Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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	09/27/2024

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33954 Based on interview and record review, the facility failed to conduct a thorough investigations for 3 of 7 sample residents (Residents 1, 6, and 7) reviewed for accidents/incidents. Failure to conduct a thorough investigation to identify root cause(s) and consistently consider all potential contributing factors, such as last time checked on, last time toileted/changed, and other factors placed the residents at risk for unidentified abuse and/or neglect, inappropriate corrective actions, and ineffective care planning that potentially impacted the overall well-being of the residents. Findings included . Review of the facility policy titled Incident Documentation and Investigation revised date 10/2022, showed the policy of this facility was to document and investigate investigations in order to protect residents from further incidents and a thorough investigation may require 2 phases of fact gathering. The policy showed that an incident report would be completed for falls, witnessed, unwitnessed or staff lowered resident to the floor. The licensed nurse obtains witness statements from assigned nursing assistant, nursing assistants in the immediate area, nursing assistants from the prior shift to the incident's discovery, visitors, family, roommates and the alleged perpetrator as indicted. <RESIDENT 1> Resident 1 admitted to the facility on [DATE] with diagnoses to include Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and aftercare and rehabilitation after spinal fusion surgery. According to the admission Minimum Data Set (MDS - an assessment tool) assessment, dated 09/05/2024, the resident had severe cognitive impairment and needed supervision or assistance with the activities of daily living of eating, toileting, bathing, dressing, donning/doffing footwear, and personal hygiene. Review of a fall incident investigation, dated 09/04/2024, showed Resident 1 was found next to their bed on the floor at 7:15 PM. The resident's incontinence brief was off and staff noted there was a large amount of feces. The resident was unable to state what occurred. The investigation did not include any witness statements, and showed no documentation of the last time the resident had been checked on or the last time they had received any care such as toileting or incontinent care. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a joint interview on 09/27/2024 at 12:52 PM, Staff A, Administrator, and Staff B, Director of Nursing, were interviewed regarding Resident 1's incident on 09/04/2024 at 7:15 PM. Staff A stated they did not have witness statements for the investigation. They were asked how long the 1:1 monitoring lasted, Staff A stated they did 1:1 monitoring overnight, Staff B stated when the resident's spouse wasn't in the building, they would place Resident 1 at the nursing station. Review of a fall incident investigation, dated/timed 09/06/2024 at 2:45 PM, showed Resident 1 was found sitting on the floor in the dining room. The investigation indicated the intervention initiated was placing the resident on 1:1 monitoring, but there was no documentation related to 1:1 monitoring was included in the incident investigation or the clinical record. The investigation did not include any witness statements, and showed no documentation of the last time the resident had been checked on or the last time they had received any care such as toileting or incontinent care. The investigation included no documentation whether the facility had substantiated abuse/neglect, and it did not indicate if the resident's care plan was being followed at the time of their fall. In a joint interview on 09/27/2024 at 12:52 PM, Staff A, Administrator, and Staff B, Director of Nursing, were interviewed regarding the incident that occurred on 09/06/2024. Staff B stated the resident was not on 1:1 monitoring at the time of this fall, but it was implemented after the fall. Staff A stated they did not have documentation of 1:1 monitoring after the fall, and they didn't have documentation of when the resident had last been seen by staff. Staff A stated they had not care planned the 1:1 monitoring after this fall, but that it should have been care planned. Staff B stated they didn't know which staff had left the resident in the dining room prior to their fall. Staff A stated they were unsure if the care plan was followed at the time of the fall. Review of a fall incident investigation, dated 09/07/2024 at 1:30 AM, showed Resident 1's spouse reported to staff that the resident had rolled out of bed. The resident was unable to state what occurred. The investigation showed following this incident the resident's bed was moved against the wall on one side and the spouse would remain at their bedside for 1:1 observation. Review of an incident investigation, dated/timed 09/07/2024 at 4:00 PM, showed Resident 1 was found lying on their right side on the floor by