follow-up with current dentist. Review of 09/22/2024 progress note showed Resident 1 experienced a significant change in condition and was transferred to the hospital. Review of a 09/30/2024 hospital discharge summary showed diagnostics identified a large erosive mass involving the left aspect of the head and neck with metastatic adenopathy [condition that occurs when cancer cells spread from a tumor to the lymph nodes, causing the lymph nodes to swell]. Reference WAC 388-97-1060 (3)(j)(vii).