STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505325	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bainbridge Island Health & Rehab Center	835 Madison Avenue North Bainbridge Island, WA 98110

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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 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** 46793 . Based on interview and record review, the facility failed to provide the necessary care and services to maintain residents' highest practicable level of well-being for 1 of 5 sampled residents (Resident 27) reviewed for bowel management. The failure to initiate bowel care in accordance with physicians' orders placed residents at risk for pain/discomfort, nausea, decreased appetite and a diminished quality of life. Findings included . Resident 27 was admitted to the facility on [DATE]. The Significant Change Minimal Data Set, (MDS, an assessment tool), dated 07/30/2024 documented Resident 27 was severely cognitively impaired. A physician's order, dated 01/24/2024, documented Miralax (a laxative) 17 grams was to be mixed with eight ounces of fluids and given to resident, if no bowel movement (BM)after three days or if resident complained of constipation with abdominal discomfort. A physician's order, dated 09/05/2023, documented bisacodyl (a laxative) 5 milligrams (mg) was to be given 12 hours after no results with Miralax. A physician's order, dated 01/24/2024, documented bisacodyl suppository 10 mg was to be given 12 hours after no results with bisacodyl 5 mg. A physician's order, dated 01/24/2024, documented Fleet enema 7-19 grams was to be given 12 hours after no results with bisacodyl 10 mg. A physician's order, dated 07/27/2024, documented Senna (laxative) 10 milliliters (ml) was to be given two times daily, and increase to 17.6 mg after two days with no BM. Resident 27's bowel record documented no BMs on 06/27/2024-07/01/2024 (5 days), 07/10/204-07/18/2024 (9 days), 08/13/2024-08/26/2024 (13 days) and 09/05/2024-09/10/2024 (6 days). Resident 27's 06/27/2024-07/01/2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) documented no administration of the bowel protocol medications. (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	A progress note, dated 07/01/2024, documented Resident 27 was toileted but it was not documented on the bowel record. Resident 27's 07/10/2024-07/18/2024 MAR/TAR documented the bisacodyl 5 mg was administered on 07/16/2024 (after seven days with no BM). A progress noted dated 07/17/2024 documented a fleet enema was given to Resident 27. The fleet enema was documented as effective. Resident 27's July 2024 bowel record documented no BM until 07/19/2024. Resident 27's 08/13/2024-08/26/2024 MAR/TAR showed no documentation on 06/16/2024 (four days without a BM). Miralax 17 grams was given on 08/17/2024 and 08/18/2024, but no further bowel protocol was followed. A progress note, dated 08/19/2024, documented Resident 27 had gone three or more days without a BM. No further intervention was given until 08/20/2024, when a bisacodyl 10 gm was given (eight days with no BM). A progress note dated 08/21/2024, documented Miralax 17 gm was given. There was no documentation on 08/22/2024-08/23/2024, regarding any bowel protocol/management. On 08/24/2024 Miralax 17 gm was given (12 days without a BM). Resident 27's 09/05/2024-09/10/2024 MAR/TAR showed no documentation regarding any bowel protocol/management. A hospice note, dated 09/09/2024, documented Resident 27 had gone four days without a BM and an enema had not been completed. No documentation provided for bowel protocol/management on 09/10/2024. On 09/12/2024 at 9:29 AM, Staff D, Licensed Practical Nurse/Resident Care Manager, said the bowel protocol was initiated after a resident has no BM for three days. If there was still no BM, then on the next shift, staff would offer a suppository. If there was still no BM on the next shift, then staff would offer an enema. Staff D said all refusals need to be reported to the provider. At 2:46 PM, Staff B, Director of Nursing Services, with Staff C, Interim Administrator present for interview, said the general bowel protocol was after three days with no BM, Miralax was to be given. If still no BM, then on the next shift a bisacodyl suppository was offered. If there were still no results the next shift would offer a fleet enema. Staff B said some residents had different bowel management protocols specific to that resident. When asked about Resident 27's bowel protocol, Staff B said Resident 27 had standing (routine/daily) orders for Miralax and Senna. However, if Resident 27 had gone three days without a BM, then they would have started with giving Resident 27 an extra dose of Miralax (17 grams). If no results, then they give bisacodyl 5 mg. If there was still no results, then a second