the nursing station. The resident stated they hit their head on the floor and staff observed drainage coming from the resident's surgical incision. The investigation indicated the resident was sent to the hospital for further evaluation of their head injury and to rule out a brain bleed. The investigation did not include any witness statements, and showed no documentation of the last time the resident had been checked on or the last time they had received any care such as toileting or incontinent care. The investigation included no documentation whether the facility had substantiated abuse/neglect, and it did not indicate if the resident's care plan was being followed at the time of their fall. The investigation indicated the intervention after the fall was discussion with the family for them to provide a sitter 24 hours a day or have family sit with them around the clock because of their lack of judgement regarding safety and impulsiveness. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/27/2024 at 12:52 PM. Staff A and B were interviewed regarding Resident 1's fall on 09/07/2024 at 4:00 PM, neither Staff A or B could state which staff had last seen the resident or when staff had last seen them prior to the fall. They were asked what the plan was for monitoring the resident, Staff A stated somebody should have seen them, Staff B stated they should have had a witness statement, but they didn't. Staff A stated there was no documentation whether they substantiated abuse/neglect. Staff A and B were unable to provide any information regarding the lack of witness statements. Staff A and B were unable to state what interventions had been put in place after the fall to prevent future falls. They were asked about the 1:1 monitoring intervention, and Staff B stated they had talked to the family about a private sitter, but the family said they would think about it. They were asked if additional supervision of the resident had been care planned for when the resident's family was not present, no information was provided. Review of a fall incident investigation, dated/timed 09/12/2024 at 5:58 PM, showed Resident 1 was found lying on the floor in front of their wheelchair by the east dining room. The investigation indicated the resident had impulsiveness that was nearly constant. The investigation indicated the resident had multiple falls, even with their spouse in a 1:1 caregiver capacity. The investigation indicated the resident's spouse was unable to be in the facility much of the day due to their own needs. The investigation showed the facility would provide a 1:1 sitter when the resident's spouse was unavailable. The investigation did not include any witness statements, and showed no documentation of the last time the resident had been checked on or the last time they had received any care such as toileting or incontinent care. The investigation included no documentation whether the facility had substantiated abuse/neglect, and it did not indicate if the resident's care plan was being followed at the time of their fall. In a joint interview on 09/27/2024 at 12:52 PM, Staff A, Administrator, and Staff B, Director of Nursing, were interviewed regarding Resident 1's fall on 09/12/2024. Staff A stated they did not know when staff had last seen the resident prior to their fall. Staff B stated they did not know which staff left the resident in the dining room unattended, neither staff could provide any information why there were no witness statements. They were asked what the plan was to prevent future falls, Staff A stated the facility was supposed to provide a 1:1 sitter but they had no documentation of that. Staff A stated the facility had a form to be used for when staff do 1:1 monitoring, but they did not use it in this case. Neither Staff A nor Staff B could provide any information how facility staff were supposed to be monitoring the resident at the time of the fall. Review of a fall incident investigation, dated/timed 09/17/2024 at 5:48 PM, showed a staff found Resident 1 laying on the floor outside the east nurse's station. The investigation did not indicate which staff, if any, was responsible for monitoring the resident at the time of their fall or whether they were on any 1:1 monitoring at the time of the fall. The investigation did not include any witness statements, and showed no documentation of the last time the resident had been checked on or the last time they had received any care such as toileting or incontinent care. The investigation included no documentation whether the facility had substantiated abuse/neglect, and it did not indicate if the resident's care plan was being followed at the time of their fall. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a joint interview on 09/27/2024 at 12:52 PM, Staff A, Administrator, and Staff B, Director of Nursing, were interviewed regarding Resident 1's fall on 09/17/2024. Staff A stated there was no documentation of a plan to prevent future occurrences and there was no root cause analysis completed. Neither Staff A nor Staff B could provide any information about a documented plan for increased supervision of the resident. They were asked what the plan for monitoring the resident was at the time of this fall, neither staff could provide any information. Staff A stated they thought the care plan was being followed at the time of the fall. Staff A stated they did not have any witness statements regarding this fall. <RESIDENT 6> Resident 6 admitted to the facility on [DATE] with diagnoses to include a stroke. Review of an incident investigation, dated 09/04/2024, showed Resident 6's spouse had reported their feeding (tube feeding) did not appear to be running at the appropriate rate. The investigation determined the tube feeding was programmed to infuse the incorrect rate of tube feeding and it was not programmed to infuse free water at all. The investigation indicated that two nurses were involved, but it did not identify the nurses. The investigation did not include any witness statements from nursing regarding the tube feed administration, proper flow rates, lack of documentation or how many days the tube feeding infused at the incorrect rate. The investigation indicated a nurse was educated but it did not identify the nurse or what they were educated on. The investigation indicated they did not have time to speak with the day nurse from Monday/Tuesday. The investigation was not thorough and did not indicate if the facility substantiated abuse/neglect. In a joint interview on 09/27/2024 at 12:52 PM, Staff A, Administrator, and Staff B, Director of Nursing Services, were interviewed regarding the investigation. Staff A stated they didn't know from the investigation who failed to administer the correct amount of tube feeding solution. Staff B stated they didn't know who the nurses were that did the medication errors, but they could go back and see who was on shift. Staff B stated they had educated all nurses but had no documentation. Staff A stated they did not know which other nurses were involved. Staff B stated the longest the nurses may have infused the wrong rates was 24 - 36 hours. Joint review of the medication administration records revealed discrepancies in the amounts of free water and tube feeding solution infused over several days/shifts, the investigation failed to include any documentation regarding them, neither Staff A nor Staff B could provide any information regarding those, Staff B stated they should have documented that. <RESIDENT 7> Resident 7 admitted to the facility on [DATE] with diagnoses to include a stroke. Review of an incident investigation, dated 07/20/2024 at 10:48 AM, showed Resident 7 received medications Metoprolol and Amlodipine (both blood pressure medications) when they should have been held because they had parameters to hold them if the resident's pulse was below 60. Review of a progress note, dated 07/20/2024 at 10:35 PM, showed Resident 7 received their morning dose of Amlodipine and Metoprolol when their heart rate was 58 and the medication should have been held according to parameter limits. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 1's July 2024 Medication Administration Records (MARS) showed on 07/20/2024 the nurse had documented they had not given them am doses of Metoprolol and Amlodipine. In an interview on 09/27/2024 at 12:15 PM, Staff A, Administrator, and Staff B, Director of Nursing, were unable to provide any information why the MARs showed the medications had not been administered, but the progress note, and incident investigation, indicated they had been administered. Staff A and B were also unable to provide any information whether the facility had identified that the licensed nurse making the medication errors had failed to properly document they had administered the medications. Staff A and B stated they didn't know the identity of the licensed nurse that had administered the medications outside of hold parameters. Staff A and B stated they were unable to provide any information why there was no witness statements included in the investigation. Staff A and B stated they were unable to provide any information which medication right the licensed nurse had not ensured when they administered the medications outside hold parameters. Staff A and B were unable to state what measures the facility had taken to ensure a repeat occurrence of the incident did not occur, except for Staff A stated they provided the licensed nurses education, but they were only able to provide documentation of education to one nurse. Refer to WAC 388-97-0640 (6)(a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33954 Based on interview, and record review the facility failed to provide assistance with activities of daily living (ADLs) to include providing oral care of 1 of 3 sample residents (Resident 1) reviewed for ADL's. The failure to provide oral care placed residents at risk for poor hygiene, unmet needs and a diminished quality of life. Findings included . Resident 1 admitted to the facility on [DATE] with diagnoses to include Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). According