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	10/11/2024

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

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 37544 Based on interview and record review, the facility failed to ensure 3 of 5 sampled residents (Resident 2, 26, and 14), reviewed for unnecessary medications, were informed of the potential risks associated with the use of psychotropic medications (medications that can affect the mind, emotions, and behaviors). This failure placed the residents and/or their representative at risk of not being fully informed of the potential risks and benefits of taking the medications. Findings included <Resident 2> The 08/06/2024 quarterly assessment documented Resident 2 had diagnoses which included anxiety and depression. In addition, the assessment documented the resident received psychotropic medication. Review of the Order Summary Report from 01/01/2024 through 10/09/2024 documented on 05/10/2024, the physician had prescribed a psychotropic medication, Fluoxetine, to treat Resident 2's depression. Review of the Medication Administration Records (MARS) from May 2024 through September 2024 showed the resident had received Fluoxetine daily as prescribed. Review of Resident 2's record found no documentation and/or an informed consent form had been completed that explained the risks and benefits of taking a psychotropic medication were discussed, either verbally or written, with the resident and/or their representative prior to the resident receiving the medication. <Resident 26> The 07/23/2024 annual assessment documented Resident 26 had diagnoses which included anxiety, depression, and obsessive-compulsive disorder, a mental disorder that caused recurrent, unwanted thoughts and repetitive behaviors that can not be controlled. The assessment further showed Resident 26 received psychotropic medication. Review of the Order Summary Report from 07/01/2023 through 10/10/2024 documented on 05/24/2024, the physician prescribed a psychotropic medication, Olanzapine, to help treat the symptoms of Resident 26's anxiety and depression. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the May through September 2024 Medication Administration Records (MARS) showed Resident 26 received the Olanzapine daily as prescribed. Review of Resident 26's found an informed that included the risk and benefits of taking Olanzapine had been completed on 05/29/2024, four days after the resident received the first dose of the medication. In an interview on 10/10/2024 at 11:40 AM with Staff A, Administrator and Staff B, Regional [NAME] President, Staff B stated it was the expectation that informed consents were obtained before the first dose was given to the resident. When informed no informed consent was found for Fluoxetine for Resident 2, and the informed consent for Resident 26's Olanzapine had been obtained four days after the medication had been given, Staff B stated they would follow up with Medical Records to see if the informed consents had been obtained. In a follow up interview at 1:23 PM, Staff B confirmed no informed consent had been obtained for the Fluoxetine, and the informed consent for the Olanzapine had not been obtained prior to the first dose being given. 40297 <Resident 14> Review of Resident 14's medical record showed the provider ordered sertraline, an antidepressant, on 02/01/2024, for depression. Review of Social Services assessments dated 04/18/2024, 07/11/2024, and 10/04/2024, showed Resident 14 received sertraline for insomnia. Review of Medication Administration Records from February to October 2024 showed the staff administered sertraline to Resident 14 daily. Record review showed no documentation the staff provided and obtained informed consent for the sertraline. In an interview on 10/09/2024 at 10:25 AM, Staff D, Social Services Director, stated that the Resident Care Managers were responsible for obtaining consents for psychotropic mediations prior to administration. Staff D acknowledged there was no consent for sertraline in Resident 14's medical record. Reference WAC 388-97--0300(3)(a), -0260, -1020(4)(a-b).

