

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  06/12/2025
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)		
F 0600  Level of Harm - Actual harm  Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to protect the resident's right to be free from neglect when they failed to initiate Cardiopulmonary Resuscitation (CPR) or call 911 for Emergency Medical Services (EMS) timely to respond correctly to a medical emergency for 1 of 2 residents (Resident 1) reviewed for abuse and neglect. Resident 1 experienced harm when the resident was found unresponsive, required CPR that was not initiated by facility staff and an unexpected death occurred. The facility staff were aware of the CPR protocol but failed to follow directives that resulted in a delay in 911 EMS call, and the initiation of CPR was delayed by 45 minutes. These failures placed all residents at risk of unmet care needs and potential neglect.</p> <p>The facility corrected the above deficient practice prior to the initiation of the abbreviated survey on [DATE]. This failure was a past noncompliance G (the facility was not in compliance at the time the situation occurred; however, there was sufficient evidence that the facility corrected the non-compliance after it was identified) situation and was no longer outstanding. The facility removed the neglect by educating staff on emergency response, reviewing their CPR policy, conducting mock code [NAME], reviewing all residents' POLST forms for accuracy, reviewing the crash cart and CPR training for completion. of death, performed CPR drills on the day, evening and night shifts, and implemented a plan of correction to sustain ongoing compliance.</p> <p>Findings included .</p> <p>Review of the facility policy titled, Abuse/Neglect/Misappropriation/Exploitation, last revised 10/2022, reviewed on [DATE] documented the facility would protect residents from mistreatment, neglect, abuse by implementing procedures designed to prevent, identify, report and investigate potential instances of abuse, neglect and exploitation. Neglect was described as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 505309	If continuation sheet Page 1 of 10

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility policy titled CPR dated 05/2019, documented the facility was to provide guidance in CPR to ensure every effort to honor residents documented wishes as related to end-of-life decisions. The policy states the facility shall be able to and does provide emergency basic life support immediately when needed, including CPR, to residents requiring such care prior to the arrival of emergency medical personnel in accordance with the related physician's orders and the residents' advance directives. Facilities will initiate CPR for full code residents immediately unless obvious signs of irreversible death as defined per regulatory guidelines (e.g. rigor mortis, dependent lividity, decapitation, transection, or decomposition) are present or initiating CPR could cause injury or peril to the rescuer.</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses to include left femur fracture, malnutrition (lack of sufficient nutrients in the body) and dysphagia (difficulty or inability to swallow).</p> <p>Review of Resident 1's Quarterly Minimum Data Set (MDS-an assessment tool) assessment dated [DATE] showed the resident was cognitively intact.</p> <p>Review of Resident 1's Physician Orders for Life-Sustaining Treatment (POLST) form, signed on [DATE], documented the resident wished to have CPR initiated if they were found without a pulse and apneic (not breathing).</p> <p>Review of Resident 1's physician's orders on [DATE] documented an order to attempt resuscitation/CPR and full treatment, order initiated on [DATE].</p> <p>Review of Resident 1's progress note dated [DATE] at 12:15PM, which was a late entry and was documented on [DATE] at 12:16 PM, Staff E, Licensed Practical Nurse (LPN) documented the resident was found unresponsive with no heart rate or breathing noted. Staff E documented they called the residents time of death as 1:04 PM.</p> <p>Review of an EMS incident report #25-W03792 dated [DATE], documented EMS arrive at the facility and assessed Resident 1 at 1:52 PM. EMS report stated The general impression of the resident was they were unresponsive, pulse less and apneic (not breathing). The resident was warm to the touch and did not have any rigor mortis, dependent lividity (purplish-blue discoloration of the skin that occurs on dependent parts of the body after death), or any other obvious signs of death present. EMS documented they moved the resident to the floor and initiated CPR. CPR continued until 2:23 PM, when time of death was called by a physician.