| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505326 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/12/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Heartwood Extended Healthcare | 1649 East 72nd<br>Tacoma, WA 98404 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0567<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to manage his or her financial affairs.<br><br>46067<br><br>Based on interview and record review, the facility failed to ensure residents had access to their money during evenings and weekends for 1 of 37 sampled residents (Resident 36) reviewed for personal funds. This failure placed residents at risk for decreased autonomy (independence), dishonored residents rights, and a diminished quality of life.<br><br>Findings included .<br><br>During an interview on 04/09/2024 at 12:56 PM, Resident 36 stated they did not have a lock box and had to keep funds in their room because they did not have access to personal funds after business hours.<br><br>Review of Resident 36's financial Trial Balance statement, dated 04/08/2024, showed Resident 36 had a monthly deposit allowance of $45.36 and an available balance total of $407.18.<br><br>During an interview on 04/10/2024 at 1:53 PM, Staff D, Business Office Manager, stated residents did not have access to personal funds after hours.<br><br>During an interview on 04/12/2024 at 1:09 PM Staff A, Administrator, stated residents did not have access to personal funds after hours (due to a recent petty cash audit) like they should, which did not meet their expectation.<br><br>Reference WAC 388-97-0340 (1)(2)(3). |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505326 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/12/2024 |
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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>46472<br><br>Based on observations and interviews the facility failed to protect the resident's right to personal privacy for 2 of 4 Residents (Resident 52 and 69) reviewed for dignity. The failure to provide privacy and maintain dignity during the provision of personal cares and wound treatment for Resident 52 and for Resident 69 placed the residents at risk for embarrassment, frustration, and undignified quality of life.<br><br>Findings included .<br><br><Resident 52><br><br>During an observation on 04/09/2024 at 9:34 AM, Resident 52 was seated in their wheelchair facing the doorway. The door was not closed and the privacy curtain was not pulled to provide privacy during care. Staff T, Certified Nursing Assistant (CNA), was observed re-arranging Resident 52's shirt and exposed Resident 52's left breast which was observed from the hallway.<br><br>In an interview on 04/09/2024 at 9:41 AM, Staff T stated they tried to shut the door, but the door did not have a doorknob and would not stay closed. Staff T stated they pulled the curtain but must not have pulled the curtain far enough to provide privacy.<br><br><Resident 69><br><br>During a wound care observation provided by Staff K, Licensed Practical Nurse (LPN), on 04/10/2024 at 11:40 AM, Staff K ensured the door was shut and the curtain was pulled to provide Resident 69 with the privacy, and started the wound care. At 11:44 AM, Staff S, LPN, Resident Care Manager, entered the room without knocking or asking to enter, and stood at the opening of the curtain to speak to Staff K regarding another (unidentified) resident. When Staff S left the room, they did not close the door. Resident 69 stated in a frustrating tone, Can we just open the curtain and let everyone in while I am getting my dressing changed? Staff K asked to have the door closed because they were in the middle of the dressing change. Staff K stated Resident 69 liked to have the door closed and the curtain pulled during care, and staff should always knock before entering.<br><br>Reference: WAC 388-97-0360(1)(b)(d). |

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| F 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident when there is a significant change in condition<br><br>46472<br><br>Based on observation, interviews, and record review the facility failed to timely identify (or should have identified) a significant change is status for 1 of 2 residents (Resident 6) reviewed for change of condition. The failure to conduct a Significant Change in Status Assessment (SCSA) within 14 days of the determination of a resident's significant change in status placed the resident at risk for unmet care needs, diminished quality of care/quality of life.<br><br>Findings included .<br><br><Resident 6><br><br>During an observation and interview on 04/09/2024 at 10:13 AM, Resident 6 was observed lying in their bed, the shades closed, and the room very dark. Resident 6 stated they were aware they had gained a considerable amount of weight which they contributed to their food choices, their loss of mobility and independence, their body altering leg amputation, pain, and lack of motivations/loss of interest in doing anything. Resident 6 stated before they came to this facility, they could walk, and they were continent of bladder. Resident 6 stated they disliked living in a nursing facility, felt like they were never happy, and disliked sharing a room with anyone. Resident 6 stated they barely ever got up out of bed which was their choice. Resident 6 stated they had no clothes that fit them, so they lie in bed, naked, under their bedding. Resident 6 stated they had teeth that were in bad condition and was scheduled for extraction of all their teeth, which they were looking forward to. Resident 6 stated there are many days they had experienced oral pain because of their poor dental condition.