to the admission Minimum Data Set (MDS - an assessment tool) assessment, dated 09/05/2024, the resident had severe cognitive impairment and needed supervision or touching assistance with oral hygiene. In a phone interview on 09/26/2024 at 2:52 PM, Collateral Contact 1 stated staff were not brushing Resident 1's teeth, so they had to do it. Review of Resident 1's care plan, print date 09/26/2024, showed they were care planned to receive oral care twice daily, in the morning and at bedtime. The care plan also showed that Resident 1 required supervision of 1 person assist with oral care. Review of Resident 1's oral care documentation for 09/04/2024 through 09/22/2024, showed they did not receive oral care at all on 09/21/2024, and they received oral care only once daily on nine days. In a joint interview on 09/27/2024 at 12:52 PM, Staff A, Administrator, and Staff B, Director of Nursing, were unable to provide any information about the lack of oral cares for Resident 1. Staff A stated the documentation is the evidence and it is not there. Refer to WAC 388-97-1060 (2)(c)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33954 Based on interview and record review, the facility failed to provide adequate supervision, update and consistently implement the care plan to prevent accidents/falls for 1 of 3 residents (Resident 1) reviewed for accidents. The facility failure to provide adequate supervision and implement appropriate interventions placed residents at risk for future falls, injury, and diminished quality of life. Findings included . Review of a facility policy titled Fall Risk Overview, revised date 02/2020, showed it was the policy of this facility to evaluate each resident's fall risk in order to develop and implement care plan interventions that create a safe and secure environment where falls and injuries are minimized. The facility fall risk program included identification of residents at risk for falls, development of care plan interventions to minimize fall risk, implementation of fall risk interventions and evaluation of effectiveness of fall risk interventions. The policy indicated an individualized care plan was to be developed and implemented to minimize fall risk and injury. Resident 1 admitted to the facility on [DATE] with diagnoses to include Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), atrial fibrillation (atrial fibrillation - irregular heart rhythm) requiring anticoagulation (anticoagulation - treatment with blood thinning medications to prevent clotting), and aftercare and rehabilitation after spinal fusion surgery. According to the admission Minimum Data Set (MDS - an assessment tool) assessment, dated 09/05/2024, the resident had severe cognitive impairment and needed supervision or assistance with the activities of daily living of eating, toileting, bathing, dressing, donning/doffing footwear, and personal hygiene. A review of Resident 1's clinical record on 09/26/2024 showed the resident had five falls in the first eight days of their admission to the facility. Review of an incident investigation, dated 09/04/2024 at 7:15 PM, showed Resident 1 was found on the floor in their room next to their bed. The resident had their incontinence brief off and staff noted there was a large amount of feces on the floor near them. The resident was confused and unable to state what had happened. The investigation indicated the resident had a small skin tear to their ear and a small laceration on their head, and a small skin tear to their pinky finger on their left hand. Review of an incident investigation, dated 09/06/2024 at 2:45 PM, showed Resident 1 had an incident in the dining room, found on the floor, appeared to be attempting to transfer themselves from their wheelchair. The facility concluded the root cause of the incident was the resident attempted to stand and ambulate without assistance. The incident investigation indicated the intervention was education to the staff that the resident must be monitored and visualized at all times due to impulsivity and falls in the recent past. The investigation also indicated an intervention was the resident being monitored 1:1 by staff in the dining room until their spouse arrived to assist with monitoring them 1:1. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a fall incident investigation, dated 09/07/2024 at 1:30 AM, showed Resident 1's spouse came out of the room to notify staff the resident had rolled out of bed. The investigation documented the interventions implemented after this incident included moving the bed against the wall, placed the spouse's bed up against the resident's bed and the spouse would remain with the resident for 1:1 observation. Review of a fall incident investigation, dated 09/07/2024 at 4:00 PM, showed Resident 1 was found on the floor by the nursing station and the incident was unwitnessed. The investigation indicated Resident 1 stated they hit their head on the floor, and serosanguinous (a combination of blood and serum (serum - straw colored part of blood)) drainage