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] at 10:43 AM, Staff E stated they were the first nurse to assess Resident 1 when they were found unresponsive on [DATE] at 1:03PM. Staff E stated they attempted to find a pulse and could not and did not see the resident breathing. Staff E stated they thought Resident 1 was on hospice services, so they did not check the resident's POLST form. Staff E stated they knew they should have checked it but did not. Staff E stated they left the room and went to alert Staff D, LPN, the residents assigned nurse who was on a lunch break that the resident was found unresponsive, with no pulse and was not breathing. Staff E stated Staff D said they were not expecting Resident 1 to pass away. Staff E asked Staff D if Resident 1 was on hospice (form of medical care for people near end of life) and they did not reply. Staff D went with Staff E to assess Resident 1 and Staff D was unable to find a pulse. Staff E stated they did not initiate CPR, or call EMS. Staff E stated they learned Resident 1 was a full code when EMS asked Staff D, who replied they were a full code. Staff E stated that no one in the facility initiated or performed CPR, EMS initiated CPR when they arrived at the facility. Staff D stated they should have checked Resident 1's POLST form when they were found unresponsive and initiated CPR.</p> <p>In an interview on [DATE] at 12:29 PM, Staff D stated they gave Resident 1 medications in the morning of [DATE] around 9:50 AM and the resident was alert, talking, and at their baseline. Staff D stated they were on their lunch break when Staff E had notified them that Resident 1 had passed away. Staff D stated they went with Staff E to assess Resident 1 and they were already gone, and their hands had turned purple, they could not find a pulse or breaths and admitted they had not used their stethoscope to listen to their heart or lungs. Staff D stated they were in shock or panic mode and did not check Resident 1's POLST form. Staff D stated they did not initiate CPR, or call EMS services when they found Resident 1 unresponsive. Staff D stated they called Staff F, LPN, In-service director, since they were on-call, they asked the residents code status, and I told them the resident was a full code. Staff F stated they would call Staff C, Registered Nurse, Assistant Director of Nursing Services (RN/ADNS) to notify them. Staff F called back and told me to call EMS and the coroner. Staff D stated no facility staff-initiated CPR, and the EMS staff-initiated CPR after stating Resident 1 was still warm. Staff D stated a full code meant they needed to initiate CPR.</p> <p>In an interview on [DATE] at 12:02 PM, Staff F, LPN/Inservice Director stated they were on call when Resident 1 was found unresponsive on [DATE] and received a phone call from Staff D around 1:30 PM telling them the resident had passed away. Staff F asked Staff D if they coded the resident, meaning did they give the resident CPR and Staff D replied Staff E had done it. Staff F stated they did not know what Staff D thought they meant when that question was asked, but stated they did not specifically ask if they had initiated CPR. Staff F stated they would call Staff C and call back with further instructions. Staff C asked Staff F if EMS had been called, and that was when Staff F found out Staff D had not yet called EMS. Staff F stated they asked Staff D what Resident 1's code status was, and they were informed the resident was a full code. Staff F stated they found out on [DATE] that Resident 1 had not received CPR from any facility staff. Staff F stated Resident 1's POLST should have been assessed first and foremost, and CPR should have been initiated immediately upon finding the resident unresponsive.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In a joint interview on [DATE] at 4:24 PM, with Staff B, Registered Nurse/Interim Director of Nursing Services (RN/IDNS) and Staff C, Registered Nurse (RN)/Assistant Director of Nursing (ADNS) stated the expectations for an unresponsive resident would be to check the resident for a pulse, call for a licensed nurse if one is not in the room, check the POLST form, grab the crash cart and initiate code blue, initiate CPR if indicated. Staff C stated they were notified by Staff F that Resident 1 was found unresponsive and facility staff-initiated CPR. Staff C stated they found out later that neither Staff D nor Staff E initiated CPR. Staff C asked Staff F if EMS had been called and found out that had not been completed, and they instructed staff to call EMS, the coroner and Resident 1's family. Staff C stated the expectation was CPR would be initiated for a resident who was full code. Staff C stated CPR should have been initiated for Resident 1.</p> <p>In an interview on [DATE] at 4:48 PM, Staff A, Administrator stated it was their expectation that staff follow the facility CPR policy and initiate CPR in accordance with the residents' POLST form. Staff A stated they were under the impression staff had initiated CPR, but upon reviewing documentation, they found it was not supportive of that claim. Staff A stated Resident 1 was a full code and facility staff had not initiated or performed CPR, which was determined the following day after the resident had passed away. Staff A stated that the amount of time it took Staff D to call EMS was too long but was unsure of how long. Staff A confirmed that EMS did initiate CPR upon arrival at the facility and it should have been initiated by facility staff prior to EMS arrival.</p> <p>Cross reference F678</p> <p>Reference WAC 388-97-0640(1)(3)(c)</p>		