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 40297 Based on interview and record review, the facility failed to identify what information was conveyed to the hospital at the time of transfer for 1 of 2 sampled residents (Resident 34) reviewed for hospitalization s. This failure placed the resident at risk for a disruptive and ineffective transition from the facility to the hospital setting. Findings included . <Resident 34> Review of 03/17/2024 progress notes showed Resident 34 experienced a change in condition and the staff called the on-call provider who recommended Resident 34 go to the emergency room for an evaluation. Review of Resident 34's medical record showed no documentation the facility communicated to the hospital the minimum required information at the time of the Resident 34's transfer on 03/17/2024, including: The basis for the transfer, the specific resident need(s) that could not be met, facility attempts to meet the resident needs, or the information provided to the receiving facility to include contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, Advance Directive information, all special instructions or precautions for ongoing care as appropriate, comprehensive care plan goals, and all other necessary information, including a copy of the resident's discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care. Review of 05/20/2024 and 07/06/2024 progress notes showed Resident 34 experienced a change in condition and the staff transferred the resident to the hospital for emergency care or evaluation. Review of Resident 34's medical record showed no documentation the facility communicated to the hospital the minimum required information at the time of the Resident 34's transfers on 05/20/2024 or 07/06/2024. In an interview with Staff B, Director of Nursing, and Staff E, Corporate Nurse, on 10/10/24 at 11:53 AM. Staff B stated that when a resident is transferred to the hospital, the nurses send with the resident a little discharge packet found at the Nurses Station. Staff B stated the packet has a checklist of what information the staff must send with the resident to the hospital when a change in condition occurs. Staff B stated the nurses also complete a Transfer to Hospital evaluation in resident's electronic medical record which is then forwarded to the receiving hospital. The Transfer to Hospital evaluation shows the resident's vital signs, allergies, reason for transfer, type of assistance or other care information required. The Transfer to Hospital Evaluation provided the staff the opportunity to show if other additional information, like a resident's face sheet, medication list, and a copy of the POLST [Physician Order for Life Sustaining Treatment], was sent. Staff B and E confirmed and acknowledged that the medical record failed to show the minimum required information the staff conveyed to the hospital at the time of Resident 34's transfers. Staff B stated, I don't see what information was sent to the hospital. Reference WAC 388-97-0120.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 40297 Based on interview and record review, the facility failed to ensure it completed a notice of bed hold for 1 of 2 (Resident 34) sampled residents reviewed for hospitalization . This failure placed the resident and/or their representative at risk for a lack of knowledge regarding their right to hold their bed while in the hospital. Findings included . <Resident 34> Review of the progress notes showed that on 03/17/2024, 05/20/2024, and 07/06/2024, Resident 34 experienced a change in condition and the staff transferred the resident to the local hospital for emergency care. Record review showed no documentation the facility offered Resident 34 and/or their representative a notice of bed hold at the time of or shortly after the hospital transfers for 03/17/2024 and 05/20/2024. In an interview with Staff B, Director of Nursing, and Staff E, Corporate Nurse, on 10/10/24 at 11:53 AM. Staff E confirmed via record review that the facility did not but should have offered the notice of bed hold to Resident 34 and/or their representative at the time of the hospital transfer and stated, I didn't see it. Reference WAC 388-97-0120 (4).

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 37544 Based on interview and record review, the facility failed to ensure 1 of 5 sampled residents (Resident 26), reviewed for Pre-Admission Screening and Resident Review (PASARR) [an assessment completed prior to admission into a skilled nursing facility to determine whether a resident with a diagnosis of a serious mental illness needed specialized mental health services] was completed accurately and if indicated, a referral for additional screening had been made. Findings included . <Resident 26> The 07/23/2024 annual assessment documented Resident 26 had diagnoses which included anxiety, depression, and obsessive-compulsive disorder, a mental disorder that caused recurrent, unwanted thoughts and repetitive uncontrollable behaviors. Review of Resident 26's record showed a PASARR level 1 was initiated on 07/06/2024, but the form was incompletely filled out, with Section IV of the form being blank. Additional record review found no other documentation that showed a fully completed PASARR had been done. In an interview on 10/10/2024 at 10:10 AM, Staff D, Social Service Director, stated a PASARR needed to be completed prior to admission, and after review of Resident 26's record, confirmed the PASARR had not been fully completed. Reference (WAC): 388-97-1915 (1)(2)(a-c)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to ensure an adequate indication for the use of an antidepressant for 1 of 5 sampled residents (Resident 14) reviewed for unnecessary medications. This failure placed the resident at risk to receive unnecessary medications and/or experience adverse side effects. Findings included . <Resident 14> Review of a 07/21/2024 annual assessment showed Resident 14 admitted to the facility on [DATE]. This assessment