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	03/03/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45433 Based on interview and record review, the facility failed to implement care planned interventions related to monitoring during a viral infection for 2 of 3 residents (1 and 2) whose care plans were reviewed. This failure put the residents at risk for worsening of their condition and unmet care needs. Findings included . <Resident 1> Review of Resident 1's medical record showed they tested positive for influenza on 02/19/2025. Review of the resident's care plan showed that on 02/19/2025 a new focus was added for risk of infection due to Influenza. New interventions for the focus included: assess lung sounds, assess sputum or other respiratory discharge, check vital signs and monitor for abnormalities. Review of Resident 1's February 2025 medication administration record (MAR) showed they were administered an antiviral medication from 02/20/2025 through 02/24/2025, for a total of ten doses. Further review of the same MAR did not show orders, or a place to record, the resident's lung sounds, sputum or other respiratory discharge, or when or how often to monitor the resident's vital signs. Review of the vital sign section of Resident 1's chart showed sporadic vital signs recorded. The Resident's oxygen level, pulse, respiration per minute and blood pressure were all recorded on 02/21/2025. The Resident's temperature was recorded on 02/19/2025 at 1:19 AM, again at 5:03 AM and again at 10:42 PM. The next temperature was recorded on 02/21/2025 at 1:31 PM. Review of the progress note section of Resident 1's chart did not show nurse notes with any further vital signs, assessment of lung sounds or sputum from 02/19/2025 through 02/24/2025. <Resident 2> Review of Resident 2's medical record showed they tested positive for influenza on 02/19/2025. Review of the resident's care plan showed that on 02/19/2025 a new focus was added for risk of infection due to Influenza. New interventions for the focus included: assess lung sounds, assess sputum or other respiratory discharge, check vital signs and monitor for abnormalities. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's February 2025 medication administration record (MAR) showed they were administered an antiviral medication from 02/20/2025 through 02/24/2025, for a total of ten doses. Further review of the same MAR did not show orders, or a place to record, the resident's lung sounds, sputum or other respiratory discharge, or when or how often to monitor the resident's vital signs. Review of the vital sign section of Resident 1's chart showed sporadic vital signs recorded. The Resident's oxygen level, pulse, respiration per minute, blood pressure and temperature were all recorded on 02/20/2025, 02/21/2025 and 02/22/2025. The Resident's temperature was recorded on 02/24/2025. Review of the progress note section of Resident 1's chart did not show nurse notes with any further vital signs, assessment of lung sounds or sputum from 02/19/2025 through 02/24/2025. During an interview on 03/03/2025 at 2:55 PM, Staff C, Nursing Assistant, stated that the nursing assistants collect the resident vital signs during their shift. They stated that the nurse on each shift filled out a form with a list of names, times, and what vital signs needed to be collected, they then attach the form to a clipboard and leave it in a specified area. Staff C further stated that when the vital signs were recorded the Nursing Assistant would leave the clipboard with the nurse and the nurse would then enter the information into each resident record. During an interview on 03/03/2025 at 3:08 PM Staff B, Resident Care Manager, stated that each resident who had a viral infection should have orders on their MAR for vital signs to include which vital signs and how often to collect them. They stated there should also be a place to record the nurse assessment of the resident's lung sounds and sputum, quality and quantity, or if there was none present. They stated that for residents who took an antiviral, the nursing staff would monitor for the length of time the resident took the antiviral and longer if needed. They further stated that they were not aware of a standard process in the facility for how long to monitor the resident and where/when to put the orders for vital sign monitoring or lung assessment. During an interview on 03/03/2025 at 3:32 PM, Staff A, Administrator, stated that they had confirmed with Staff B, that the nurse would fill out a vital sign sheet with who needed vitals and when, and the nurse would get that information from the resident's medical record. They further confirmed that the facility did not keep the paper sheets where the vital signs were recorded and that there was not another location the staff recorded vital signs or the assessment of lung sounds. Reference WAC 388-97-1020(1), (2)(a)(b)