

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505289	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Birch Creek Post Acute & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 5601 S Orchard Street Tacoma, WA 98409	

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)
<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>40817</p> <p>Based on interview and record review, the facility failed to resolve grievances brought forward by the resident council (RC) for 2 of 3 months (March and April 2024) when reviewed for resident council. This failure placed the residents at risk of not having group grievances resolved, reduced capacity to provide input to the facility, and a diminished quality of life.</p> <p>Findings included .</p> <p>During an interview on 05/22/2024 at 10:20 AM, the RC stated Staff P, Director of Activities, recorded the RC grievances at each meeting, but the RC did not receive a response back. The RC stated that occasionally a department head would come to RC to respond to a grievance, but this was not routine.</p> <p>Review of RC minutes, dated March 2024, showed grievances related to medical equipment stored on hallways, healthy options in the vending machine, staff use of walkie talkies, meat on no meat days, staff attending RC, and meals not served at scheduled times.</p> <p>Review of the grievance log, dated March 2024, showed one grievance generated from the RC, which was related to meals not served at scheduled times.</p> <p>Review of RC minutes, dated April 2024, showed a section Review Grievances with Done individually if needed, not as a group; follow-up with patients to be done as/if needed individually. Review showed grievances related to residents wanting assistance to go outside, more frequent resident checks from staff, croissants not being croissants, role of social services in the building, concern of scented wipes, and wanting to re-open the dining room.</p> <p>Review of the grievance log, dated April 2024, showed no grievances generated from the RC.</p> <p>During an interview on 05/23/2024 at 11:39 AM, Staff P stated RC grievances were recorded in the RC minutes and followed-up on individually. Staff P stated the RC was aware of the facility response to RC grievances because the RC minutes were printed in the facility activity newsletter. Staff P stated they were unable to provide documentation of an official facility response to the March or April 2024 RC grievances.</p> <p>(continued on next page)</p>

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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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/23/2024 at 11:53 AM, Staff A, Administrator, stated they were the facility's grievance official. Staff A stated RC grievances were logged in the grievance log, discussed at the next daily meeting, were referred to the appropriate department head for follow-up, and would be responded to at the next RC meeting. Staff A stated they were unaware of the all the RC grievances in the RC minutes, and this did not meet expectation.</p> <p>Reference WAC 388-97-0920(1-6)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926</p> <p>Based on interview, observation, and record review, the facility failed to report to the administrator and investigate an allegation of abuse for 1 of 2 sampled residents (Resident 19) reviewed for abuse and neglect. Failure to report alleged abuse and neglect placed the residents at risk for unidentified abuse, mistreatment, and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 19 was admitted to the facility on [DATE] with multiple diagnoses to include high blood pressure, right lower leg fracture, depression, and asthma. Resident 19 was cognitively intact.</p> <p>During an interview on 05/20/2024 at 10:27 AM, Resident 19 stated a couple of days ago a woman came into their room and threw ice water on them. Resident 19 stated they reported it to facility staff.</p> <p>Review of a progress note, dated 05/18/2024, showed Resident 19 was banging on the wall and the resident from the next room came to Resident 19's room. Review showed that there was a verbal altercation between Resident 19 and this resident.</p> <p>During an interview on 05/22/2024 at 10:40 AM, Staff B, Director of Nursing Services, stated they were not aware of any investigations involving Resident 19.</p> <p>During an interview on 05/23/2024 at 9:47 AM, Staff B stated the incident with Resident 19 should have been reported to administration and investigated.</p> <p>Reference WAC 388-97-0640(6)(c)</p>

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344</p> <p>Based on interview and record review, the facility failed to provide written notification of the reason for transfer/discharge to the hospital to the resident or responsible party for 2 of 3 sampled residents (Residents 7 and 69) reviewed for hospitalization . This failure placed the residents at risk for diminished protection from being inappropriately discharged .</p> <p>Findings included .</p> <p>Resident 7</p> <p>Resident 7 admitted to the facility on [DATE] with a recent readmission on 05/20/2024 with multiple diagnoses to include a stroke (lack of blood flow to part of the brain). The discharge minimum data set (MDS), a required assessment tool, dated 05/11/2024, showed Resident 7 was able to make their needs known.</p> <p>Review of Resident 7's MDS tracking record showed Resident 7 discharged to the hospital on 05/11/2024 with return anticipated and readmitted to the facility on [DATE].</p> <p>Review of Resident 7's electronic health record (EHR) showed no documentation that a written notice of transfer/discharge was provided to Resident 7 and/or a responsible party for the transfer to the hospital on 05/11/2024.</p> <p>During an interview on 05/22/2024 at 11:28 AM, Staff B, Director of Nursing Services, stated they provided verbal notification for the transfer to the hospital and did not provide written notification/documentation to the resident or responsible party.