<br><br>Review of the Level 1 Pre-Admission Screening and Resident Review (PASRR-a screening tool used to identify individuals with significant mental illness or developmental disabilities), dated 06/12/2023, showed Resident 6 had no serious mental illness indicators, developmental disabilities, or diagnosis of dementia.<br><br>Review of the 11/4/2022 Admission Minimum Data Set (MDS-assessment tool) showed Resident 6 had no problems with their cognition, no indicators of a mood disorder, and [they] believed they could increase their independence with some activities of daily living (ADLs). Resident 6 was frequently incontinent of bladder. Resident 6 diagnoses included surgical aftercare following a lower limb amputation, diabetes, morbid obesity, and required extensive assistance with ADLs. Resident 6 weighed 346 pounds and was not assessed to have a significant weight loss/gain. Resident 6 was assessed to have no dental problems and did not receive any psychotropic medications.<br><br>Review of a Physician Order (PO) dated 11/07/2022 showed Resident 6 was started on an anti-depressant medication for depression with insomnia.<br><br>Review of the 02/11/2023 quarterly MDS showed Resident 6 had a decline in mood with increase in mood indicators and received an anti-depressant medication, but no diagnoses of depression. The MDS showed Resident 6 had a decline in urine continence and their weight was not assessed.<br><br>(continued on next page) |

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| F 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the 05/20/2023 quarterly MDS showed Resident 6 weighed 398 pounds, which was a 14% weight gain in six months, but was not coded for a significant weight gain. In an interview on 04/11/2024 at 2:45 PM, Staff F, MDS Coordinator, stated the resident should have been coded for a significant weight increase but was not, and must have been an oversight. Staff F stated they depended on the nursing team to notify them of identified changes in status of residents and then they discussed the concerns as a team and did not recall Resident 6 coming up for a significant change. Staff F stated when they completed the MDS, if there were items coded that were actual significant changes from the previous assessment, they would typically see the alert from PCC and address them, but agreed the alerts for significant changes was dependent on the accuracy and completeness of the assessment being done. Staff F stated they would review the resident and try to determine when/if they experienced a significant change in status.<br><br>Review of the 08/15/2023 quarterly MDS showed Resident 6 had a decline in cognition and was coded to have indicators of delirium that included continuous inattention, disorganized thinking, and altered level of consciousness. Resident 6 had a decline in mood with a significant increase in depression indicators in section D. Resident 6 continued to receive daily anti-depression medication but the diagnosis was not coded in section I of the MDS. Resident 6's weight was 379 pounds.<br><br>Review of a PO, dated 09/22/2023, showed Resident 6 began taking a second anti-depressive medication for depression and anxiety.<br><br>Review of the 11/03/2023 Annual comprehensive MDS showed Resident 6 continued to have cognition changes and indicators of delirium. Resident 6 continued to report indicators of depression and was assessed to socially isolate themselves sometimes. Resident 6's weight was assessed to be 379 pounds, which was not the most recent weight on record of 448 pounds on 10/05/2023. Based on the weight of 448 pounds, Resident 6 had another significant weight gain of 18% in five months-from the last documented weight of 379 on 06/15/2023.<br><br>Review of a PO, dated 11/15/2023, showed Resident 6's second anti-depressant medication was discontinued and replaced with a different anti-depressant medication and the diagnosis was major recurrent depressive disorder.<br><br>Review of an updated Level 1 PASRR, dated 12/02/2023, showed Resident 6 had indicators of a mood disorder and required a Level II PASRR evaluation for significant mental illness, a change from the previous PASRR screening.<br><br>Review of the 02/01/2024 quarterly MDS showed Resident 6's cognition and mood were not assessed. Resident 6 received anti-depressant medication without diagnoses coded to support the use of the medication. Resident 6 weight was 460 pounds.<br><br>Review of Resident 6's April 2024 Medication Administration Record (MAR) showed a PO, dated 02/08/2024, for an anti-psychotic medication, ordered routinely, for the treatment of resistant depression with severe psychotic features.<br><br>Review of Resident 6's medical record showed they experienced a 30% weight gain over the past year, experienced and overall decline in mood, started two anti-depressants and an anti-psychotic medication since admission to treat major depression with new onset of psychotic features, was assessed to have a decline in cognition with indicators of delirium, was self-isolating.<br><br>(continued on next page) |

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| F 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | REFERENCE WAC 388-97-1000(3)(b). |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344<br><br>.<br><br>Based on observation, interview, and record review, the facility failed to accurately assess 7 of 20 sampled residents (Residents 27, 88, 6, 9, 51, 69, and 72) whose minimum data sets (MDS, a required assessment tool) were reviewed. The failure to accurately assess the residents care needs directly affected the ability to develop a comprehensive care plan that met the residents care needs and placed them at risk for further unmet needs, inaccurate medical records, medical complications,and diminished quality of care/quality of life.<br><br>Findings included .<br><br><Resident 27><br><br>During an interview on 04/08/2024 at 12:05 PM, Resident 27 stated they had fallen out of bed one time.