bisacodyl 10 mg suppository would be offered. If there was still no result, then staff would offer a fleet enema. When shown the 06/27/2024-07/01/2024 dates with no BM, Staff B said the bowel protocol should have been started. When shown the 07/10/2024-07/18/2024 dates with no BM, Staff B said the bowel protocol should have been started. When shown the 08/13/2024-08/26/2024 dates with no BM, Staff B said the bowel protocol should have been started. When shown the 09/05/2024-09/10/2024 dates with no BM, Staff B said the bowel protocol should have been started. Reference WAC 388-97 -1060 (1)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on observation, interview, and record review, the facility failed to maintain, label/date, and properly store oxygen tubing/supplies and nasal cannula (NC, flexible tubing that sits inside the nose and delivers oxygen) for 1 of 1 sampled resident (Resident 9) reviewed for respiratory care. This failure placed the residents at risk for unmet care needs, respiratory infections, and a diminished quality of life. Findings included . The facility Oxygen Administration policy, revised 04/2024, documented oxygen tubing is to be replaced every seven (7) days or when visible soiled. Resident 9 was admitted to the facility on [DATE]. The Annual Minimal Data Set, (MDS, an assessment tool), dated 06/25/2024, documented Resident 9 was moderately cognitively impaired. A physician's order, dated 04/23/2024, documented oxygen tubing was to be changed every Sunday or as needed. On 09/09/2024 at 12:29 PM, Resident 9 was wearing the NC. The oxygen machine was running at 3 liters per minute. Oxygen tubing was dated 09/01/2024. On 09/11/2024 at 9:54 AM, Resident 9 was wearing the NC. The oxygen machine was running at 3 liters per minute. Oxygen tubing was dated 09/11/2024. The September 2024 oxygen Treatment Administration Record (TAR) documented the oxygen tubing was changed on 09/01/2024 (Sunday) and 09/08/2024 (Sunday). On 09/11/2024 at 9:56 AM, Staff B, Director of Nursing Services, was asked to observe the oxygen tubing on Resident 9's oxygen machine. Staff B said the date on the tubing was marked 09/11/2024. After showing Staff B the September 2024 TAR, Staff B said her expectation was the oxygen tubing was to be changed every Sunday, as ordered. When asked if the oxygen tubing should have been changed on 09/08/2024, Staff B said yes. When asked if staff should be signing for things that have not completed, Staff B said no. Reference WAC 388-97-1060 (3)(j)(vi)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50392 Based on observation and interview, the facility failed to maintain a kitchen environment which allowed each resident to have nourishing, palatable and well-balanced meals without cross contamination for 1 of 1 kitchen reviewed for food safety. This failure put residents at risk for food-borne illness, unsanitary conditions, and a diminished quality of life. Findings included . <Food preparation observations> On 09/11/2024 at 11:53 AM, Staff H, Cook, dropped his writing pen on the floor, he picked it up with bare hands and did not clean the pen. Staff H then wrote on a clip board and put the pen back onto his shirt by clipping the pen onto his shirt collar. Staff H did not wash hands after using the pen. At 1:09 PM, during tray line observation, Staff H, with gloved hands took the pen from out of his shirt and wrote on a piece of paper that was on the food tray, then with the same gloves picked up a hamburger bun and put it on a plate and continued to build burgers. <Tray line observations> Tray line assembly started on 09/11/2024 at 11:58 AM. At 11:58 AM, Staff H, went to the steam table and began taking temperatures of food without cleaning the thermometer in between items temped on steam table. At 12:08 PM, Staff H, adjusted their glasses with bare hands, did not wash hands, grabbed gloves and put them on. At 12:24 PM, Staff H, touched their glasses and then touched their mask with gloves on, did not change gloves and picked up plates and placed them on the steam table. Staff H picked up hamburger buns and placed them on plates. Staff H then used a spatula to transfer hamburger patties onto hamburger buns, touching the top of the hamburger patty with the other hand. Staff H did not wash hands or change gloves. At 12:27 PM, Staff H, pushed their reading glasses up with gloved hands and adjusted hat, then went to plate warmer lifted the lid and took plates out, and continued to plate food. No glove change was observed. At 12:31 PM, Staff H, used gloves to flip hanging name tag to back of his shirt, did not change gloves and got plate from plate warmer, then picked up hamburger buns and placed them on the plate. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:35 PM, Staff H, pushed up reading glasses on his face with gloves, then grabbed condiment packets from container and placed them on the food tray. Staff H put hamburger buns on a plate along with lettuce and tomato. Staff H then used spatula to transfer hamburger patties onto hamburger buns, touching the top of the hamburger patty with the other hand. Staff H did not wash hands or change gloves. At 12:41 PM, Staff H, adjusted dials on the steamer table and resumed plating food without a glove change. At 12:44 PM, Staff H, wiped thermometer with dish towel that had been used to wipe steam table counter, then began temping food on steam table. At 12:49 PM, Staff H, adjusted the temperature with the dial on the steam table with gloved hands, then got plates out of the warmer, he then picked up hamburger buns and put them on the plate. Staff H then used spatula to transfer hamburger patties onto hamburger buns, touching the top of the hamburger patty with the other hand. Staff H did not wash hands or change gloves. At 12:56 PM, Staff H, took several plates out of the plate warmer and held the stack of plates' edges against his shirt, he then placed the plates on the steam table. Staff H picked up two condiment packets and placed them on a tray and then picked up hamburger buns and placed them on a plate. Staff H then used spatula to transfer hamburger patties onto hamburger buns, touching the top of the hamburger patty with the other hand. Staff H moved a nearby cart by its handles, then continued to plate food, grabbing lettuce. Staff H then wiped gloves on a dishtowel that was observed to have been used to wipe down steamer table, and then picked up tomatos and placed them on hamburger patty. Staff H did not wash hands or change gloves. On 09/11/2024 at 2:45 PM, Staff I, Dietary Supervisor, said that usually during food service ladles and tongs wereused. Staff I said after adjusting glasses, touching a name tag or touching mask, that those actions would be an interruption to touching food, and he would expect them to use clean gloves when going back to handling food. When asked about touching food condiment packages and then touching food, Staff I said it would have been better to have the dietary aid put the condiments on the tray. When asked what the process would be for cleaning the thermometer between each food temping, Staff I said staff should be using sanitizer bucket and towel to wipe down between each poke. On 09/13/2024 at 10:21 AM, Staff A, Administrator and Staff C, Interim Administrator, said their expectation was to prevent cross contamination of food borne illness in the kitchen by following guidelines such as hand washing, hair nets, temperatures of foods and use by dates. When asked if it would it be acceptable for staff to touch glasses, hair/hat, badge or mask then touch food, Staff C said it was not acceptable without staff changing their gloves. When asked if it was acceptable to use a pen that had been dropped on the floor then touch food with the same gloved hands, Staff C said that was not acceptable. When asked if they would expect staff to use gloved hands to build a burger and with gloves touch buns, patties, lettuce, and tomatos, Staff C said they should be using utensils. Reference WAC 388-97-1100

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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** 46793 Based on observation, interview and record review the facility failed to follow transmission-based precautions (TBP) when donning (taking on)/doffing (taking off) Personal Protective Equipment (PPE) for 1 of 2 sampled rooms (room [ROOM NUMBER]) reviewed for TBP. This failure placed the residents at an increased risk for infections and a decreased quality of life. Findings included . On 09/09/2024 at 1:36 PM, during lunch meal services, Staff J, Registered Nurse, donned gown, gloves, a N95 mask (fitted mask to protect against COVID and other droplet transmitted illnesses)over the top of an already worn surgical mask and gloves. Staff J entered room [ROOM NUMBER] and was handed a lunch meal tray. At 1:46 PM, Staff J existed room [ROOM NUMBER] wearing only a surgical mask (had doffed in room [ROOM NUMBER]), and then went into to room [ROOM NUMBER] wearing the same surgical mask. On 09/12/2024 at 9:29 AM, Staff D, Licensed Practical Nurse/Resident Care Manager, said the proper PPE donning procedure for a COVID positive room was putting on a gown, an N95, goggles and gloves. When asked if double masking was acceptable, Staff D stated, No, you want a tight seal. At 10:22 AM, Staff B, Director of Nursing Services, said the proper donning procedures was to put on the gown, gloves, switch from a surgical mask to N95 mask and then goggles before entering the room. When asked if double masking was acceptable, Staff B said no. When the observation was reported, Staff B said that was not acceptable. Reference WAC 388-97-1320 (2)(b)