</p> <p>Resident 69</p> <p>Resident 69 admitted to the facility on [DATE] with a recent readmission on 01/31/2024 with multiple diagnoses to include a stroke. The discharge MDS, dated [DATE], showed Resident 69 was unable to speak.</p> <p>Review of Resident 69's MDS tracking record showed Resident 69 discharged to the hospital on 01/21/2024 with return anticipated and readmitted to the facility on [DATE].</p> <p>Review of Resident 69's EHR showed no documentation that a written notice of transfer/discharge was provided to Resident 69 and/or a responsible party for the transfer to the hospital on 01/24/2024.</p> <p>During an interview on 05/22/2024 at 11:31 AM, Staff B stated they provided verbal notification for transfer to the hospital and did not provide written notification/documentation to the resident or responsible party.</p> <p>During an interview on 05/23/2024 at 7:00 AM, Staff A, Administrator, stated transfer/discharge information should have been provided to the residents and/or representatives in writing.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Reference WAC 388-87-0120(2)(a-d), -0140 (1)(a)(b)(c)(i-iii)</p>

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<p>F 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344</p> <p>Based on interview and record review, the facility failed to provide a bed hold notice in writing at the time of transfer to the hospital or within 24 hours of transfer to the hospital for 2 of 3 sampled residents (Residents 7 and 69) reviewed for hospitalization . This failure placed the residents at risk for lack of knowledge regarding the right to hold their bed while they were at the hospital and diminished quality of life.</p> <p>Findings included .</p> <p>Resident 7</p> <p>Resident 7 admitted to the facility on [DATE] with a recent readmission on 05/20/2024 with multiple diagnoses to include a stroke (lack of blood flow to part of the brain). The discharge minimum data set (MDS), a required assessment tool, dated 05/11/2024, showed Resident 7 was able to make their needs known.</p> <p>Review of Resident 7's MDS tracking record showed Resident 7 discharged to the hospital on 05/11/2024 with return anticipated and readmitted to the facility on [DATE].</p> <p>Review of Resident 7's electronic health record (EHR) showed no documentation that Resident 7 was offered a bed hold for the transfer/discharge on 05/11/2024.</p> <p>During an interview on 05/22/2024 at 11:04 AM, Staff H, Admissions Director (AD), stated a bed hold was not offered to Resident 7 for the transfer/discharge on 05/11/2024 and should have been.</p> <p>Resident 69</p> <p>Resident 69 admitted to the facility on [DATE] with a recent readmission on 01/31/2024 with multiple diagnoses to include a stroke. The discharge MDS, dated [DATE], showed Resident 69 was unable to speak.</p> <p>Review of Resident 69's MDS tracking record showed Resident 69 discharged to the hospital on 01/21/2024 with return anticipated and readmitted to the facility on [DATE].</p> <p>Review of Resident 69's EHR showed no documentation that Resident 69 or their responsible party was offered a bed hold for the transfer/discharge on 01/24/2024.</p> <p>During an interview on 05/22/2024 at 1:20 AM, Staff H stated they were unable to locate documentation that a bed hold had been offered or provided for Resident 69's discharge on 01/24/2024 and there should have been.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/23/2024 at 7:00 AM, Staff A, Administrator, stated it was the expectation that bed holds be offered at the time of transfer to the hospital and/or the Admissions Director would follow up with the resident or responsible party within 24 hours and the documentation should be in the resident's medical record.</p> <p>Reference WAC 388-97-0120 (4)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148</p> <p>Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards for 1 of 21 sampled residents (Resident 154) reviewed for monitoring. Failure to ensure clinical symptoms for congestive heart failure were monitored and addressed and failure to monitor for adverse side effects of an anticoagulant (AG, blood thinning medication) placed the resident at risk for decreased comfort, poor clinical outcomes, and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of Resident 154's electronic health record (EHR) showed the resident admitted on [DATE] with a diagnoses of congestive heart failure and kidney disease and was receiving an AG medication daily to prevent blood clots.</p> <p>Review of the admission orders, dated 05/13/2024, showed to notify the primary clinician for new onset or worsening lower extremity edema (leg swelling), nighttime dyspnea (difficulty breathing), and to monitor for bleeding.</p> <p>Observation and interview on 05/20/2024 at 11:23 AM showed Resident 154 sat on the side of the bed. They breathed loudly and both hands and feet were swollen. The resident stated they had a hard time sleeping and was taking a water pill but stopped. The resident also stated that they were taking a blood thinner and did have bruising issues but did not have any bruises at that time.</p> <p>Review of the EHR showed no orders to monitor edema/swelling/dyspnea and no orders to monitor for bruising/bleeding. Review showed no care plan entry for congestive heart failure to include interventions related to edema/swelling/dyspnea or care plan entry to monitor for bleeding/bruising related to AG therapy.</p> <p>Observation and interview on 05/21/2024 at 12:28 PM showed Resident 154 sat at the side of the bed. Both hands and both feet appeared swollen. The resident stated the swelling was a little better now than in the morning.</p> <p>Review of the daily skilled documentation dated 05/21/2024 at 12:55 PM showed Resident 154 had no edema in either lower leg.