showed the staff assessed the resident to have severely impaired cognition, no signs or symptoms of depression, no hallucinations or delusions and that the resident wandered. The assessment showed Resident 14 used an antidepressant, the staff noted an indication for the use of the antidepressant, and the staff did not identify any psychiatric/mood disorder. Review of Resident 14's medical diagnosis list included the diagnoses of dementia without any behavioral, psychotic, or mood disturbances or anxiety, multiple sclerosis [a progressive neurological disorder], and insomnia. Review of a 01/15/2024 Pre-admission Screening and Resident Review [PASRR, an assessment that prevents people with mental disabilities from being inappropriately admitted to nursing facilities] showed Resident 14 was assessed to have no serious mental illness indicators, to include Mood Disorders - Depressive or Bipolar. This screening showed Resident 14 had a diagnosis of dementia but that a neurological disorder was the primary diagnosis. Review of 01/15/2024 progress notes showed Resident 14's representative reported to the staff that the resident historically gets up in the night a lot and has been cognitively and functionally declining at home for a while. Review of progress notes of 01/17/2024 showed the resident continued to be awake most of night and the provider started Resident 14 on Trazadone [an antidepressant] at bedtime for sleep. Record review showed that the dose of Trazadone was doubled on 01/31/2024 and that Resident 14, only slept four hours intermittently that night shift. Review of a 02/01/2024 progress note showed the staff spoke to the provider, who discontinued the Trazadone and prescribed sertraline (an antidepressant) for depression. Review of 02/13/2024 provider notes showed they assessed Resident 14 with worsening cognitive and physical function due to multiple sclerosis and dementia. The provider described the resident experienced agitation and had been up frequently during the night, agitated regarding location, spouse not being present, and confused about details to person, place, and location. Review of 06/21/2024, 08/23/2024, and 09/13/2024 provider notes showed the provider added the diagnosis of Alzheimer's dementia with behavioral disturbance. The provider notes showed no indication for the use of the antidepressant sertraline. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of 04/18/2024, 07/11/2024 and 10/04/2024 Psychotropic Medication Reviews completed by Staff D, Social Services Director, showed Resident 14 received sertraline for insomnia, and the target behaviors included depression, sadness, behaviors. The Summary and Recommendations section showed the resident received Trazadone [another antidepressant] for depression and sleepless legs, even though Trazadone was discontinued on 02/01/2024. The summaries showed Resident 14 did not struggle with depression. Additional record review showed the staff monitored Resident 14's behaviors for anxiety as evidenced by Agitation/Wandering and the hours of sleep. Review of April, July and October 2024 Medication Administration Records (MAR) showed the staff administered sertraline to Resident 14 for, UNSPECIFIED DEMENTIA, MILD, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY, contrary to the 04/18/2024, 07/11/2024, and 10/04/2024 Psychotropic Medication Reviews that showed the indication for the sertraline was insomnia. In an interview on 10/10/24 at 10:45 AM, Staff D stated that the sertraline was started to address sleep deprivation and anxiety. Staff D acknowledged the diagnosis in the MAR contradicted the indication for the use of sertraline in the Psychotropic Medication Reviews. Staff D directed the surveyor to ask the Resident Care Manager when they were asked if the diagnosis of dementia without behavioral disturbances was an appropriate indication for the use of an antidepressant. In an interview with Staff B, Director of Nursing, and Staff E, Corporate Nurse, on 10/10/24 at 12:36 PM. Staff B stated the current diagnosis, is not the right diagnosis for the sertraline and that the Resident 14 does have behavioral disturbances. We need to change it [the diagnosis]. Reference WAC 388-97-1060 (3)(k)(i).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42802 Based on observation, interview, and record review, the facility failed to destroy a deceased resident's controlled medication timely, in accordance with currently accepted professional standards, in 1 of 1 medication storage rooms. Additionally, the facility failed to ensure that controlled medications were stored in a permanently affixed, locked storage compartment in the medication refrigerator. These failures placed the facility at risk for potential diversion or misappropriation of controlled medications. Findings included . On [DATE] at 3:12 PM, the medication room refrigerator was inspected with Staff F, Registered Nurse/Resident Care Manager (RN/RCM). The refrigerator contained a small, metal box with a padlock. Staff F opened the padlock with the key, and it contained 4 bottles of liquid Lorazepam (a sedative/controlled medication.) One of the bottles was labeled for Resident 1. The metal box was not secured to the refrigerator and could be removed. During a concurrent interview, Staff F stated that Resident 1 had passed away a few weeks ago. They further stated that their Lorazepam should have been destroyed at that time. Staff F stated the medications were secure since they were in a locked box in a locked room. When asked about a permanently affixed box, they stated they did remember that term from the previous survey. Staff F further reported the facility did trial of a few of those boxes, but they were not big enough, so it went by the wayside. Staff F acknowledged the failed practice was a repeat deficiency from the previous year. According to their medical record, the Resident 1 expired on [DATE], 20 days earlier. On [DATE] at 5:05 PM, Staff A, Administrator was informed of the observations