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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>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record review, the facility failed to ensure staff recognize and report timely allegations of abuse/neglect for 2 of 2 residents (Resident 1 and 2) reviewed for allegations of abuse/neglect. These failures to timely report and investigate allegations of abuse/neglect and unexpected death placed residents at risk for potential abuse/neglect.</p> <p>Findings included .</p> <p>According to the Washington State Reporting Guidelines for Nursing Homes (Purple Book) dated [DATE], showed Unexpected Death, possibly related to abuse or neglect, Not related to abuse/neglect but suspicious needed to be reported to the State Hotline, Law enforcement agency as needed if a crime was suspected, Coroner or Medical Examiner and must be logged within 5 days of the event/incident.</p> <p>&amp;lt;RESIDENT 1&amp;gt;</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses to include left femur fracture, malnutrition (lack of sufficient nutrients in the body) and dysphagia (difficulty or inability to swallow).</p> <p>Review of the facility provided state reporting log, dated [DATE], showed Resident 1 had an incident on [DATE], coded as a 70, which was 'other' with no description next to it. Resident 1 was not coded as an unexpected death on the reporting log and was not reported or investigated as an unexpected death.</p> <p>Review of Resident 1's progress note dated [DATE] at 1:15 PM as a late entry documented on [DATE] at 12:16 PM, documented Staff D, Licensed Practical Nurse (LPN) was called to Resident 1's room where the resident was found unresponsive with no heart rate and was not breathing.</p> <p>Review of Resident 1's electronic medical record (EMR) showed the resident was not on hospice services or receiving end-of-life care prior to their death on [DATE].</p> <p>In an interview on [DATE] at 12:29 PM, Staff D stated Resident 1 was alert and oriented on the morning of [DATE] and not on hospice services or receiving end-of-life care.</p> <p>In an interview on [DATE] at 12:02 PM, Staff F, LPN/Inservice Director stated Resident 1 was an unexpected death as they seemed at their baseline and the resident was not on hospice services or receiving end-of-life care prior to their death on [DATE].</p> <p>In an interview on [DATE] at 4:24PM, Staff C, Registered Nurse (RN)/Assistant Director of Nursing (ADNS) stated they were unaware than an unexpected death had to be added to the facility incident log or reported to the state agency.</p> <p>In an interview on [DATE] at 4:48 PM, Staff A, Administrator stated their expectation was that the policy and procedure should be followed for an unexpected death, and they considered an unexpected death to be any resident who was not on hospice or has had a significant decline.</p> <p>(continued on next page)</p>

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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>In an interview on [DATE] at 1:25 PM, Staff A stated they were unaware Resident 1 should have been reported as an unexpected death.</p> <p>&amp;lt;RESIDENT 2&amp;gt;</p> <p>Resident 2 was admitted to the facility on [DATE] with diagnoses to include sarcopenia (condition characterized by loss of muscle mass, strength and function), chronic pain syndrome, dementia (decline in mental ability, affecting memory, thinking, language and judgement) and was legally blind.</p> <p>Review of Resident 2's Annual Minimum Data Set (MDS-an assessment tool) assessment dated [DATE] documented they required substantial/maximal assistance (staff do more than 50% of the work to complete tasks) or were dependent on staff in their activities of daily living, and care needs.</p> <p>Review of Resident 2's Kardex (staff instructions for resident care needs) dated [DATE] showed staff were to be sure the resident's call light was within reach and they needed a prompt response to all requests for assistance.