was seen on the floor from the resident's surgical incision, and the doctor ordered to send the resident to the emergency department to rule out a brain bleed. The facility concluded the root cause of the fall was the resident was attempting to transfer and ambulate without assistance. The intervention was discussion with the family for them to provide a sitter 24 hours a day, or have family sit with them around the clock because of their lack of judgement regarding safety and impulsiveness. Review of emergency department records, dated 09/07/2024, showed Resident 1 was discharged back to the nursing home with a head contusion (bruise). Review of a Fall Risk Evaluation, dated 09/08/2024, showed Resident 1 was a high risk for falls. Review of a nursing progress note, dated/timed 09/11/2024 at 1:11 PM, showed Nursing Concerns: 1:1, high fall risk, cognitive concerns. Review of a fall incident investigation, dated 09/12/2024 at 5:59 PM, showed Resident 1 was found on the floor in the east dining room. The resident's medical provider ordered for them to be sent to the emergency department, but the resident declined after emergency medical services and their spouse arrived at the facility. Review of a fall incident investigation, dated 09/17/2024, showed Resident 1 was seen laying on the floor right outside the east nursing station at 5:46 PM. A visitor witnessed the fall, no staff witnessed the fall. The resident stated they were trying to walk over to the window of the dining room and tripped over their feet. Review of a progress note, dated/timed 09/18/2024 at 5:26 PM, showed Resident 1 had a 1:1 aide from 6:00 AM - 2:00 PM. Review of a physician progress note, dated/timed 09/18/2024 at 9:00 PM, showed the physician documented the resident was currently on one-to-one observation. Review of a nursing progress note, dated/timed 09/23/2024 at 10:54 AM, showed Nursing Concerns to include: 1:1, high fall risk, cognitive concerns. On 09/26/2024, a review of Resident 1's clinical record showed no documentation could be found of 1:1 observation/s. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's care plan, copy date 09/26/2024, showed an intervention, dated 09/08/2024, the spouse has been asked to stay at facility to assist with monitoring as a 1:1. An additional intervention indicated the resident's spouse was currently staying in to help monitor them 1:1 during the night. In a phone interview on 09/26/2024 at 2:52 PM, Collateral Contact 1, stated they had asked facility staff for fall mats, but the facility declined as they felt the fall mats were too dangerous. In a joint interview on 09/27/2024 at 12:52 PM, Staff A, Administrator, and Staff B, Director of Nursing Services, were interviewed, regarding Resident 1's multiple falls. For the fall on 09/04/2024, Staff B stated when Resident 1's spouse was not in the facility the resident would be placed at the nursing station. Regarding the fall on 09/06/2024, Staff A and B were asked what the plan was to prevent future occurrences, Staff A stated Staff B gave informal education to the nurses on duty, but they had not documented that. They were asked for documentation of the 1:1 monitoring and close monitoring of the resident Q15min (every 15 minutes) per the investigation summary, and Staff A stated they didn't have that documentation. Staff A and B were asked about the care plan not including 1:1 monitoring/q15 minute checks, and Staff A stated that should have been care planned. Staff A and B were asked for documentation of staff education that the resident must be monitored and visualized at all times; Staff A stated it was not documented. For the fall on 09/07/2024 at 4:00 PM, Staff A and B were asked what the plan was for monitoring them as they were not near their call light, Staff A stated somebody should have seen them, Staff B stated there should have been a witness statement. Staff B stated they had a conversation with the resident's family to see if they were interested in having a private sitter, and the family said they would think about it. Staff B stated even with them trying to watch the resident, they would still fall. Staff A and B were asked if additional supervision had been care planned for the resident, they were unable to provide any information. Staff B stated the resident was confused and impulsive. Regarding the fall on 09/12/2024, Staff A and B were asked for the plan to prevent future occurrences, Staff A stated the facility was to provide a 1:1 sitter, but they had no documentation of that. Staff A added that the facility did have a form for 1:1 monitoring but they did not use it in this case. Regarding the fall on 09/17/2024, Staff A stated there was no documentation of a plan to prevent future occurrences, and that they had not documented the root cause of the fall. Staff A stated the facility had no documented plan for increased supervision of Resident 1. Refer to WAC 388-97-1060 (3)(g)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 33954 Based on interview and record review, the facility failed to