<br><br>Review of Resident 27's electronic health record (EHR) showed the resident readmitted to the facility on [DATE] and was able to make needs known.<br><br>Review of the facility's incident reporting log dated November 2023 showed that Resident 27 had incidents of falls logged for falls on 11/17/2023 and 11/21/2023.<br><br>Review of Resident 27's quarterly MDS dated [DATE] showed that the resident did not have a fall since admission or reentry into the facility.<br><br>During an interview on 04/12/2024 at 10:30 AM, Staff F, Registered Nurse/MDS Coordinator, (RN/MDS) stated that Resident 27's 01/10/2024 quarterly MDS was coded no for falls and should have been coded, yes, and this did not meet expectations.<br><br>During an interview on 04/12/2024 at 10:38 AM, Staff B, Director of Nursing Services (DNS), stated that Resident 27 had documented falls on 11/17/2023 and 11/21/2023. Staff B stated that Resident 27's quarterly MDS was inaccurately coded for falls and needed to be modified to correct the coding.<br><br><Resident 88><br><br>Observation on 04/09/2024 at 9:39 AM, showed Resident 88 with broken upper teeth down to the gums and missing lower teeth.<br><br>Review of Resident 88's admission MDS dated [DATE] showed that the resident admitted to the facility on [DATE] with diagnoses that included stroke and dysphagia (a condition that affects the ability to produce and understand spoken language). It showed that Resident 88 had no natural teeth or broken natural teeth.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident 88's dental visit document dated 03/18/2024 showed that the dentist recommendation included that Resident 88 had upper and lower teeth extraction (removal) and new upper and lower dentures.<br><br>During an interview on 04/11/2024 at 1:59 PM, Staff F, RN/MDS, stated that Resident 88's 01/29/2024 admission MDS showed no natural teeth and that was not coded correctly and needed to be modified.<br><br>During an interview on 04/11/2024 at 2:11 PM, Staff B, DNS, stated that Resident 88's 01/29/2024 admission MDS was not coded accurately, and this did not meet expectations.<br><br>46472<br><br><Resident 6><br><br>Review of the 05/20/2023 quarterly MDS showed Resident 6 weighed 398 pounds.<br><br>Review of Resident 6's weight record showed they weighed 349 pounds on 11/4/2022 (no weights recorded between 11/05/2022 and 04/07/2023); a 14% weight gain in 6 months but was not coded for a significant weight gain.<br><br>Review of the 11/03/2023 Annual MDS showed Resident 6's weight was 379 pounds, which was their weight from 06/15/2023, not their most recent weight.<br><br>Review of Resident 6's weight record showed they weighed 448 pounds on 10/05/2023, which was an 18% weight gain in five months but was not coded for a significant weight gain.<br><br>Review of Resident 6's 02/01/2024 quarterly MDS showed they received an anti-depressant medication, however there was no diagnosis coded in section I for the for anti-depressant medication. Additionally, they had no dental problems.<br><br>In an interview on 04/09/2024 at 10:13 AM, Resident 6 stated they had teeth, that were broken and in bad condition. They often had oral pain and was scheduled for extraction of all their teeth soon.<br><br>In an interview on 04/11/2024 at 2:45 PM, Staff F, MDS Coordinator, stated the resident should have been coded for a significant weight gain, and should have correct diagnoses codes for use of the antidepressants but did not. Staff F stated Resident 6's previous assessments showed they were edentulous so they would need to review further.<br><br><Resident 9><br><br>Review of the 11/21/2023 Significant Change in Status Assessment MDS, section A1500 showed Resident 9 was not considered by the State Level II PASRR (Preadmission Screening and Resident Review -screening process) to have a serious mental illness or intellectual disability.<br><br>Review of the 01/19/2017 Level II Initial Psychiatric Evaluation, Resident 9 had a developmental delay disability from birth, a long history of bipolar disorder (a type of depression), and a history of delusions.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 04/11/2024 at 12:15 PM, Staff F stated the coding was incorrect.<br><br><Resident 51><br><br>Review of the 03/28/2024 Hospital Discharge Summary showed Resident 51's primary diagnoses upon readmission to the facility included heart failure with COPD exacerbation and respiratory failure. Other diagnoses included morbid obesity, osteoarthritis (OA) of both knees, anemia, chronic venous stasis ulcers on the left lower leg, and weighed 454 pounds.<br><br>Review and comparison of the March 2024 and April 2024 Medication Administration Records (MARs) during the observation period for the 4/04/2024 Quarterly MDS showed the following coding errors that required assessment:<br><br>Section I:<br><br>I0020B. was coded as pneumonia but Resident 6 primary medical condition was not pneumonia.<br><br>I0200. was coded NO but Resident 51 received an iron supplement for anemia.<br><br>I0600. was coded as NO but Resident 51 received multiple heart medications and diuretics and cardiology consultation confirmed diagnosis.<br><br>I0900. was coded as NO but Resident 51 Received dressing changes to the lower legs for venous statis ulcers (VSU) caused by peripheral vascular disease.<br><br>I2000. was coded as YES but Resident 51 did not have diagnosis of pneumonia.<br><br>I6200. was coded as NO but Resident 51 received treatment for chronic lung disease and had a recent re-hospitalization .<br><br>I6300. was coded as NO but Resident 51 was just hospitalized for respiratory failure.<br><br>I8000.: Resident 51 received a medication for the treatment of an intestinal bleed, but the diagnoses were not coded.