</p> <p>In an interview on [DATE] at 11:00 AM, Staff E, Nursing Assistant Certified (NAC), stated staff reported Resident 2's call light appeared to be deliberately moved out of reach of the resident during night shifts on [DATE] and was unable to recall the date of the second report. Staff E stated they reported the first incident to Staff B, Registered Nurse (RN)/ Interim DNS on [DATE] and the second incident to Staff C on [DATE]. Staff E stated they were unsure if they told Staff B or Staff C that it had been reported that the call light appeared, it was intentionally positioned away from the resident or if they only reported the call light was out of reach from the resident. Staff E stated they were a mandated reporter, and this should have been reported to the state agency, especially for Resident 2, as they can't see, and are dependent on the call light for staff assistance.</p> <p>In a joint interview on [DATE] at 4:24 PM, Staff B and Staff C stated they were both informed of a concern about Resident 2's call light being out of reach but were unaware of the report that it could have been intentionally moved out of Resident 2's reach.</p> <p>In an interview on [DATE] at 4:48 PM, Staff A stated they were aware of a report that Resident 2's call light had not been within reach but was not made aware the report included it could have been intentional.</p> <p>In an interview on [DATE] at 1:25 PM, Staff A stated they were unaware of the concern with facility staff not reporting allegations of abuse and neglect. Staff A stated their expectations are that staff follow the abuse and neglect reporting policy and to complete reporting timely.</p> <p>Reference WAC 388-97-0640(5)(a)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to ensure staff performed Cardio-Pulmonary Resuscitation (CPR) to 1 of 1 resident (Resident 1) who was found unresponsive and had a physician order to initiate CPR and signed POLST (Physician Order for Life Sustaining Treatment- a form indicating the resident's wishes to have or not have CPR) for life-sustaining care and services. The failure to train staff on the facility's expectation how to respond to a resident requiring CPR, locate, for immediate reference, resident POLST/Advanced Directives, and accurately assess signs of irreversible death, resulted in staff not following Resident 1's CPR directives, and placed other current residents with CPR directives at risk of not receiving CPR and/or full medical interventions in an emergency which constituted an Immediate Jeopardy (IJ-noncompliance that has caused or is likely to cause, serious injury, harm, impairment, or death to a resident).</p> <p>The facility corrected the above deficient practice prior to the initiation of the abbreviated survey on [DATE]. This failure was a past noncompliance IJ (the facility was not in compliance at the time the situation occurred; however, there was sufficient evidence that the facility corrected the non-compliance after it was identified) situation and was no longer outstanding. The facility removed the immediacy by educating staff on emergency response, reviewing their CPR policy, conducting mock code [NAME], reviewing all residents' POLST forms for accuracy, reviewing the crash cart and CPR training for completion. of death, performed CPR drills on the day, evening and night shifts, and implemented a plan of correction to sustain ongoing compliance.</p> <p>Findings included .</p> <p>Review of facility policy titled CPR dated 05/2019, documented the facility was to provide guidance in CPR to ensure every effort to honor residents documented wishes as related to end-of-life decisions. The policy states the facility shall be able to and does provide emergency basic life support immediately when needed, including CPR, to residents requiring such care prior to the arrival of emergency medical personnel in accordance with the related physician's orders and the residents' advance directives. Facilities will initiate CPR for full code residents immediately unless obvious signs of irreversible death as defined per regulatory guidelines (e.g. rigor mortis, dependent lividity, decapitation, transection, or decomposition) are present or initiating CPR could cause injury or peril to the rescuer.</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses to include left femur fracture, malnutrition (lack of sufficient nutrients in the body) and dysphagia (difficulty or inability to swallow).</p> <p>Review of the Quarterly Minimum Data Set (MDS- an assessment tool) assessment dated [DATE] documented the resident was cognitively intact.</p> <p>Review of Resident 1's POLST form sign by a physician on [DATE], documented the resident wished to be a full code status, attempt CPR and the primary goal is prolonging life by all medically effective means.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's provider's (MD, ARNP, PA-C) orders documented the resident was full treatment, attempt resuscitation/CPR, order initiated on [DATE].