STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505303	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Omak	901 Shumway Rd Omak, WA 98841

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 42802 Based on interview and record review, the facility failed to honor a resident's right to refuse care for 1 of 3 residents (1) investigated for abuse. two staff members insisted that a resident have a shower, despite their initial refusal. This failure placed the resident at risk for feelings of disrespect and decreased self-worth. Findings included . According to an admission assessment, dated 03/04/2024, Resident 1 had diagnoses which included a fractured pelvis and arthritis. The assessment further showed that the resident was able to understand, be understood and required assistance with bathing. A progress note from the social worker, dated 05/30/2024 at 1:43 PM, documented that the resident said they were forced to take a shower on 05/27/2024 and the aides said they smelled like a dog. The nursing assistants identified were immediately suspended, left the facility and appropriate notifications were made. The facility conducted a thorough investigation. A review of Resident 1's Bathing/Shower task in their medical record documented they did have a shower on 05/27/2024. The facility investigation, completed on 05/31/2024, documented that Staff C, Nursing Assistant (NA) and Staff D, NA, did push Resident 1 to take a shower, despite an initial refusal. The investigation further documented Resident 1's roommate overheard an aide say that if the resident didn't shower, they would smell like a wet dog. Resident 1 then got into the shower chair, and allowed Staff C to give the shower, while Staff D stayed in the resident room and changed the bed linens. Staff E, NA was called into the shower room to assist Staff C, if needed. During an interview on 06/12/2024 at 12:30 PM, Resident 1 stated that they were pushed into taking a shower that time, but had not had any more incidents. Resident 1 further stated that the issue was over, and they felt safe with the caregivers. During an interview on 06/12/2024 at 1:45 PM, Staff E, NA stated that if a resident refused care, they checked back later or requested that another staff member offer. If the resident still declined, they should let the nurse know. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked about the incident with Resident 1, Staff E said that they had been called into the shower room in case Staff C needed help. Staff E further stated that Resident 1 did seem kind of mad, but did not say no and let Staff E help them undress for the shower. Staff E was not aware that the resident had refused the shower in their room. During an interview on 06/12/2024 at 2:00 PM, Staff F, NA, stated that a resident refused care, they would ask again later. Staff F further stated they would try to offer a bed bath, but could not force the resident. During an interview on 06/12/2024 at 2:11 PM, Staff G, Licensed Practical Nurse, stated that they would try to determine why a resident refused care, would offer again and let nursing management know of any refusals. During an interview on 06/12/2024 at 2:18 PM, Staff H, NA, stated they handled refusals of care by reapproaching later. Staff H further stated they encouraged residents to accept care, but could not make them. During an interview on 06/12/2024 at 2:30 PM, Staff B, Director of Nursing, acknowledged that Staff C and Staff D violated Resident 1's rights, and this was failed practice. Reference: WAC 388-97-0180(1-4)