</p> <p>Observation on 05/22/2024 at 11:10 AM showed Resident 154 laid in bed. Both feet appeared more swollen and both hands were swollen. The resident stated the swelling was a little better after laying down than it was that morning.</p> <p>During an interview on 05/22/2024 at 9:29 AM, Staff C, Licensed Practical Nurse/Unit Manager, stated Resident 154 should have care plans related to congestive heart failure and AG therapy to include interventions/orders to monitor for edema, dyspnea, and bruising/bleeding but they had not been entered into the resident's EHR.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/22/2024 at 10:59 AM, Staff B, Director of Nursing Services, stated it was the expectation that residents with congestive heart failure and edema, such as Resident 154, have care plans and orders in place to monitor for worsening symptoms. It was the expectation that residents receiving AG medications be monitored for adverse side effects of the medication.</p> <p>Reference WAC 388-97- 1620(2)(b)(i)(ii),(6)(b)(i)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>34567</p> <p>Based on observation, interview, and record review, the facility failed to ensure hearing aids were implemented and/or provided the necessary auditory (hearing) services in a timely manner for 1 of 3 sampled residents (Resident 33) reviewed for communication/sensory. This failure placed the resident at risk for diminished independence with activities of daily living, unmet needs, and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 33 was admitted to the facility in October 2023. The minimum data set (MDS), a required assessment tool, dated 05/17/2024, showed the resident had moderate difficulty hearing.</p> <p>Review of Resident 33's inventory list showed the resident had hearing aids documented within their possession upon admission in October 2023.</p> <p>Observation and interview on 05/20/2024 at 10:12 AM showed Resident 33 laid in bed without hearing devices in place. When speaking towards Resident 33, the resident responded by yelling, What? What? loudly while leaning forward and angling their ear toward the communication. Resident 33 stated they had hearing aids but did not know where they were after coming to the facility.</p> <p>Review of Resident 33's care plan, dated 10/11/2023, showed the resident had communication problems related to being hard of hearing. No hearing aids were documented to be used in the care plan's interventions but directed staff to raise voice volume during interactions.</p> <p>Review of Resident 33's multidisciplinary care conference notes, dated 04/15/2024, showed documentation that Resident 33 was hard of hearing (HOH); however, no documentation showed that hearing aids or the resident's hearing deficit referral was discussed.</p> <p>During an interview on 05/21/2024 at 1:10 PM, Staff C, Licensed Practical Nurse/Unit Manager (LPN/UM), stated Resident 33 was HOH but had never seen the resident with any hearing aids. Staff C stated that if the resident was HOH, then an audiology (hearing) consult should have been made.</p> <p>Review of the facility's referral binder for the 300/400 wing showed no audiology consult was documented or made for Resident 33.</p> <p>During an interview and observation on 05/21/2024 at 1:27 PM, Resident 33 was asked whether they might know where their hearing aids were located. Resident 33 was then observed to point in the direction of their closet and stated, They may be in a plastic bag in there. Staff E, Certified Nurse Aid (CNA), located a plastic bag in the closet containing the hearing aids.</p> <p>During an interview on 05/21/2024 at 1:36 PM, Staff B, Director of Nursing Services, stated it was their expectation that if Resident 33 was HOH, then staff were directed to ask whether the resident had hearing aids and, if not, referral for an audiology appointment should be made.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567</p> <p>Based on observation, interview, and record review, the facility failed to provide showers as scheduled and/or shaving for 4 of 5 sampled residents (Residents 59, 72, 10, and 22) reviewed for activities of daily living (ADLs, a term used to collectively describe fundamental skills required to care for oneself, such as eating, bathing, grooming, personal hygiene, toileting, and mobility). This failure placed the residents at risk for medical complications, unmet needs, feelings of worthlessness, decreased mood, and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 59</p> <p>Resident 59 was admitted to the facility on [DATE] with diagnoses of depression and anxiety. the quarterly minimum data set (MDS, a required assessment tool), dated 03/09/2024, showed Resident 59 was able to make their needs known and required substantial/maximal assistance with shower/bathing.</p> <p>During an interview on 05/20/2024 at 11:18 AM, Resident 59 stated they should have a shower twice a week but did not receive them consistently.</p> <p>Review of Resident 59's focus care plan, dated 09/07/2022, showed for the resident to receive showers on Tuesday and Friday.</p> <p>Review of the April 2024 and May 2024 shower task sheet showed Resident 59 had received two showers, two partial showers, and refused four times in two months.</p> <p>Resident 72</p> <p>Resident 59 admitted to the facility on [DATE] with diagnoses to included depression. Review of the quarterly MDS, dated [DATE], showed Resident 59 was able to make needs known and require substantial/maximal assistance with shower/bathing.</p> <p>During an interview on 05/20/2024 at 11:47 AM, Resident 72 stated that they were to receive two showers a week, but they received only one shower a week.</p> <p>Review of the April 2024 and May 2024 shower task sheet showed that Resident 72 had received one shower and refused six times in two months.