<br><br>I8000.: Resident 51 received multiple diuretics and had a recent hospitalization for edema/fluid volume overload, but that diagnosis was not coded.<br><br>I8000.: Resident 51 diagnosis of morbid obesity with BMI >50 was not coded.<br><br>I8000.: Resident 51 received medication and treatment for osteoarthritis, but OA was not coded.<br><br>I8000.: Resident 51 received a routine daily antiviral medication, but the diagnosis was not coded.<br><br>Section K:<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident 51's weight was documented as 433 on the MDS. Further review of Resident 51's weight record showed they weighed 454 pounds on 03/28/2024 at the hospital. There was no weight documented in Resident 51's record for the date or readmission to the facility. The next weight documented was on 04/03/2024 and was 469 pounds (an increase of 15 pounds or 3% in one week).<br><br>Section M:<br><br>M1030 of the MDS showed no venous or arterial ulcers. According to the MAR, Resident 51 had dressings applied to the lower extremities for VSU,.<br><br>M1040.D. was coded as NO. According to the MAR, Resident 51 had an abdominal wound and received dressing changes and should have been assessed.<br><br>Section N:<br><br>N0415.G. was coded as NO, but Resident 51 received several different diuretics.<br><br>No415.J. was coded as NO, but Resident 51 received a hypoglycemic medication daily.<br><br><Resident 69><br><br>Review of the Resident 69's electronic health record (EHR) and 03/01/2024 Annual MDS showed: GG0115. B was coded as impairment to only one side but Resident 51 had diagnoses of paralysis of both lower extremities and a left lower leg amputation, and I0900 was coded as NO but Resident 51 had a diagnosis of PVD.<br><br>In an interview on 04/11/2023 at 12:30 PM, Staff F stated the coding was in error and should be accurate.<br><br>50392<br><br><Resident 72><br><br>During an observation and interview on 04/08/2024 at 11:40 AM, Resident 72 laid in bed on their back and stated staff did not get them up into wheelchair when they ask.<br><br>Review of Resident 72's admission MDS dated [DATE] showed no information related to the residents' ADL abilities to include transfers.<br><br>During an interview on 04/10/2024 at 12:45 PM, Staff F, RN/MDS stated that Resident 72's admission MDS was coded incorrectly and did not contain ADL information and should have.<br><br>Reference WAC 388-97 -1000 (1)(b). |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148<br><br>Based on observations, interviews, and record review, the facility failed to develop, implement, and/or update person-centered comprehensive care plans (CP) and ensure the appropriate CP information for direct care staff carried over to the Kardex (bed-side CP direct care staff depend on to provide person-centered care) for 6 of 20 residents (Residents 55, 70, 13, 52, 6, and 69) reviewed for comprehensive CPs. These failures placed the residents at risk for poor clinical outcomes, lack of services, unmet care needs, medical complications, diminished quality of care/quality of life.<br><br>Findings included .<br><br><Resident 55><br><br>Review of the 03/18/2024 Admission Minimum Data Set (MDS-assessment tool) showed Resident 55 they admitted to the facility on [DATE] and had diagnosis of depression.<br><br>Review of the physicians' order (PO), dated 03/13/2024 showed Resident 55 was to receive an anti-depressant medication to treat their depression, starting on 03/14/2024.<br><br>Review of Resident 55's comprehensive CP showed no care plan in place for depression.<br><br>During an interview on 04/11/2024 at 2:39 PM, Staff B, Director of Nursing Services (DNS) stated Resident 55 should have had a care plan for depression but didn't and this did not meet expectation.<br><br><Resident 70><br><br>Review of the 08/10/2023 Admission MDS showed Resident 70 assessed to require the use of an indwelling supra-pubic urinary catheter (a tube placed into the bladder through the abdomen to drain urine).<br><br>Review of a PO, dated 12/15/2023, showed Resident 70 was ordered an anti-biotic medication for the treatment of a urinary tract infection, with a stop date of 12/22/2023.<br><br>Review of Resident 70's electronic health record (HER) on 04/11/2024 showed no orders to provide routine catheter care and no catheter CP for the management and care of their catheter.<br><br>During an interview on 04/11/2024 at 9:12 AM, Resident 70 stated I never get catheter care.<br><br>During an interview on 04/11/2024 at 9:12 AM, Staff J, Nursing Assistant-Registered (NAR), stated to determine what residents required such care needs as routine catheter care daily, they would look at the residents Kardex (a direct abbreviate CP for direct care staff) for the information.<br><br>During an interview on 04/11/2024 at 9:23 AM, Staff L, Registered Nurse (RN) stated catheter care should have been in the CP and there should have been an order in the Treatment Administration Record (TAR) for the nursing staff to perform and document routine catheter site care.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 04/11/2024 at 2:41 PM, Staff B stated it was their expectation that catheter care be included in the resident's CP and provided every shift as the standard of care.<br><br>46472<br><br><Resident 13><br><br>An observation, on 04/09/2024 at 8:50 AM, showed Resident 13 smoking in the parking lot, not following the facility smoking policy.<br><br>Review of the tobacco use care plan (CP), dated 03/20/2024 showed Resident 13 would adhere to the facility smoking policies. The CP did not show whether Resident 13 required supervision with smoking, required the use of a smoking apron or other safety modalities while smoking, of if they had any previous unsafe smoking behaviors or incidents of non-compliance to the smoking policy.