maintain complete and accurate clinical records for 3 of 7 residents (Residents 1, 6, and 7) reviewed for incidents and care and services. The failure to ensure thorough documentation of incidents, care and services, and food preferences placed residents at risk for unmet needs, repeat occurrences of incidents, and diminished quality of life. The failure to obtain witness statements for incidents resulted in lost evidence regarding incidents that occurred in the facility making it impossible to ascertain what occurred. Findings included . <RESIDENT 1> Resident 1 admitted to the facility on [DATE] with diagnoses to include Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), aftercare and rehabilitation after spinal fusion surgery. According to the admission Minimum Data Set (MDS - an assessment tool) assessment, dated 09/05/2024, the resident had severe cognitive impairment and needed supervision or assistance with the activities of daily living of eating, toileting, bathing, dressing, donning/doffing footwear, and personal hygiene. Review of an incident investigation, dated 09/04/2024, showed Resident 1 had a fall in their room at 7:15 PM and their incontinence brief was off and there was a large amount of feces near the resident. Review of Resident 1's progress notes showed no corresponding progress note regarding their fall on 09/04/2024. There was a progress note dated/timed 09/06/2024 at 1:58 PM, that indicated the resident had had a fall at 7:15 PM and the resident was found on the ground next to their bed and a large amount of feces was noted on the floor. Review of Resident 1's care plan, print date 09/26/2024, showed the resident was care planned to be at risk for falls and they had falls in their room on 09/06/2024, and two falls in their room on 09/07/2024. Review of an incident investigation, dated 09/06/2024, showed Resident 1 fell in the dining room, and review of an incident investigation for the second fall on 09/07/2024 showed the resident fell by the nursing station. In a phone interview on 09/26/2024 at 2:52 PM, Collateral Contact 1, stated they could not get fresh fruit for Resident 1 and that they had to bring it in on their own. (continued on next page)

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 09/27/2024
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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/27/2024 at 11:15 AM, Staff E, Dietary Manager, stated they were unable to provide any information Resident 1 was not able to obtain fresh fruits at the facility, they stated they did have fresh fruits at the facility, but they didn't think it was the resident's preference to get fresh fruit with their meals. Staff E stated they could no longer access Resident 1's tray cards or food preferences documentation as they had already discharged from the facility and their record keeping systems did not maintain that type of documentation after a resident discharged . In an interview on 09/27/2024 at 12:52 PM, Staff A, Administrator, stated the progress note dated 09/06/2024 was a late entry for the incident on 09/04/2024 and it should have been labeled as a late entry. Regarding the care plan indicating the resident had falls in their room when the incident investigations indicated they were in the dining room and by the nursing station, Staff A stated the care plan was not accurate, and Staff B stated for the second fall on 09/07/2024 the resident definitely fell by the nursing station and not in their room. Regarding no documentation available for review regarding Resident 1's food preferences, Staff A stated once a resident discharged , they no longer could access that type of information. <RESIDENT 6> Resident 6 admitted to the facility on [DATE] with diagnoses to include a stroke. Review of Resident 6's Medication Administration Records (MARS) from 09/01/2024 - 09/27/2024, showed an order for Jevity tube-feeding solution to be administered at 65 milliliters (ml)/hour for 22 hours a day (1430 mls total) and to document the actual amount administered for the 22 hours. Review of the MARS showed on 09/01/2024 staff documented they administered 1400 mls on day shift and 721 mls on night shift, for a total of 2121 mls. The MARs showed on 09/02/2024 staff documented 982 mls on dayshift and there was no documentation on the night shift. On 09/03/2024 staff documented they administered 660 mls on dayshift and N/A (not applicable) was documented on night shift, and in another order location on the MARS staff documented 650 mls was administered on both day and night shift. On 09/04/2022 there was no documentation at all on dayshift and 2930 mls was documented on night shift, then in another location on MARS they documented they administered 650 mls on both day and night shift. Review of an Order Audit Report, dated 08/22/2024, showed an order for Free water Flush: 200 ml every four hours, and to document the amount infused. Review of Resident 6's MARs from 09/01/2024 - 09/27/2024, showed an order for free water flushes, 200 ml every four hours six times a