STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505309	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Coupeville Rehab and Nursing Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 [NAME], Kally L. Based on interview and record review, the facility failed to provide resident focused care through consistent monitoring, assessment and evaluation of the resident's condition to identify a change in condition for a suspected urinary tract infection (UTI) and to implement physician orders for 1 of 5 residents (Resident 1) reviewed for quality of care. This failed practice placed residents at risk for unmet needs, hospitalization , and diminished quality of life. Findings included . Review of McGreer's criteria (set of surveillance definitions used to identify infections in long-term care settings) showed the constitutional criteria for a UTI (a set of signs and symptoms that indicate a patient may have an infection, even if diagnostic testing has not confirmed it) included fever, acute change in mental and/or functional status and leukocytosis (high white blood cell count). Resident 1 admitted to the facility on [DATE] with diagnoses to include low back pain, chronic pain, cardiomyopathy (disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body) and spondylosis (a condition that causes the spine to degenerate, resulting in abnormal wear on the cartilage and bones in the spine). Review of the Admission Minimum Data Set (MDS- an assessment tool) assessment dated [DATE] showed the resident had moderately impaired cognition. The St. Louis University Mental Status Examination (SLUMS-cognitive examination) dated [DATE] showed they had dementia. Review of Resident 1's current care plan showed the following: - Focus Area- the resident is independent with reminders to wash their hands after bathroom use (Initiated on [DATE], revised on [DATE]). Interventions showed the resident was mostly independent but may need occasional moderate assistance of one person with toileting, they rarely ask for assistance (Initiated on [DATE], revised on [DATE]). (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Focus Area- the resident had impaired cognitive function/dementia and/or impaired thought processes related to diagnoses of mild cognitive impairment (Initiated/revised on [DATE]). Interventions showed to identify and treat any contributing cause of impaired cognition such as pain, infection, acute illness, and medication changes; monitor, document and report any changes in cognitive function, and the resident required supervision/assistance with all decision making. - Resident 1 had unwitnessed falls on [DATE] and [DATE] and a physical therapy referral was made. Review of Resident 1's progress notes dated [DATE] through [DATE] showed they were on alert monitoring for pain related to changes in their pain medication on [DATE]. On [DATE], it was documented that Resident 1 had experienced an episode of high blood pressure, and the physician was not notified until [DATE], the day the resident expired. On [DATE] Resident 1 was seen by the physician after they were noted to have a temperature of 100.2 degrees Fahrenheit, an elevated heart rate, increased respirations, and several episodes of vomiting and diarrhea. Resident 1 was placed on an antibiotic medication, intravenous fluids and was diagnosed with a urinary tract infection. Review of Resident 1's Documentation Survey Report v2 (Nursing Assistant charting for care provided) for [DATE], showed missing documentation on the evening shift of [DATE] and [DATE] and overnight on [DATE] to[DATE], there were no entries that toileting hygiene had been provided. In an interview on [DATE] at 2:26 PM, Collateral Contact 1 (CC1) stated Resident 1 passed away in the facility on [DATE] in pain, after being diagnosed with a urinary tract infection. CC1 stated Resident 1 had not been seen by a physician for several months until they voiced concerns about neglect and then the resident was finally seen on [DATE]. CC1 stated Resident 1 had been referred for a physical therapy evaluation which had not been completed. In an interview on [DATE] at 11:22 AM Staff G, Nursing Assistant Certified (NAC), stated Resident 1 would hide their episodes of incontinence by removing their linens from their bed. Staff G stated Resident 1 would walk the halls of the building ,d+[DATE] times a day. Staff G stated they noticed changes in Resident 1 a week prior to their passing and described the resident as staying in bed for breakfast, more lethargic, and awake more at night. Staff G stated Resident 1's passing was not expected, and they took a quick turn for the worse. In an interview on [DATE] at 2:25 PM Staff F, Resident Care Manager, stated Resident 1 was mostly independent, walked hallways of the facility daily, and required supervision because of