<br><br>Review of Resident 13's EHR showed unsafe smoking incidents or behaviors occurred on 02/21/2024 at 3:03 PM, on 03/06/2024 at 2:20 PM and 4:00 PM (when an extra smoke detector was placed in the room due to smoking non-compliance), and on 03/08/2024 at 11:50 AM. These unsafe smoking events were not updated on the CP.<br><br>Review of Resident 13's Kardex did not direct the care staff on what to monitor for or what to do in the event of an unsafe smoking event. The only detail about smoking was they had a locked box for their paraphernalia, but it did not say where.<br><br>Review of the Kardex care area regarding routine weight monitoring showed staff were to weigh Resident 13 as ordered but did not give the order/frequency/time of day/by whom the weight was to be measured.<br><br>Review of the Meals/Eating and Toileting care area did not provide staff with the diet Resident 13 was required to receive, that they were on an altered diet texture, or where they ate their meals. The Kardex did not provide directive for care that were person-centered and met Resident 13's care needs.<br><br><Resident 52><br><br>Review of Resident 52's nutritional CP intervention, dated 01/24/2023 showed a diet order NPO, pureed with mildly thick liquids if requested. This intervention was also placed on the Kardex for the direct care staff to provide.<br><br>Further review of Resident 52's CP showed it was not updated with current personalized interventions and goals, old information was not removed, and directives to staff that carried over to the Kardex were conflicting and unclear.<br><br>Review of the leisure CP revised 06/07/2022 showed generic system generated interventions that were not person centered.<br><br>Review of the skin impairment CP dated 08/22/20222 showed no person-centered interventions for the prevention of skin breakdown.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the trauma CP, dated 09/16/2022, showed Resident 52 may have past trauma but [they] were unable to communicate. Resident 52 was able to communicate on 04/08/2024. The Trauma CP showed no updated or revisions since 09/16/2022.<br><br>Review of the comprehensive CP showed CPs for anti-depressant and anti-anxiety medication but Resident 52 did not received either type of medication.<br><br>Review of the April 2024 MAR showed Resident 52 received a medication for diabetes, seizures, a thyroid disorder, and an eye disorder, but there were no CPs for the management of these problems.<br><br>Multiple observations of Resident 52's oral health showed they had dental concerns but no dental CP was developed.<br><br>Similar findings were found for:<br><br><Resident 69><br><br>Review of Resident's EHR and CP showed the psychotropic and behavior CPs did not contain personalized target behaviors and the activity CP was not personalized.<br><br>Resident 69 was assessed to be incontinent of bowel, with episodes of loose stools, and received multiple routine medications for the treatment of constipation. Resident 69 had no bowel management CP.<br><br><Resident 6><br><br>Review of Resident 6's MDS, MARs, and other clinical documents showed their CPs lacked person-centered information that addressed their identified care needs including dental concerns, nutrition/weight monitoring, preferences, activities, mood, person-centered target behaviors, and other medical needs.<br><br>REFERENCE WAC 388-97-1020(1)(2)(a)(b)(c)(d)(e)(f). |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344<br><br>.<br><br>Based on interview and record review the facility failed to conduct timely/routine care planning conferences with the resident and/or responsible party for 3 of 4 residents (Residents 63, 72 and 78) reviewed for care conferences. This failure placed the residents at risk for unmet needs, not being involved and/or informed of their care plan (CP), and a diminished quality of life.<br><br>Findings included .<br><br><Resident 63><br><br>Review of the 03/20/2024 Quarterly Minimum Data Set (MDS-assessment tool) showed Resident 63 readmitted to the facility on [DATE], diagnoses included a brain injury caused by lack of oxygen, and dysphasia (a condition that affects the ability to speak and/or understand spoken language). Resident 63 was usually able to make their needs known.<br><br>In an interview on 04/08/2024 at 2:23 PM, Resident 63's Responsible Party stated they did not recall when an actual care conference was conducted or what their CP was.<br><br>Review of Resident 63's electronic health record (EHR) on 04/09/2024 showed the last time a care plan conference was conducted was on 09/27/2022.<br><br>During an interview on 04/10/2023 at 8:59 AM, Resident 63 was asked if they could answer a few questions, which Resident 63 gave a Thumbs Up that indicated yes. When asked if they had gone to a care conference, Resident 63 gave a thumbs down sign that indicated, no. When asked if their family or responsible party had gone to a care conference for them, Resident 63 gave a thumbs down sign.<br><br><Resident 72><br><br>Review of Resident 72's quarterly MDS, dated [DATE], showed they admitted to the facility on [DATE].<br><br>During an interview on 04/08/2024 at 11:56 AM, Resident 72 stated they had one care conference since they arrived at the facility.<br><br>Review of Resident 72's progress note, dated 11/06/2023, showed a care conference was scheduled for 11/10/2023. Review of the progress notes on 11/10/2023 showed no documentation the care conference occurred. Review of a progress note, dated 02/06/2024, showed a care conference was held (four months after being admitted to the facility).<br><br><Resident 78><br><br>Review of the 03/19/2024 Admission MDS showed Resident 78 admitted to the facility on [DATE].<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 04/08/2024 at 3:39 PM, Resident 78 stated they did not recall having a care conference since admission.