</p> <p>During an interview on 05/21/2024 at 9:51 AM, Staff C, Licensed Practical Nurse/Unit Manager (LPN/UM), stated was their expectation that residents got their showers/baths throughout the week.</p> <p>38344</p> <p>Resident 10</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 10 readmitted to the facility on [DATE] with diagnoses to include heart failure and dementia (impaired ability to remember, think, or make decisions that interfere with doing everyday activities).</p> <p>Multiple observations on 05/20/2024, 05/21/2024, and 05/22/2024 showed Resident 10 with a substantial amount of facial hair.</p> <p>During an interview on 05/20/2024 at 12:10 PM, Resident 10 stated that they would like to have their facial hair removed because they were unable to shave themselves and that they told staff of their request last week. Resident 10 stated they could not recall the last time they had a shower.</p> <p>Review of Resident 10's ADL care plan initiated on 12/18/2018 showed interventions that included to assist with daily hygiene/grooming and to provide shower assistance on the evening shift on Wednesday and Saturday.</p> <p>During an interview on 05/22/2024 at 9:27 AM, Staff J, CNA, stated that Resident 10 asked to be shaved that morning.</p> <p>During an interview and observation on 05/22/2024 at 1:06 PM, Staff K, LPN/RCM, stated Resident 10 had facial hair and asked the resident if they wanted to be shaved and Resident 10 said yes. Staff K stated that residents were usually shaved on shower days. Staff K reviewed Resident 10's electronic health record (EHR) and stated the resident had a bed bath on 05/11/2024 and there were no other bathes or showers documented and there should have been.</p> <p>46148</p> <p>Resident 22</p> <p>Resident 22 admitted to the facility on [DATE] with diagnosis of chronic obstructive pulmonary disease (COPD, a long-term lung disease).</p> <p>Observation on 05/20/2024 at 10:22 AM showed Resident 22 laid in bed with long facial hair and their hair appeared oily.</p> <p>During an interview on 05/20/2024 at 2:30 PM, Collateral Contact 1 stated Resident 22 had not been getting enough showers or being shaven.</p> <p>During an interview on 05/22/2024 at 8:54 AM, Staff F, CNA, stated they had assisted Resident 22 with bathing and that the resident wanted to be shaved but would rather a male caregiver do it.</p> <p>During an interview on 05/22/2024 at 8:50 AM, Staff G, CNA/Bath Aid, stated residents should receive at least two showers/bed baths a week and they should be shaved if needed at that time.</p> <p>Review of Resident 22's shower/bathing documentation showed the resident had received four bed baths in the prior 30 days and no showers.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Birch Creek Post Acute & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 5601 S Orchard Street Tacoma, WA 98409	
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/22/2024 at 10:49 AM, Staff B, Director of Nursing Services, stated it was their expectation that residents be offered assistance with bathing and shaving twice a week, or more if needed, and once a week shower was not enough. Staff B stated that Resident 22 should have been offered to be shaved by a male caregiver.</p> <p>Reference WAC 388-97-1060 (2)(c)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344</p> <p>Based on observation, interview, and record review, the facility failed to provide oxygen therapy per provider orders and/or ensure oxygen tubing was dated and regularly changed for 2 of 2 sampled residents (Residents 41 and 22) reviewed for respiratory care. These failures placed residents at risk for unmet care needs, medical complications, and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 41</p> <p>Resident 41 admitted to the facility on [DATE] with multiple diagnoses to include chronic obstructive pulmonary disease (COPD, causes restricted airflow and breathing problems) and cancer (a disease in which abnormal cells divide uncontrollably and destroy body tissue) in part of the lung (organ to help one breath) or bronchus (passageway into the lungs).</p> <p>Observations on 05/20/2024, 05/21/2024, and 05/22/2024 showed Resident 41 had an oxygen machine with a prefilled humidifier container (used to humidify the oxygen) at the bedside set to deliver four liters per minute of oxygen to the resident through an attached oxygen tube with a nasal cannula (device to deliver oxygen through the nose) in place. The tubing and the humidifier were not dated.</p> <p>Review of the provider order, dated 05/15/2023, showed Resident 41 was prescribed continuous oxygen to be delivered at three liters via nasal cannula.</p> <p>Review of Resident 41's medication administration record (MAR) showed no documentation that oxygen was being administered as ordered by the provider, nor documentation related to care of the oxygen equipment such as changing and dating the oxygen tubing. It showed no provider order for the use of a prefilled humidifier.</p> <p>During an interview and observation on 05/22/2024 at 4:18 PM, Staff K, Licensed Practical Nurse/Unit Manager, stated Resident 41 had oxygen being delivered with a prefilled humidifier at four liters per minute via a nasal cannula. Staff K stated the tubing and humidifier were not dated and should have been. Staff K informed Resident 41 that their oxygen was at four liters and Resident 41 stated a nurse had increased the oxygen when they were having problems breathing but it should now be on three liters because they were breathing fine. Staff K stated there was no order for the use of the humidifier and that oxygen should not be administered at four liters without a provider's order. Staff K stated there was no documentation in Resident 41's May 2024 MAR or treatment administration record (TAR) to show that the resident was being provided oxygen as ordered by the provider and this did not meet expectations.