</p> <p>Review of Resident 1's nursing progress created on [DATE] at 7:40 PM, showed Staff D, Licensed Practical Nurse (LPN) documented that around 1:06 PM, they were on their break and were notified by another Licensed Nurse (LN) at 1:04 PM that Resident 1 was no longer here. Staff D documented they went into the resident's room with another nurse to assess the resident. Resident 1 was not breathing, no pulse (heartbeat) was felt to the left wrist, and their bilateral fingers and hands were turning purple. Staff D documented they called Staff F, Nurse Manager, to inform them of the situation. Staff F asked them if they had called anyone else, and Staff D stated No. Staff F instructed them to call the family. While Staff D was calling the family, Staff F called back and asked if 9-11 had been called and Staff D stated No. Staff F made another call and then called back and instructed Staff D to call 9-11 and the coroner's office. 9-11 was called at 1:45 PM (approximately 40 mins after discovering Resident 1 unresponsive) and Emergency Medical Services (EMS) arrived five minutes later. Staff D documented going into the resident's room with EMS to inform them of the situation. One of the Emergency Medical Technicians (EMT) felt the resident's arm and stated that it was still warm. The EMT's placed the resident on the floor to initiate CPR. Information given to police officer and they stated they were going to their car to call the coroner. The police officer returned to inform this LN that corner was going to call with their estimated time of arrival. Staff D documented that they did not see the EMT's leave. Staff D documented they went into the resident's room around 2:40 PM and saw the resident laying on the floor with a blanket covering them. At 4:53 PM the on-call provider service was called, and a message was sent to the Physician Assistant (PA). At 5:45 PM, the PA called back, and they were informed of what occurred with Resident 1.</p> <p>Review of a witness statement dated [DATE], showed Staff E documented at approximately 1:02 - 1:03 PM on [DATE] they were called to Resident 1's room. Staff E stated they entered the room to find the resident unresponsive, no heartbeat or breathing, I called it at 1:04 PM. There was no documentation or assessment from a Registered Nurse or medical staff related to the pronouncement of Resident 1's death.</p> <p>Review of a witness statement dated [DATE], showed Staff F documented on [DATE] at 1:30 PM they received a call from Staff D to notify them that Resident 1 was found unresponsive at 1:03 PM. Staff F asked, You coded the resident because they were a Full code right? Staff D stated they were on a break and another LN did. Staff F stated they would notify Staff C Registered Nurse (RN)/Assistant Director of Nursing (ADNS) for further instructions and call back. Staff F documented that Staff C asked if staff had called 911 and Staff F stated, they didn't say. Staff F then called the Administrator, and they stated to have Staff D call 911 and the coroner. Staff F called Staff D back and told them to call 911 and the coroner. Staff F stated at approx. 2:39 PM they received a call from Staff D to tell them what happened when EMTs and police arrived. On [DATE], Staff F was in the facility and was informed by Staff C that they had not initiated CPR on Resident 1 on [DATE], as they were under the impression the resident was on hospice (form of medical care for people near end of life).</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of an EMS report incident #25-W03792, dated [DATE], documented EMS arrived at the facility and assessed Resident 1 at 1:52 PM. EMS report stated The general impression of the resident was they were unresponsive, pulse less and apneic (not breathing). The resident was warm to the touch and did not have any rigor mortis, dependent lividity (purplish-blue discoloration of the skin that occurs on dependent parts of the body after death), or any other obvious signs of death present. EMS documented they moved the resident to the floor and initiated CPR. CPR continued until 2:23 PM, when time of death was called by a physician.</p> <p>In an interview on [DATE] at 10:43 AM, Staff E, LPN stated they were the first nurse to assess Resident 1 when they were found unresponsive on [DATE] at 1:03PM. Staff E stated they attempted to find a pulse and could not and did not see the resident breathing. Staff E stated they thought Resident 1 was on hospice services, so they did not check the resident's POLST form. Staff E stated they knew they should have checked it but did not. Staff E stated they left the room and went to alert Staff D, LPN, the residents assigned nurse who was on a lunch break that the resident was found unresponsive, with no pulse and was not breathing. Staff E stated Staff D said they were not expecting Resident 1 to pass away. Staff E asked Staff D if Resident 1 was on hospice and they did not reply. Staff D went with Staff E to assess Resident 1 and Staff D was unable to find a pulse. Staff E stated they did not initiate CPR, or call EMS. Staff E stated they learned Resident 1 was a full code when EMS asked Staff D, who replied they were a full code. Staff E stated that no one in the facility initiated or performed CPR, EMS initiated CPR when they arrived at the facility. Staff D stated they should have checked Resident 1's POLST form when they were found unresponsive and initiated CPR.