<br><br>Review of the HEHC Care Conference Evaluation, dated 03/20/2024, was initiated however, the form was blank and there was no documentation that showed a care conference had been held.<br><br>During an interview on 04/10/2024 at 9:26 AM, Staff U, Social Services Director, stated care conferences were conducted upon admission, on a quarterly basis, and as needed. Staff U stated that care conferences were to be documented in the progress notes or on the HEHC Care Conference evaluation tool, in the electronic health record (EHR). After reviewing Residents' 63, 72 and 78 EHR's, Staff U stated that the documentation for care conferences did not met expectations.<br><br>During an interview on 04/10/2024 at 11:12 AM, Staff B, Director of Nursing Services, stated Resident 63 did not have care conferences held on a quarterly basis and should have. Staff B stated Resident 78's 03/20/2024 blank care conference form did not meet expectations. Staff B stated Resident 72 should have had a care conference held shortly after admission and that did not happen.<br><br>Reference WAC 388-97-1020(2)(c)(d). |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148<br><br>34567<br><br>Based on observation, interview and record review, the facility failed to ensure services provided met professional standards of practice for anti-hypertensive medication administration, orthostatic vital signs, physician orders, insulin administration, injection site rotation for injections, weight monitoring, edema monitoring, and care of patients with heart failure for 9 of 20 sampled residents (Residents 70, 73, 47, 16, 51, 52, 6, 36, and 69) reviewed. These failures placed residents at risk of unmet needs, medical complications, injuries, and diminished quality of care/quality of life.<br><br>Findings included .<br><br>ANTI-HYPERTENSIVE MEDICATION PARAMETERS (Residents 16 & 69):<br><br>POLICY<br><br>Review of the facility's Standing Physician Orders, dated 09/01/2022, provided by the Medical Director to be used for the care of residents when needed, and unless otherwise specified. The document showed any of the orders could be implemented following an appropriate nursing assessment of the patient and initiation of a PO for physician signature in the electronic medical record system. For patients who took blood pressure medications, the facility protocol was to hold all blood pressure medications if the systolic blood pressure (SBP - the top number of the blood pressure reading) was 110 or less. If the blood pressure medication was a beta blocker or a calcium channel blocker (selected classes of anti-hypertensive medications to treat high blood pressure) then the nurses were also supposed obtain the heart rate (HR) and hold if the SBP was less than 110 or the HR was less than 60.<br><br><Resident 16><br><br>Review of the 03/02/2024 Admission MDS showed Resident 16's diagnoses included high blood pressure and an irregular heart rate condition, and a depression disorder. Resident 16 received routine anti-psychotic medication.<br><br>Review of a Provider note, dated 02/27/2024, showed Resident 16's blood pressure (bp) goal was 140/90 or less and to be notified if SBP was greater than 180 or less than 90.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident 16's March 2024 and April 2024 MARs showed a PO, dated 02/24/2024, for an extended-release Beta blocker (select class of blood pressure medications to treat high blood pressure, chest pain, and heart failure- typically administered one time a day when given in the sustained release form) medication to be administered twice a day, and to hold (DO NOT GIVE) if their systolic blood pressure (SBP-the top number of a blood pressure reading) was less than 110 or their heart rate (HR) was less than 60. The order failed to include Resident 16's established bp goal of 140/90 or direction to notify the provider if the SBP was more than 180 or less than 90. The March 2024 MAR documentation showed the nurses obtained the SBP and HR prior to the administration of the medication and on 31 of 62 administrations that were ordered, Resident 16's SBP was less than 110 but the medication was administered when it should have been held. The April 2024 MAR showed between 04/01/2024 and 04/12/2024, 16 of 24 administrations that were ordered were administered when the SBP was less than 110. Additionally, on 04/09/2024, Resident 16's SBP was less than 90, the medication was administered, and the record showed no documentation the provider was notified.<br><br>Review of the Resident 16's Progress Notes and Provider Notes did not provide documentation to show the medication was ever held, the provider was ever notified of the low bp's, or that the provider reviewed and identified the low bp's or evaluate the need for any medication adjustments ion did not show nursing notified the provider of the consistently low blood pressures.<br><br>During an interview on 04/12/2024 at 10:28 AM, Staff R, stated nurses were expected to take the blood pressures and or pulses prior to the administration of the medications when indicated, not administer the medication, document the rationale for the medication hold, and notify the provider if it was a consistent problem or if the vital signs were outside set parameters for immediate notification.<br><br>During an interview on 04/12/2024 at 10:45 AM, Staff Q, Assistant Director of Nursing Services (ADON) stated that it was their expectation that all medications that had (or required) a specific evaluation prior to administration would not be administered if the evaluation results were outside established parameters, such as hold parameters for anti-hypertensive medications.