</p> <p>During an interview on 05/22/2024 at 4:42 PM, Staff B, Director of Nursing Services (DNS), stated nurses were to document on the MAR or TAR when administering oxygen as ordered by the provider and there should be an order for a humidifier when being used continuously. Staff B stated that oxygen equipment, such as tubing and humidifiers, should be dated, and provider's oxygen orders followed. Staff B stated that Resident 41's oxygen therapy/services and documentation did not meet expectations.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>46148</p> <p>Resident 22</p> <p>Resident 22 admitted to the facility on [DATE] and was placed on hospice on 05/10/2024 with diagnosis of COPD.</p> <p>Review of the electronic health record (EHR) showed Resident 22 was receiving oxygen therapy at two liters per minute through a nasal canula and frequently removed the tubing from their nose. No documentation related to care of the oxygen equipment such as changing the tubing was included.</p> <p>Observation on 05/20/2024 at 10:30 AM showed Resident 22 laid in bed with an oxygen machine at the bedside set to deliver two liters per minute of oxygen. The tubing was not dated and was laying on the floor next to the bed.</p> <p>During an interview on 05/22/2024 at 9:28 AM, Staff B, DNS, stated that it was their expectation that oxygen tubing be changed, and the tubing dated weekly and there should be an order in the residents' EHR, but this had not been done recently and should have been.</p> <p>Reference WAC 388-97-1060 (3)(j)(vi)</p>

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<p>F 0755</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>38344</p> <p>Based on observation, interview, and record review, the facility failed to consistently reconcile controlled medications in 3 of 3 medication carts (Medication Carts 400, 100, and 300) reviewed for medication storage. This failure placed residents at risk for misappropriation of their medications and the facility at risk for diversion of controlled medications.</p> <p>Findings included .</p> <p>Observation and interview on 05/22/2024 at 3:18 PM showed the 400-hall medication cart's-controlled substance books number II and III/IV signed shift audit records pages dated May 2024 had no signatures to show the count was reconciled by the nurses at change of shift on 05/22/2024. Staff L, Registered Nurse/Agency Staff (RN/AS), stated they had counted the scheduled medications with the off going nurse at change of shift; however, both had not signed the books and should have. Staff L stated there were several dates missing documentation in the May 2024 shift audit records in both books and there should not have been.</p> <p>Observation and interview on 05/23/2024 at 7:50 AM showed the 100-hall medication cart's-controlled substance books number II and IV signed shift audit records pages dated May 2024 had missing signatures. Staff M, Licensed Practical Nurse/AS (LPN/AS), stated they had counted and signed with the off going nurse at change of shift; however, they noted there was missing documentation in the May 2024 shift audit records signature pages in both books.</p> <p>Observation and interview on 05/23/2024 at 8:45 AM showed the 300-hall medication cart's-controlled substance books number C/2 and IV signed shift audit records pages dated May 2024 had missing signatures. Staff N, LPN, stated there were missing signatures/documentation in both controlled substance books shift audit records and there should not be.</p> <p>During an interview on 05/23/2024 at 11:02 AM, Staff B, Director of Nursing Services, stated at every change of shift the oncoming nurse and the off going nurse should count the scheduled medications and document/sign the shift audit record in the controlled substance books in each medication cart. Staff B stated there were missing signatures/documentation in the 100, 300, and 400 controlled substance books shift audit records, and this did not meet expectations.</p> <p>Reference WAC 388-97-(1)(a)(ii) (b)(ii),(c)(ii-iv)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344</p> <p>Based on interview and record review, the facility failed to act on and/or consistently follow the consultant pharmacist's medication regimen review (MRR) recommendations in a timely manner for 3 of 5 sampled residents (Resident 20, 22, and 11) reviewed for unnecessary medication use. These failures placed the residents at risk for experiencing adverse side effects, medical complications, and a decreased quality of life.</p> <p>Findings included .</p> <p>Resident 20</p> <p>Resident 20 admitted to the facility on [DATE] with diagnoses to include coronary artery disease (damage or disease in the heart's major blood vessels) and Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors).</p> <p>Review of Resident 20's pharmacist recommendation dated 01/25/2024 showed a recommendation that if indicated and congruent with goals of therapy, consider starting Eliquis (blood thinner) medication after obtaining a weight and if weight was greater than 60 kilograms (kg) start 5 milligrams (mg) twice a day and if weight was less than 60 kg, start 2.5 mg twice a day.</p> <p>Review of Resident 20's electronic health record (EHR) showed no documentation of the physician/prescriber response to the 01/25/2024 pharmacist MRR recommendations or an order for Eliquis.</p> <p>Review of Resident 20's pharmacist recommendation dated 02/25/2024 showed a recommendation that if indicated and congruent with goals of therapy, consider starting Eliquis at 5 mg twice a day and to consider decreasing escitalopram (antidepressant medication) back down to 10 mg daily. It showed the physician/prescriber response dated 03/15/2024 of the rationale why the provider disagreed with prescribing Eliquis; however, they agreed to decreasing the escitalopram to 10 mg.