

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2024
NAME OF PROVIDER OR SUPPLIER Regency Coupeville Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 311 Northeast 3rd Street Coupeville, WA 98239	

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 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** 43954</p> <p>Based on interview, and record review, the facility failed to ensure that an allegation of abuse was reported immediately, not longer than 2 hours after the allegation of abuse was made for 1 of 3 (Resident 1) residents reviewed for abuse allegations or injury of unknown source. This failure placed Resident 1 and other residents at risk for potential continued abuse, unrecognized abuse, and a decreased quality of life.</p> <p>Findings included .</p> <p>Review of the facility provided policy titled, Abuse/Neglect/Misappropriation/Exploitation, revised date of 10/2022, showed a mandated reporter include facility employees, and mandated reporters must immediately report to the Abuse Hotline.</p> <p>Resident 1 admitted to the facility on [DATE] with diagnoses to include chronic respiratory failure, chronic obstructive pulmonary disease (a condition involving constriction of the airways and difficulty or discomfort in breathing), oxygen dependence, and schizophrenia (a serious mental condition of a type involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, withdrawal from reality).</p> <p>Review of Resident 1's progress notes, dated 03/26/2024, showed no documentation related to their allegation of abuse.</p> <p>Review of Resident 1's progress note, dated 03/27/2024 at 8:36 AM, Staff A, Registered Nurse (RN)/Director of Nursing Services (DNS), documented the resident had a follow up skin check to assess their facial area, there was no documentation identifying the resident's allegation of abuse.</p> <p>In an interview on 04/04/2024 at 12:02 PM, Resident 1 stated they reported to Staff E, Nursing Assistant Certified (NAC), and Staff C, Licensed Practical Nurse (LPN), that Staff E had punched them in the eye the morning of 03/26/2024. Resident 1 stated they then reported the incident to Staff B, LPN, the evening of 03/26/2024.</p> <p>In an interview on 04/05/2024 at 11:50 AM, Staff B stated they entered Resident 1's room on the evening of 03/26/2024 at 8:05 PM, and the resident stated a nurse punched them in the eye that morning. Staff B stated they contacted the facility Administrator who completed the state report.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the state reporting form showed the report was submitted to the state on 03/26/2024 at 8:58 PM, which was over 12 hours after it was reported to Staff E and Staff C.</p> <p>In an interview on 04/05/2024 at 12:28 PM, Staff C stated Staff E had self-reported to them Resident 1 made an allegation against them (Staff E) that they were slapped in the eye. Staff C stated they knew Resident 1 had a diagnosis of schizophrenia and they didn't believe the allegation the resident made. Staff C stated they had not reported the allegation to anybody else or reported to the state agency. Staff C stated they were a mandated reporter and should have notified the state agency immediately.</p> <p>In an interview on 04/05/2024 at 1:30 PM, Staff A stated their expectation to an allegation of abuse was an immediate response, which included mandated reporting, validate the safety of the resident, remove staff pending an investigation, and initiate staff and resident interviews. Staff A stated Staff C had done nothing after the allegation was reported to them on the morning of 03/26/2024.</p> <p>Refer to WAC: 388-97-0640(5)(a)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43954</p> <p>Based on interview, and record review, the facility failed to ensure residents were protected during the facility's investigation phase to prevent further potential abuse or mistreatment for 1 of 3 residents (Resident 1) investigations reviewed for abuse when they allowed the staff member to continue to work with Resident 1 and other residents after an allegation of abuse. This failure placed all residents at risk for continued potential abuse from Staff E, Nursing Assistant Certified (NAC), and a decreased quality of life.</p> <p>Findings included .</p> <p>Review of the facility policy titled, Abuse/Neglect/Misappropriation/Exploitation, revised date of 10/2022, showed that all alleged incidents of abuse and injuries of unknown source are thoroughly investigated to determine what occurred and make necessary changes to the provision of care and services to prevent reoccurrences. The policy also showed that protecting the resident from further harm means keeping the resident safe by immediate suspension of the alleged perpetrator.</p> <p>Resident 1 admitted to the facility on [DATE] with diagnoses to include chronic respiratory failure, chronic obstructive pulmonary disease (a condition involving constriction of the airways and difficulty or discomfort in breathing), oxygen dependence, and schizophrenia (a serious mental condition of a type involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, withdrawal from reality).</p> <p>On 03/26/2024 at 7:40 AM, Staff C, Licensed Practical Nurse (LPN), stated Staff E reported Resident 1 stated that they were slapped by Staff E.</p> <p>Review of Resident 1's progress notes, dated 03/26/2024, showed no documentation related to the resident allegation of abuse by Staff E.</p> <p>Review of Resident 1's survey documentation report (NAC documentation), from 03/13/2024 through 03/31/2024, showed Staff E had provided care to Resident 1 for the remainder of the day shift on 03/26/2024 following the allegation of abuse.</p> <p>In an interview on 04/05/2024 at 11:50 AM, Staff B, LPN, stated on 03/26/2024 at 8:05 PM, Resident 1 reported that they were hit in their right eye. Staff B then contacted the Administrator, who completed the state report.</p> <p>Review of the state report showed the allegation was reported on 03/26/2024 at 8:58 PM, which was over 12 hours after the first time the allegation was reported.</p> <p>In an interview on 04/05/2024 at 10:50 AM with Staff D, Registered Nurse (RN)/Assistant Director of Nursing Service (ADNS), stated they had told all staff if there was a resident reported an allegation of abuse related to a staff member, they were to verify resident safety and suspend alleged staff pending an investigation.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/05/2024 at 12:28 PM, Staff C stated after Staff E had self-reported to them regarding Resident 1's allegation of abuse on 03/26/2024 at 7:40 AM, they did not remove Staff E from duty to protect Resident 1 or other residents Staff E. Staff C stated they did not report to state hotline within 2 hours, and they did not report the allegation to anyone. Staff C stated Staff E continued to care for Resident 1 and all the other residents they had been assigned, until the end of their shift at 2:00 PM. Staff C stated they did not believe Resident 1's allegation of abuse and it was their fault Staff E continued to work with residents on 03/26/2024.</p> <p>In an interview on 04/05/2024 at 1:30 PM, Staff A, RN/ Director of Nursing Services, stated it was their expectation there would be an immediate response for an allegation of abuse, to include validation of the safety of the resident(s), removal of staff pending the investigation, and to start interviews with residents and staff. Staff A stated staff had been given the permission to remove any staff involved in an allegation of abuse from the area or the building, pending a facility investigation of the allegation. Staff A stated no safety precautions or protections were put in place for Resident 1 or other residents on the morning of 03/26/2024. Staff A stated that Staff C did nothing after being notified of the allegation on the morning of 03/26/2024. Staff A stated Staff E had continued to work the remainder of their shift until 2:00 PM with Resident 1 and other residents.</p> <p>Refer to WAC 388-97-0640(6)(a)(b)</p>		