

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  02/21/2025
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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43954</b></p> <p>Based on observation, interview and record review, the facility failed to ensure that thorough investigations were completed for 2 of 4 residents (Resident 1 and 2) reviewed for allegations of abuse/neglect. Failure to conduct thorough investigations to identify root cause and all contributing factors related to allegations of abuse/neglect placed all residents at risk for unidentified abuse, unidentified corrective actions, and potential harm and decreased quality of life.</p> <p>Findings included .</p> <p>Review of the facility provided policy titled, Abuse/Neglect/Misappropriation/Exploitation, revised 10/2022 showed during the investigation, the data collection involved interview of the alleged resident victim, interview caregivers, family, visitors, roommates and the alleged perpetrator.</p> <p>&lt;RESIDENT 1&gt;</p> <p>Resident 1 admitted to the facility on [DATE] with diagnoses to include sepsis (chemicals released into the bloodstream to fight infection trigger inflammation throughout the body), acute cystitis (inflammation of the bladder, or urinary tract infection), myasthenia gravis (chronic autoimmune disorder with rapid weakness and fatigue of voluntary muscles), and mild cognitive impairment.</p> <p>Review of Resident 1's progress notes dated 01/29/2025 and 01/30/2025 showed no documentation related to the allegation of abuse/neglect reported by the resident's family.</p> <p>Review of Resident 1's allegation investigation, dated 02/03/2025 and completed by Staff A, Administrator, and Staff B, Registered Nurse (RN) Director of Nursing Services (DNS) showed no statement from Resident 1, their family member, or nursing staff assigned to care for the resident at the time of alleged incident.</p> <p>In an interview on 02/21/2025 at 10:47 AM, Staff C, Social Services Director (SSD), stated they were notified by Resident 1's family member on 01/29/2025 that they had concerns about the resident's care on 01/27/2025. Staff C stated they did not document the allegation, or communication with the family member. Staff C stated that obtaining statements is part of an investigation, but they had not obtained any statements related to the allegation. Staff C stated that they told Staff A at the morning meeting on 01/30/2025 of the allegation they were informed of on 01/29/2025.</p> <p>&lt;RESIDENT 2&gt;</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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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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 2 was most recently admitted to the facility on [DATE] with diagnoses to include osteoporosis, Parkinson's disease, dementia, anxiety and major depressive disorder.</p> <p>Review of Resident 2's progress note dated 02/05/2025 at 5:17 PM showed the resident had an unwitnessed fall at 1:30 PM on 02/05/2025.</p> <p>Review of Resident 2's fall investigation, dated 02/08/2025, completed by Staff B showed no resident or staff statements were obtained during the investigation process.</p> <p>In an interview on 02/21/2025 at 12:01 PM, Staff B stated their expectations were statements from residents, and staff related to an allegation of abuse or neglect should be obtained and included in the investigation. Staff B stated present staff members or any staff who may know about the incident should complete statements. Staff C stated there should be documentation related to allegations in a resident's medical record. Staff B confirmed there was no documentation related to Resident 1's allegation in their electronic medical record, or alert charting documentation to monitor for psychosocial or latent injury. Staff B stated there were no documented statements included in Resident 2's investigation file.</p> <p>In an interview on 02/21/2025 at 12:32PM, Staff A stated they did not document the conversation they had with Resident 1's family member on 01/30/2025 related to their allegation. Staff A agreed there should be statements obtained during the investigation process, and documentation of allegations should be completed in their electronic medical records as well as alert charting documentation following an incident or allegation.</p> <p>Reference WAC: 388-97-0640 (6)(a)(b)</p>		