<br><br><Resident 69><br><br>Review of Resident 69's March 2024 and April 2024 MARs showed a 10/27/2023 PO for a calcium channel blocker bp medication be administered every morning at 8:00 AM for high blood pressure. The PO did not contain the hold parameters for SBP or HR as required prior to administration and there were no documented SBP or HR. The MARS showed the medication was administered every day and none of the doses were held.<br><br>Review of Resident 69's bp record showed that on 15 of 42 morning administrations, within the hour of administration of the bp medication, the SBP was less than 110.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 04/12/2024 at 9:30 AM, Staff S, LPN, RCM, stated the facility protocol for anti-hypertensive administration was that the nurse measured the resident's bp and pulse (if required) prior to the administration of the medication and followed the hold parameters when the measurements were outside parameters. Staff S stated they were unsure why there was no hold parameter with the bp medication order for Resident 69, but there were standing order for nurses to add them to the bp medications, and all nurses were aware of the requirement that all bp medication should have some type of monitor and hold parameters. Staff S stated it appeared the medication was never held but Resident 69 frequently had blood pressures entered by staff that were below hold parameters for the medication and should have not been administered.<br><br>ORTHOSTATIC VITAL SIGNS (Orthos)(Residents 47, 16, 69):<br><br><Resident 47><br><br>Review of the quarterly MDS dated [DATE] showed Resident 47's diagnoses included heart disease, stroke, depression, anxiety, and dementia with behavioral disturbances. Resident 47 received a routine anti-psychotic medication.<br><br>Review of the psychotropic medication care plan (CP), dated 03/25/2024, Resident 47's risk for adverse side effects due to their anti-psychotic (AP) medication they were prescribed, which included risk of postural hypotension (sudden, significant drop in blood pressure and/or pulse with position changes that can increase risk of falls). The CP showed a 03/25/2024 intervention to monitor for the adverse side effect and obtain orthostatic vital signs (Ortho's-a series of three sets of blood pressure and pulse: first lying, then sitting up, then standing.) monthly and as needed. The CP did not show Resident 47 refused to have Ortho's obtained.<br><br>Review of Resident 47's March 2024 showed a PO, dated 03/20/2024, directing staff to obtain Ortho's monthly while on AP medication, scheduled for 03/21/2024 but no Ortho's were documented.<br><br>Review of Resident 47's Nurse Progress Notes (NPN) did not show documentation to support Ortho's were obtained, attempted, or refused. March 2024 MAR showed orthostatic blood pressures were not documented on 03/21/2024. Resident 47's progress notes did not show documentation of orthostatic blood pressures being obtained or refused.<br><br><Resident 16><br><br>Review of Resident 16's March 2025 MAR showed a 02/24/2024 PO for Ortho's to be obtained on 03/26/2024, while lying, sitting, and standing. The blood pressure documented was 107/84 for all three readings: lying, sitting, and standing.<br><br>During an interview on 04/12/2024 at 10:45 AM, Staff Q, Assistant Director of Nursing Services (ADON) stated that it was their expectation that residents who were on antipsychotic medication would have orthostatic blood pressures/pulses obtained as ordered.<br><br><Resident 69><br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident 69's March 2024 MAR showed a 10/27/23 PO for ortho's to be obtained monthly due to taking an AP medication. The MAR showed on 03/26/2024 the nurse documented a bp of 129/77 for the lying, sitting, and standing bps.<br><br>In an interview on 4/12/2024 at 9:38 AM, Staff S stated the facility protocol for ortho's was to take the residents bp and pulse while lying down, then have the resident sit upright, take another bp and pulse, and then if able, stand up and take another bp and pulse. Staff S stated they did not understand why Resident 69's bp was documented as the same reading for the lying and sitting Ortho's, and because Resident 69 could not stand they should have documented unable to stand.<br><br>INSULIN/BLOOD SUGAR MONITORING (Resident 69):<br><br><Resident 69><br><br>Continuous Glucose Monitoring (CGM):<br><br>In an interview on 04/08/2024 at 12:40 PM, Resident 69 stated they were supposed to be on a continuous glucose monitoring device (CGM - a device that attached to the skin, is changed about 4-5 times per month, and continuously monitors the individuals blood sugars), but did not receive it and did not know why.<br><br>Review of the endocrinology consultation note, dated 11/30/2023, showed Resident 69 had complicated Type 1 diabetes. The provider documented Resident 69 would benefit from, and met Medicare requirements for the use of a continuous glucose monitoring device (CGM) due to the need for frequent daily BS testing/insulin injections and the need for frequent insulin regime adjustments based on fluctuating blood sugar trends. The provider prescribed a CGM sensor (one every ten days, 90-day supply with 12 refills) and CGM receiver device. In addition, the provider also ordered to check their blood sugar readings before a meal and two hours after the meal and contact the provider if they developed problems with very low or very high blood sugar, and to ensure injection sites were rotated routinely to avoid lipohypertrophy (a lump of fatty tissue that develops under the skin with repeated injections in the same place and can affect the body's ability to absorb insulin and cause serious complications).<br><br>Review of a provider progress note dated 01/24/2024 showed Resident 69 asked the provider about the CGM ordered by endocrinology and the provider documented they would have nursing follow up.