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	04/15/2025

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 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** 38527 Based on observation, interview, and record review, the facility failed to ensure the use of an indwelling urinary catheter (a tube which drains urine from the bladder into a collection bag) was properly monitored to ensure it was functioning for 2 of 2 sampled residents (Residents 1 & 3), reviewed for urinary catheters. This failure placed the residents at risk for complications, prolonged therapy, and unmet care needs. Findings included . Review of a facility's policy titled, Indwelling Catheters, revised 04/12/2022, showed if an indwelling catheter was in use, the facility provided appropriate care for the catheter in accordance with current professional standards of practice and staff were to monitor for changes in condition related to potential catheter-associated urinary tract infections. <Resident 1> Review of the admission assessment dated [DATE] showed Resident 1 was admitted to the facility with multiple diagnoses to include neurogenic bladder (a lack of bladder control due to a brain, spinal cord, or nerve problem) and urinary tract infection (UTI). In addition, the resident was able to make their needs known, was dependent on staff assistance with activities of daily living, and had an indwelling urinary catheter. Review of Resident 1's care plan initiated 01/07/2025 showed the resident had an indwelling urinary catheter related to neuromuscular dysfunction (lack of control of muscles). Interventions included for nursing staff to empty the catheter bag every shift. Additional interventions were for LNs to monitor and document for signs and symptoms of pain, blood-tinged urine, cloudiness, no output deepening of urine, foul smelling urine, and change in behavior. Review of Resident 1's treatment administration record (TAR) for March 2025 showed staff were to measure and record urinary output every shift (twice daily). Further review showed in March 2025 staff did not document urinary output on 21 of 62 opportunities. Additionally, on 03/05/2025, 03/06/2025, 03/12/2025, and 03/21/2025 the resident's urinary output was documented at less than 30ml (milliliter; unit of measurement) per hour. (continued on next page)

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 the March 2025 progress notes showed no corresponding note on 03/21/2025 showing assessment of the low output and/or notification to the medial provider of a change in the resident's condition. A progress note the following day, 03/22/2025, showed the resident's bedsheets were soiled with urine, the urinary catheter was leaking, the resident's abdomen was firm and distended, and the resident reported they had pressure in their abdomen and perineal area (the area between the anus and genitals) since the previous day. The urinary catheter was replaced and the new catheter drained 1700ml within 25 min, after which the resident reported relief of the pressure sensation, and the abdomen was no longer hard and distended. Review of the April 2025 TAR for Resident 1 showed staff did not document urinary output on 2 of 14 opportunities. Additionally, on 04/01/2025 the resident's urinary output was documented at less than 30ml per hour. Review of the April 2025 progress notes showed no corresponding note on 04/01/2025 showing assessment of the low output and/or notification to the medial provider of a change in the resident's condition. A progress note the following day, 04/02/2025, showed the resident had a change in condition and was sent to the hospital. Observation on 04/15/2025 at 11:40 AM showed Resident 1 was sitting up in their wheelchair in their room with their urinary catheter attached to the lower portion of their wheelchair. The resident stated they had experienced multiple urinary tract infections while at the facility and that they did not feel staff responded timely when they reported concerns with their urinary catheter. Resident 1 stated before they were hospitalized on [DATE] they had reported concerns with their urinary catheter but staff did not respond until the day they were sent out. The resident stated they were diagnosed with a UTI when they arrived at the hospital. In an interview on 04/15/2025 at 1:53 PM Staff E, Licensed Practical Nurse, stated nursing assistants (NA) were responsible for routine urinary catheter care and nurses would assess the catheter if the NA or resident reported changes or concerns. Staff E stated on 04/01/2025 Resident 1 reported they were feeling unwell and the resident appeared flushed (red and hot skin as the result of illness or strong emotion) and they requested the next shift to monitor the resident. Per Staff E, the resident's condition worsened and the resident was sent to the hospital the following day where they were diagnosed with a urinary tract infection. Staff E stated the resident had frequent UTIs and were at risk for UTIs but their urine appeared clear on 04/01/2025 so no diagnostic testing of the urine was done prior to their hospitalization . In an interview at 4:36 PM the same day, Staff D, Resident Care Manager, stated urinary output was not measured on all residents, but if it was, the interdisciplinary team (IDT; group of medical professionals of various disciplines) monitored to ensure staff completed the required documentation. Staff D reviewed Resident 1's physician orders and TAR and confirmed there were many missing entries of the resident's urinary output. Staff D stated many of the staff in the facility were from an outside agency and did not always complete required documentation. (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 04/15/2025 at 5:00 PM, Staff B, Director of Nursing, stated urinary output was only measured on residents with a physician's order for monitoring as most of the residents in the facility had stable urinary statuses. Staff D confirmed Resident 1 had orders for measuring urinary output as their urinary status was complicated and further stated the facility was working on a referral to a urologist (doctor who specializes in kidney/urinary care) prior to their hospitalization . Staff D stated they were aware of concerns with tracking urinary output due to both the use of agency staff and confusion amongst staff of which residents were or were not to have their urinary output measured. <Resident 3> Review of the admission assessment dated [DATE] showed Resident 3 was admitted to the facility with multiple diagnoses to include obstructive uropathy (bloackage that prevents urine from flowing normally through the urinary system. In addition, the resident was able to make their needs known, required substantial staff assistance with activities of daily living, and had an indwelling urinary catheter. Review of Resident 3's treatment administration record (TAR) for March 2025 showed staff were to measure and record urinary output every shift (twice daily). Further review showed in March 2025 staff did not document urinary output on 21 of 62 opportunities. Additionally, on 03/01/2025, 03/03/2025, 03/18/2025, and 03/27/2025 the resident's urinary output was documented at less than 30ml (milliliter; unit of measurement) per hour. Review of the March 2025 nursing progress notes for Resident 3 showed no corresponding note on 03/18/2025 showing assessment of the low output and/or notification to the medial provider of a change in the resident's condition. A progress note dated 03/27/2025 showed the resident's urinary catheter was in place and draining yellow urine with sediment, but no assessment of the low output and/or notification to the medical provider was found. Review of the April 2025 TAR for Resident 3 showed staff did not document urinary output on 6 of 28 opportunities. Additionally, on 04/05/2025 the resident's urinary output was documented at less than 30ml per hour. Review of the April 2025 nursing progress notes for Resident 3 showed no corresponding note on 04/05/2025 showing assessment of the low urinary output and/or notification to the medial provider of a change in the resident's condition. In an interview on 04/151/2025 at 4:36 PM, Staff D reviewed Resident 3's physician orders and TAR and confirmed there were missing entries of the resident's urinary output. At 5:00 PM the same day Staff B stated the facility was aware of concerns related to staff measuring and recording urinary outputs on residents with orders that specified to monitor output amounts. Reference WAC 388-97-1060(3)(c)