confusion. Staff F stated Resident 1 was on alert monitoring for their pain management and recent constipation. Staff F stated Resident 1 developed a urinary tract infection and passed away unexpectedly on [DATE]. In an interview on [DATE] at 10:32 AM Staff E, Infection Preventionist, stated Resident 1 was continent of urine most of the time with episodes of incontinence. Staff E stated they expected nursing assistants to report to the nurse if a resident had changes in frequency of urination, complaints of pain with urination, foul odor, burning with urination, or blood in their urine. As well as any vitals outside of parameters, such as temperature and any changes in cognition or confusion. Staff E stated the facility used the McGreer's criteria to identify potential infections. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 11:58 AM Staff C, Director of Rehabilitation, stated Resident 1 had an order for a physical therapy evaluation on [DATE], but the physical therapy evaluation was not completed for the order dated [DATE]. Staff C stated there was another order for physical therapy evaluation on [DATE] which was not completed due to Resident 1 passing away. In an interview on [DATE] at 11:38 AM Staff D, NAC, stated they relied on CC 1 to tell them what Resident 1 needed because the resident did not express their needs. Staff D stated Resident 1 wore incontinent briefs, had an increase in incontinence prior to their passing and did not assist them in perineal care. Staff D stated they had not informed the nurse of Resident 1's increased incontinence and use of incontinent briefs. Staff D stated Resident 1 started to stay in their room more prior to their passing. In an interview on [DATE] at 11:35 AM Staff B, Director of Nursing Services (DNS), stated they had completed an in-service with the nursing aides on [DATE] for perineal care related to an increase in urinary tract infections within the facility. In a follow up interview on [DATE] at 1:03 PM Staff B, DNS, stated the process of identifying a change in condition in a resident included everything from changes in orders, to vitals, to cognition and therapy observations. Staff B stated the entire staff, which is the whole team, from nursing aides, shower aides, therapy staff, and nurses would report changes in a resident. Refer WAC [DATE](1)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on interviews and record review the facility failed to ensure timely physician visits (once every 30 days for the first 90 days after admission) were completed for 1 of 4 residents (Resident 1) reviewed for physician visits. This failure placed residents at risk of being denied face-to-face contact with a physician, comprehensive reviews and physician assessments of their health and well-being. Findings included . Review of Resident 1's medical record showed the resident was admitted to the facility on [DATE] with diagnoses to include low back pain, chronic pain, cardiomyopathy (disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body) and spondylosis (a condition that causes the spine to degenerate, resulting in abnormal wear on the cartilage and bones in the spine). Review of Resident 1's electronic health record (EHR) showed they were seen by a physician on [DATE], [DATE], [DATE], and [DATE]. Resident 1 was not seen by a physician again until [DATE] and [DATE]. The EHR showed that Resident 1 was not seen by a physician in [DATE] or [DATE]. In an interview on [DATE] at 2:26 PM, Collateral Contact 1 (CC1-Resident 1's representative) stated they were told the physician overseeing Resident 1's care left in the middle of [DATE] and another physician would be covering. CC1 stated the physician did not see Resident 1 until [DATE] after they had voiced concerns about neglect. In an interview on [DATE] at 2:25 PM Staff F, Resident Care Manager, stated residents are seen at least quarterly by a physician. Staff F stated if there is something concerning about a resident, they would ask the physician to see the resident earlier. Staff F stated they had physician coverage in the facility twice a week until recently. In an interview on [DATE] at 1:35 PM, Collateral Contact 2 (CC-2-Medical Director), stated they work with multiple physicians which they supervise. CC2 stated the physician that had seen Resident 1 since admission left their practice. CC 2 stated they filled in and saw residents as needed. CC2 stated they had not seen Resident 1 until [DATE], the day before they expired. CC2 stated they follow Medicare guidelines for resident visits in the nursing facility. In an interview on [DATE] at 1:03 PM Staff A, Administrator, stated they would need to check the calendar. Staff A stated residents need to be seen by a physician within 3 days of admission. No other information was provided. Refer to WAC [DATE](4)(c),(10)