</p> <p>Review of Resident 20's pharmacist recommendation dated 04/26/2024 showed a recommendation to confirm a diagnosis for use of Combivent Respimat inhaler (used to treat wheezing and shortness of breath), or if not available to change Combivent to one puff every four hours as needed (max six puffs daily) and to consider changing to a combination inhaler if needing maintenance treatment. The physician/prescriber response dated 05/08/2024 showed that the provider agreed with the recommendations.</p> <p>Review of Resident 20's EHR showed lack of documentation to ensure pharmacist's recommendations on 01/25/2024, 02/25/2024, and 04/26/2024, were implemented and/or implemented timely.</p> <p>During an interview on 05/22/2024 at 3:44 PM, Staff B, Director of Nursing Services (DNS), stated the following:</p> <p>-MRR dated 01/25/2024: Resident 20's weight was not obtained until 02/06/2024 and they were unable to locate follow-up documentation by the provider and there should have been.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-MRR dated 02/25/2024: The escitalopram dose was not decreased to 10 mg until 03/27/2024 and it should have been done sooner.</p> <p>-MRR dated 04/26/2024: Unable to find documentation that a diagnosis was confirmed, and medication changes were not implemented per recommendations, and this did not meet expectations.</p> <p>46148</p> <p>Resident 22</p> <p>Resident 22 was admitted to the facility on [DATE] with diagnosis of chronic obstructive pulmonary disease (COPD, a long-term lung disease).</p> <p>Review of Resident 22's EHR showed the resident was receiving a budesonide inhalation twice a day with a start date of 03/23/2024.</p> <p>Review of the pharmacy recommendation dated 04/26/2024 for Resident 22 showed a recommendation to add directions to rinse mouth after using budesonide nebulizer.</p> <p>Review on 05/22/2024 of Resident 22's EHR showed the order for budesonide inhalation had not been updated with the pharmacy recommendation.</p> <p>During an interview on 05/22/2024 at 3:44 PM, Staff C, LPN/UM, stated Resident 22's pharmacy recommendations should have been given to the unit manager and/or the medical provider for follow up but the system isn't really working right now.</p> <p>49926</p> <p>Resident 11</p> <p>Resident 11 was admitted to the facility on [DATE] with multiple diagnoses to include heart failure and depression.</p> <p>Review of the pharmacy recommendations from 04/24/2024 showed a recommendation to decrease levothyroxine (medication to treat abnormal thyroid function) to 75 micrograms (mcg) daily.</p> <p>Review of Resident 11's provider's order, dated 08/20/2023, showed levothyroxine 88 mcg daily.</p> <p>During an interview on 05/22/2024 at 1:40 PM, Staff B stated they could not locate follow-up regarding April 2024's pharmacy recommendations.</p> <p>Reference WAC 388-97-1300(4)(c)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344</p> <p>Based on interview and record review, the facility failed to ensure freedom from unnecessary medications for 3 of 7 sampled residents (Residents 20, 22, and 154) when reviewed for unnecessary medications and/or anticoagulant (blood thinner) medication use. The facility failed to monitor Resident 20's blood pressure (BP) and heart rate/pulse and follow parameters prior to giving medications; failed to ensure Residents 20 and 22 were provided non-pharmacological (NPI, non-medication) interventions prior to the use of as needed (PRN) pain medications; and monitor Resident 154's blood thinner medication side effects. These failures placed residents at risk of taking unnecessary medications, avoidable medication side effects, and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 20</p> <p>Resident 20 admitted to the facility on [DATE] with diagnoses to include coronary artery disease (damage or disease in the heart's major blood vessels), high blood pressure (the pressure of circulating blood against the walls of the blood vessels), and dementia (impaired ability to remember, think, or make decisions that interfere with doing everyday activities).</p> <p>Review of Resident 20's May 2024 medication administration records (MAR), dated 05/01/2024 through 05/22/2024, showed the resident was prescribed the following medications (used to treat high BP or heart failure) that required monitoring and following ordered parameters for BP and/or heart rate/pulse prior to being provided the medications:</p> <p>-Order with a start date of 11/03/2023 for Losartan Potassium 25 milligrams (mg) one time a day for high BP and give in addition to the 50 mg dose, hold for systolic BP less than 110 and pulse less than 55 and notify provider. Documentation on 05/04/2024 at 8:00 AM showed, NA, instead of a systolic BP result and on 05/15/2024 the systolic BP was 106/56 (below parameters); however, the medication was provided.</p> <p>- Order with a start date of 07/26/2023 for Losartan Potassium 50 mg one time a day, hold for systolic BP below 100. Documentation showed multiple NA results instead of a systolic BP result.</p> <p>-Order with a start date of 07/26/2023 for Carvedilol two times a day, hold for a systolic BP below 100 or pulse below 55. Documentation showed multiple NA results instead of a systolic BP or heart rate/pulse result.</p> <p>Continued review of the May 2024 MAR showed Resident 20 was provided PRN acetaminophen (used to treat mild to moderate pain) on 05/18/2024; however, there was no documentation that NPI were offered or provided prior to being given the medication.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/22/2024 at 12:46 PM, Staff K, Licensed Practical Nurse/Unit Manager (LPN/UM), stated Resident 20 should not have been provided Losartan Potassium 25 mg on 05/04/2024 due to BP was not within ordered parameters, the provider should have been notified, and that did not happen for Resident 20. Staff K stated the MAR had multiple NA, documented instead of required BP or heart rate results and this did not meet expectations.