in the medication room and acknowledged failed practice related to not destroying controlled medications for a resident who had expired, and not securing controlled medications in a permanently affixed container in the medication refrigerator. Reference: WAC [DATE] (2)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37544 Based on interview and record review, the facility failed to ensure vaccine consents, medication reviews, and advance directives records were complete and accurate for 3 of the 19 sampled residents (2, 14, 20 and 26) whose records were reviewed. Failure to ensure clinical records were complete and accurate, placed residents at risk of not having their needs met. Findings included . <Resident 2> 1. The 08/06/2024 quarterly assessment documented Resident 2 was able to make their needs known and able to make decisions regarding their care. Review of Resident 2's record showed an updated POLST form, a document that details a resident's wishes for end-of life treatment and resuscitation in the event their heart stops, had been completed on 08/15/2024, was which indicated the resident did not want to be resuscitated, and wished to have comfort measures only. The form included the signature of the resident, but did not have the signature of the medical provider. In an interview on 10/10/2024 at 11:47 AM, with Staff A, Administrator and Staff B, Regional [NAME] President, Staff B stated the POLST form should be signed by the provider as soon as possible. When informed Resident 2's updated POLST was unsigned by the provider, Staff B stated they would check with Medical Records to see if they had one that had not yet been scanned into the resident's record. In a follow-up interview at 10/10/2024 at 11:55 AM, Staff A confirmed that Resident 2's POLST had not been signed, and the provider was contacted to come in and sign the form. 40297 <Resident 14> 1. Review of a 07/21/2024 annual assessment showed Resident 14 admitted to the facility on [DATE] with complex medical conditions. The assessment showed Resident 14 used an antidepressant. Review of 01/17/2024 progress notes showed the provider started Resident 14 on Trazadone [an antidepressant] at bedtime for sleep. Review of a 02/01/2024 progress note showed the staff spoke to the provider, who discontinued the Trazadone and prescribed sertraline (an antidepressant) for depression. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of 04/18/2024, 07/11/2024, and 10/04/2024 Psychotropic [a drug that affects a person's mental state] Medication Reviews completed by Staff D, Social Services Director, showed Resident 14 received sertraline for insomnia. The Summary and Recommendations section showed the resident received Trazadone for depression and sleepless legs, even though the Trazadone was discontinued on 02/01/2024. The above information was shared with Staff D on 10/10/24 at 10:45 AM. Staff D stated that the medication review should read sertraline and not trazadone and acknowledged, It's not an accurate review. <Resident 26> The 07/23/2024 annual assessment documented Resident 26 had diagnoses which included anxiety, depression, and obsessive-compulsive disorder, a mental disorder that caused recurrent, unwanted thoughts and repetitive behaviors that could not be controlled. The assessment further showed Resident 26 received psychotropic medication. Review of the Order Summary Report from 07/01/2023 through 10/10/2024 showed Resident 2 admitted to the facility on [DATE] with the psychotropic medications, Fluoxetine, Bupropion, and Clonazepam on admission, prescribed to treat the symptoms of depression and anxiety. Additional review showed the Bupropion was discontinued on 09/14/2024. Review of the Psychotropic Medication Reviews, an assessment tool used to monitor dosages, efficacy, side effects and to determine if the psychotropic medication was appropriate for use, documented the following: - On 07/26/2023, the only medication listed was Bupropion, but the resident was also prescribed Fluoxetine and Clonazepam. - On 10/19/2023, the form listed Fluoxetine, Clonazepam, and Bupropion, but the Bupropion had been discontinued on 09/14/2023, almost a month prior to the review. - On 01/12/2024, the only medication listed was Clonazepam, however the resident was still receiving Fluoxetine. In an interview on 10/10/2024 at 12:03 PM with Staff A, Administrator, and Staff B, Regional [NAME] President, the inaccuracy and incompleteness of the Psychotropic Medication Reviews was discussed. Staff B confirmed the reviews should be accurate, and include the correct medication, dosages, and indications for the medications use. Both Staff A and Staff B acknowledged that resident's records needed to be accurate to reflect the resident's status and care needs. <Resident 20> Review of Resident 20's medical record showed an undated COVID-19 Declination Form. This form showed eight statements that either staff or residents were asked to read and check each box as a form of acknowledgment. The form specifically asked the facility to identify whether it was a resident or staff completing the consent, to include their full name, date of birth, and gender. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the COVID-19 Declination Form showed no indication whether the name of the individual whose printed name was on the form was a staff or resident, their date of birth, and gender. The form showed none of the eight statements were checked as instructed, which would demonstrate the individual completing the form acknowledged the information in the consent to include, Despite these facts I am choosing to decline the COVID-19 vaccine. The end of the form showed Resident 20's printed name and underneath it a set of initials where the form asked for Signature of the Staff, Resident or Representative. The above findings were shared with Staff G, Infection Preventionist, on 10/10/2024 at 11:23 AM. Staff G stated that the vaccine consent was not complete. Reference WAC 388-97-1720 (2)(a-m).