day for hydration, and to document the ml infused. Review of the MARS showed on 09/01/2024 staff documented free water administration in two different locations, on one location they documented they administered 600 ml on day and night shift, and in the other location they documented, on 09/01/2024 at 7:00 AM they documented NA, at 10:00 AM, they documented 200 ml, at 1:00 PM, they documented NA and 13 (which represented Not Required), at 4:00 PM they documented NA and 13 (not required), at 7:00 PM, they documented 200 ml, at 10:00 PM, they documented 200 ml. For 09/02/2024 in one location staff documented 600 ml on dayshift and there was no documentation on night shift, and in the other location they documented 200 ml each at 7:00 AM, 10:00 AM, 1:00 PM, 4:00 PM, 7:00 PM, and 10:00 PM. On 09/03/2024 staff documented free water flush as 600 ml on day shift and they documented NA on night shift, and in the other location on the MARS they documented 200 ml was administered at 7:00 AM, 10:00 AM, 1:00 PM, 4:00 PM, and 7:00 PM. (continued on next page)

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 09/27/2024
NAME OF PROVIDER OR SUPPLIER Regency Coupeville Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 311 Northeast 3rd Street Coupeville, WA 98239	

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a joint interview on 09/27/2024 at 12:15 PM, Staff A, Administrator, and Staff B, Director of Nursing, were asked about the discrepancies in documentation of the free water and tube feeding solution, they were unable to provide any information. <RESIDENT 7> Resident 7 admitted to the facility on [DATE] with diagnoses to include a stroke. Review of an incident investigation, dated 07/20/2024, showed the medications Metoprolol and Amlodipine (both blood pressure medications) were given when they should have been held because they had parameters to hold them if the resident's pulse was below 60. Review of a progress note, dated/timed 07/20/2024 at 10:35 PM, showed the resident was administered am (morning) doses of Amlodipine and Metoprolol when their heart rate was 58 and the medication should have been held according to parameter limits. Review of Resident 1's July 2024 Medication Administration Records (MARS) showed on 07/20/2024 the nurse had documented they had not given them am doses of Metoprolol and Amlodipine. In an interview on 09/27/2024 at 12:15 PM, Staff A, Administrator, and Staff B, Director of Nursing, were unable to provide any information why the MARs showed the medications had not been administered, but the progress note, and incident investigation indicated they had been administered. Refer to WAC 388-97-1720 (1)(a)(i)(ii)(iii)(b)

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 09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Coupeville Rehab and Nursing Center	311 Northeast 3rd Street Coupeville, WA 98239

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725 Based on observation and interview, facility staff failed to use appropriate standards of infection control practice for 2 of 2 residents (Residents 2 and 3) observed during resident care. Failure to utilize appropriate hand hygiene and to provide incontinent care without staff contaminating the resident's environment placed residents at risk for cross-contamination and for living in a contaminated environment. Findings included . <RESIDENT 2> Resident 2 was admitted at the facility on 01/11/2023. According to the quarterly Minimum Data Set (MDS - an assessment tool) assessment dated [DATE], showed the resident was cognitively intact, and was incontinent of urine and bowels. In an observation on 09/26/2024 at 12:50 PM, Staff C, Certified Nursing Assistant (CNA) was completing peri care (the process of washing the genital and rectal area) on Resident 2 and with the gloves they used to wash the resident's peri area (area in the body between the genital and rectal), which were contaminated gloves, staff touched the privacy curtain, contaminating the curtain. After Staff C wiped the resident's buttocks, wearing the same gloves, they placed a clean brief on the resident, which then contaminated the clean briefs. Staff C then doffed (removed) their contaminated gloves and secured the briefs, positioned the resident's gown and blanket without washing their hands or using Alcohol Based Hand Rub (ABHR) which then contaminated the gown and blanket. In an interview on 09/27/2024 at 9:45 AM, Staff C, CNA, stated that after they do the pericare on residents, they use the same gloves to put the clean briefs on. <RESIDENT 3> Resident 3 was admitted to the facility on [DATE]. In an observation on 09/27/2024 at 8:50 AM, after providing peri care on Resident 3, Staff D, CNA, did not doff their gloves or perform hand hygiene prior to placing the clean brief on the resident, contaminating the clean briefs. Staff C, CNA who was assisting with the care, wiped the resident's buttocks and used the same contaminated gloves to secure the resident's clean brief, contaminating them. Refer to WAC 388-97-1320 (1)(a)(c) 33954