</p> <p>During an interview on 05/21/2024 at 1:16 PM, Staff B, Director of Nursing Services (DNS), stated that NPI should be offered/provided prior to administering PRN pain medications. Staff B stated provider orders should be followed and Resident 20's May 2024 MAR documentation did not meet expectations.</p> <p>46148</p> <p>Resident 22</p> <p>Review of Resident 22's EHR showed the resident admitted on [DATE] and was placed on hospice on 05/10/2024 with a diagnosis of chronic obstructive pulmonary disease (COPD, a long term lung disease) and was receiving liquid oxycodone (a narcotic pain medication) PRN for pain and difficulty breathing.</p> <p>Review of the medication administration record, dated 05/10/2024 through 05/22/2024, showed the resident received oxycodone one to four times a day. There was no documentation found in the EHR that NPI were attempted prior to administration.</p> <p>During an interview on 05/22/2024 at 9:20 AM, Staff C, Licensed Practical Nurse/Unit Manager, stated that nonpharmacological interventions should have been attempted and documented in the medical record for Resident 22.</p> <p>During an interview on 05/22/2025 at 10:56 AM, Staff B stated that it was the expectation that NPI for pain relief were offered prior to administering PRN narcotic pain medications and documented in the EHR for Resident 22.</p> <p>Resident 154</p> <p>Review of Resident 154's EHR showed the resident admitted on [DATE] with diagnoses of congestive heart failure and kidney disease and was receiving an anticoagulant (blood thinning) medication daily to prevent blood clots. There was no documentation found in the EHR that the resident was being monitored for adverse side effects such as abnormal bleeding.</p> <p>During an interview on 05/22/2024 at 9:20 AM, Staff C stated that residents who were prescribed anticoagulant medications should be monitored for adverse side effects.</p> <p>During an interview on 05/22/2024 at 10:56 AM, Staff B stated that it was the expectation that Resident 154 be monitored for adverse side effects when taking anticoagulant medications.</p> <p>Reference WAC 388-97-1060 (3)(k)(i)</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p>34567</p> <p>Based on observation, interview, and record review, the facility failed to provide dental services for 2 of 3 sampled residents (Resident 33 and 204) reviewed for dental services. This failure placed the resident at risk of difficulty eating, unmet needs and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 33</p> <p>Observation and interview on 05/20/2024 at 10:12 AM showed Resident 33 had a small plastic denture cup on a bedside table that contained one upper denture. Resident 33 stated that they could not wear it because they were too loose and they needed denture adhesive to secure them better but was not provided any during their stay at the facility.</p> <p>Review of Resident 33's focus care plan dated 11/06/2023 showed the resident had oral/dental health problems related to poor repair and the resident had full top dentures. Interventions included for staff to monitor, document and report, when necessary, any signs or symptoms of oral dental problems that needed attention. Staff were required to provide mouth care as per activities of daily living (ADLs) personal hygiene.</p> <p>Observation on 05/21/2024 at 1:25 PM showed Resident 33 was not wearing their upper dentures.</p> <p>Review of a provider's order dated 05/14/2024 showed an order for Dental as needed.</p> <p>During an interview on 05/21/2024 at 1:28 PM, Staff E, Certified Nurse Aide (CNA), stated they were unaware Resident 33 needed any adhesive to secure their dentures.</p> <p>During an interview on 05/21/2024 at 1:30 PM, Staff C, Licensed Practical Nurse/Unit Manager, stated they were unaware Resident 33 had any loose dentures or in need of any dental care.</p> <p>During an interview on 05/21/2024 at 1:48 PM, Staff B, Director of Nursing Services, stated it was their expectation Resident 33 received needed dental care and/or denture adhesive to better secure the upper dentures.</p> <p>Resident 204</p> <p>Observation and interview on 05/20/2024 at 12:35 PM showed Resident 204 had multiple missing, cracked, or jagged teeth. Resident 204 stated they had not seen a dentist and was unaware whether they had any dental consult pending.</p> <p>Review of a provider's order dated 05/14/2024 showed an order for Dental consult and care as needed.</p> <p>(continued on next page)</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/21/2024 at 1:06 PM, Staff C stated Resident 204 had a standing order to see the dentist and if the resident had dental needs, then they were supposed to be placed into the referral binder for a consult. Staff C stated Resident 204's name had not been placed into the referral binder.</p> <p>During an interview on 05/21/2024 at 1:46 PM, Staff B stated it was their expectation that Resident 204 received needed dental care, especially if the resident had broken, loose, or cracked teeth upon admission.</p> <p>Reference WAC 388-97-1060 (2)(c), (3)(j)(vii)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817</p> <p>Based on observation, interview, and record review, the facility failed to follow therapeutic diets for 3 of 5 sampled residents (Residents 153, 79, and 92) when reviewed for kitchen. This failure placed residents at risk of choking, increased blood pressure, avoidable injury, and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 153</p> <p>Review of Resident 153's electronic health record (EHR) showed they admitted on [DATE], had a diagnosis of dysphagia (problems with using the mouth, lips and tongue to control food or liquid) and had a diet order for soft and bite sized food.