</p> <p>In an interview on [DATE] at 12:02 PM, Staff F stated they were on call when Resident 1 was found unresponsive on [DATE] and received a phone call from Staff D around 1:30 PM telling them that Resident 1 had passed away. Staff F asked Staff D if they coded the resident, meaning did they give the resident CPR and Staff D replied Staff E had done it. Staff F stated they did not know what Staff D thought they meant when that question was asked, but stated they did not specifically ask if they had initiated CPR. Staff F stated they would call Staff C and call back with further instructions. Staff C asked Staff F if EMS had been called, and that was when Staff F found out Staff D had not yet called EMS. Staff F stated they asked Staff D what Resident 1's code status was, and they were informed the resident was a full code. Staff F stated they found out on [DATE] that Resident 1 had not received CPR from any facility staff. Staff F stated Resident 1's POLST should have been assessed first and foremost, and CPR should have been initiated immediately upon finding the resident unresponsive.</p> <p>In an interview on [DATE] at 12:29 PM Staff D stated that they were the assigned nurse for Resident 1 on [DATE]. Staff D stated that they were on lunch in the break room when notified by Staff E, LPN that Resident 1 was nonresponsive. Staff D went to Resident 1's room and stated when they entered the room The resident was already gone. Staff D stated the resident's hands were turning purple, and the resident had no pulse or breath sounds, but stated they had not auscultated the lungs or heart (examine resident by listening to sounds from heart, lungs, or other organs). Staff D stated that if a resident was full code, then we should initiate CPR if they found them unresponsive. Staff D stated that Resident 1 was a full code status, but they did not check their code status at the time they found them unresponsive as they were in shock or a panic mode. Staff D stated that the POLST forms are located in the computer system and in binders at both nurses' stations. Staff D stated that they called the nurse manager, and the nurse manager instructed them to call 9-11 and the coroner's office. Staff D stated that when EMS arrived at Resident 1's room, they stated that the resident was still warm. They proceeded to pull Resident 1 to the floor and initiated CPR. Staff D stated they left the room at that time.</p> <p>(continued on next page)</p>		

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  06/12/2025
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 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In a joint interview on [DATE] at 4:24 PM, with Staff B, Registered Nurse/Interim Director of Nursing Services (RN/IDNS) and Staff C, stated the expectations for an unresponsive resident would be to check the resident for a pulse, call for a licensed nurse if one is not in the room, check the POLST form, grab the crash cart and initiate code blue, initiate CPR if indicated. Staff C stated they were notified by Staff F that Resident 1 was found unresponsive and facility staff-initiated CPR. Staff C stated they found out later that neither Staff D nor Staff E initiated CPR. Staff C asked Staff F if EMS had been called and found out that had not been completed, and they instructed staff to call EMS, the coroner and Resident 1's family. Staff C stated the expectation was CPR would be initiated for a resident who was full code. Staff C stated CPR should have been initiated for Resident 1.</p> <p>In an interview on [DATE] at 4:48 PM, Staff A, Administrator, stated it was their expectation that staff follow the facility CPR policy and initiate CPR in accordance with the residents' POLST form. Staff A stated they were under the impression staff had initiated CPR, but upon reviewing documentation, they found it was not supportive of that claim. Staff A stated Resident 1 was a full code and facility staff had not initiated or performed CPR, which was determined the following day after the resident had passed away. Staff A stated that the amount of time it took Staff D to call EMS was too long but was unsure of how long. Staff A confirmed that EMS did initiate CPR upon arrival at the facility and it should have been initiated by facility staff prior to EMS arrival.</p> <p>Cross reference F60 (neglect)</p> <p>Reference WAC 388-97-1060(1)</p>		