</p> <p>Observation and interview on 05/22/2024 at 11:48 AM showed Staff Q, Certified Nursing Aid (CNA), served a whole hamburger to Resident 153. Staff Q stated Resident 153 was served a whole hamburger, Resident 153's tray card showed to serve soft and bite sized foods, and that a whole hamburger was soft and bite sized.</p> <p>Resident 92</p> <p>Review of Resident 92's EHR showed they admitted on [DATE], had a diagnosis of dysphagia and had a diet order for no added salt.</p> <p>Observation and interview on 05/22/2024 at 11:48 AM showed Staff Q served a meal tray with a salt packet to Resident 92. Staff Q stated Resident 92 was served a meal tray with a salt packet, and Resident 92's tray card showed no added salt.</p> <p>Resident 79</p> <p>Review of Resident 79's EHR showed they admitted on [DATE], had a diagnosis of dysphagia and had a diet order for no added salt.</p> <p>Observation and interview on 05/22/2024 at 1:13 PM showed Staff R, CNA, served a meal tray with a salt packet to Resident 79. Staff R stated Resident 79 was served a meal tray with a salt packet, and Resident 79's tray card showed no added salt.</p> <p>During an interview on 05/23/2024 at 10:02 AM, Staff T, Dietary Manager, stated therapeutic diets were printed on the tray cards and should always be followed.</p> <p>During an interview on 05/23/2024 at 10:16 AM, Staff S, Registered Dietician, stated residents should always receive therapeutic diets as ordered. Staff S stated Resident 153 should not have received a whole hamburger and Residents 92 and 79 should not have had salt packets on their trays.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505289	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/23/2024 at 11:11 AM, Staff A, Administrator, stated that therapeutic diets should always be provided as ordered and Residents 153, 92, and 79 did not meet expectation.</p> <p>Reference WAC 388-97-1120 (2)(a), -1100(1), -1140 (6)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>34567</p> <p>Based on observation, interview, and record review the facility failed to ensure an effective infection prevention and control program was in place to prevent the transmission of communicable diseases and infections by completing the collection and analyzation of infection control data, identifying trends, and completing follow-up activities in response to those trends for 4 of 4 months (January, February, March, and April 2024) when reviewed for infection control. The facility failed to ensure the laundry/linen storage room had defined separation between dirty/contaminated waste and clean linen. These failures placed residents and staff at risk for communicable diseases and infections, poor clinical outcomes, cross-contamination, and a decreased quality of life.</p> <p>Findings included .</p> <p><Tracking and Trending></p> <p>Review of the facility policy titled Infection Control Program, revised 10/24/2022, showed the infection preventionist was responsible for gathering and interpreting surveillance data. The data collection and recording included identification of the pathogens (a microorganism that causes, or can cause, disease) and enacting treatment measure and precautions (interventions and steps taken that may reduce the risk). The infection control preventionist (ICP) was responsible for interpreting surveillance data and would analyze the data to identify trends and compare the rates to previous months in the current year and to the same month in the previous years to identify seasonal trends.</p> <p>Review of the facility's monthly infection surveillance log from January to April 2024 showed multiple skin/wounds, either community or facility acquired, that were being documented as being a prevalent trend related to infection control concerns at the facility. These infections were being documented on the log; however, the ICP did not document any analysis or implement potential corrective/preventive actions to address these issues. The facility's infection control log had multiple entries that did not identify the infectious organism.</p> <p>During an interview on 05/23/2024 at 12:46 PM, Staff D, ICP, stated their expectation was to follow up the resident's culture and sensitivity (C&S) to identify the organism, but this was not always accomplished. Staff D stated they did not have computer access to the laboratory information from one local medical center that the residents were admitted from, so Staff D did not have the information available to document. Staff D stated they did not implement interventions or address the identified trends but should have.</p> <p><Laundry Room: Safe and Sanitary Storage></p> <p>Review of the facility policy titled, Prevention of Infection- Laundry and Linen, dated 10/01/2021 showed that the facility would store the clean linen in a separate location from soiled linen and other contaminants. Nothing should be stored in that space except for clean linen.</p> <p>Observation on 05/23/2024 at 9:48 AM showed a room within the laundry room which contained a shelf with clean linens next to two large red plastic biohazard storage bins and full biohazard needle containers (approximately two feet apart).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/23/2024 at 9:50 AM, Staff O, Housekeeping Supervisor, stated the biohazard bins and used needle containers were moved to the linen room by maintenance due to lack of space elsewhere.</p> <p>During an interview on 05/23/2024 at 9:55 AM, Staff O and Staff D stated the biohazard bins and medical waste needle boxes should not be stored next to the resident's clean linen.</p> <p>During an interview on 05/23/2024 at 11:22 AM, Staff B, Director of Nursing Services, stated it was their expectation that staff would not store the resident's clean linen within a room that also stored biohazard waste. Staff B stated their expectation was that that the ICP document their analysis of the facility's monthly infection control program summary.</p> <p>Reference WAC 388-97 -1320 (2)(a)(b)(c)</p>		