<br><br>Review of the endocrinology consult note, dated 03/11/2024, showed Resident 69's BS were not well controlled. The providers orders showed in bold text Resident 69 would benefit from CGM and needed frequent changes of insulin dosing to bring BS levels closer to goal. Is it possible if the provider at the facility can help to adjust his insulin often?. The consult note was signed reviewed by the facility provider on 03/12/2024.<br><br>INSULIN ADMINISTRATON:<br><br>Review of Resident 69's March 2024 and April 2024 MARs showed a 03/21/2024 PO for a long-acting insulin to be administered every morning at 8:00 AM, but injections sites were not documented to show they were rotated.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The March 2024 MAR showed a PO, dated 10/27/2023, to check blood sugar (BS) levels before each meal and at bedtime and to call the physician if the BS was less than 80 or more than 400 and a PO dated 10/27/2023 for sliding scale insulin in addition to their routine scheduled immediate-acting insulin before each meal related to Type 1 diabetes. None of the insulin orders showed the injection site rotation was documented. Additionally, the order to check BS two hours after the meal was never initiated as directed by the endocrinologist.<br><br>The MARs showed:<br><br>On 03/01/2024 at 7:30 AM the BS was 460. The documentation did not show any sliding scale insulin was administered and showed 9-see other/nurse notes. Review of the nurse notes and physician orders showed no documentation related to elevated blood sugars, physician notification, order changes, or a re-check of the BS until 11:00 AM (which was 361).<br><br>On 03/04/2024 at 7:30 AM the BS was 266 and the required 4 units of additional insulin was not documented as given and the showed 4=vitals outside of parameters. There were no correlating nurse progress notes for the hold of the insulin at breakfast.<br><br>On 03/31/2024 at 7:30 AM the BS was 469, no sliding scale insulin was documented as given with the entry 9-see other/nurse notes. The Nurse progress notes showed no documentation on 03/31/2024 to show the physician was called, or any new orders were received, or the BS was rechecked until 11:00 AM when it was 274.<br><br>There were similar findings on the April 2024 MAR.<br><br>In an interview on 04/12/2024 at 9:42 AM, Staff S stated they were not aware a CGM was ordered for Resident 69 and would have to investigate it. Staff S stated they expected the nurses to follow the orders that correlated to the parameters set and document: their rationale for why medications were held and they notified the providers when required. Staff S stated the physician should have been called when Residents blood sugar was above 400 on the identified dates and documented, but was unable to find documentation that occurred.<br><br>PHYSICIAN ORDERS (Residents 52, 70, 73):<br><br><Resident 52><br><br>Review of the 03/12/2024 Quarterly MDS showed Resident 52 diagnoses included dysphagia (inability to swallow), was dependent on staff for nutrition, and received their nutrition through a stomach tube.<br><br>Review of the nutrition CP, revised 09/07/2023 showed an intervention dated 06/07//2022 they received 100% of nutritional needs through the stomach tube and an intervention, dated 12/05/2023, that showed Resident 52's diet was: NPO (nothing by mouth), pureed texture with mildly thick liquids if requested.<br><br>Review of Resident 52's Kardex (care directive for staff) on 04/08/2024 showed staff were to assist Resident 52 with eating one-on-one with small bites.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of diet PO dated 10/17/2023 showed Resident 52 was Nothing by Mouth (NPO), Pureed texture, mildly thickened liquids.<br><br>During multiple meal observations, Resident 52 was never observed eating and no diet trays were ever delivered.<br><br>In an interview on 04/11/2024 at 9:32 AM, Staff S stated Resident 52 was strictly NPO, and the order and CP were not correct.<br><br><Resident 70><br><br>Review of the 08/10/2023 Admission Minimum Data Set (MDS-an assessment tool) showed Resident 70 admitted on [DATE] with diagnoses including traumatic spinal cord disfunction, Quadriplegia (paralysis below the chest) and had eight Pressure Ulcers (PU- a skin injury caused by prolonged pressure or shearing injury of the skin).<br><br>During an interview on 04/08/2024 at 3:18 PM, Resident 70 stated they had PUs on both hips and one on their sacrum (tail bone).<br><br>Review of a 10/08/2023 Physician's Order (PO) for wound care treatment of the right hip PU directed nurses to cleanse the wound with normal saline, apply negative pressure wound therapy (wound vac), change three times a week, and as needed.<br><br>Review of a 10/04/2023 PO for wound care treatment of the sacrum PU directed nurses to cleanse the wound with normal saline, apply wound vac dressing, change three times a week, and as needed.<br><br>An observation of wound care on 04/12/2024 at 7:29 AM, showed Staff K, Licensed Practical Nurse (LPN), wound treatment nurse, removed the ordered wound dressings from the right hip and sacrum, cleansed both wounds as ordered, then applied a powder substance on the wound beds before they placed the new dressing treatment. The bottle of the white powdery substance read a Name Brand collagen wound care product used to promote healing of wounds.<br><br>Review of the Wound Care Specialist (WCS) provider notes dated 01/08/2024, 02/12/2024 and 04/01/2024 showed recommendations to apply the Name Brand Collagen sprinkles to the wound bed of the right hip and sacrum prior to application of the wound vac.<br><br>During an interview on 04/12/2024 at 7:42 AM, Staff K stated they did not realize the orders had not been updated to reflect the current treatment but should have been added to their orders.<br><br>During an interview on 04/12/2024 at 7:59 AM, Staff B, Director of Nursing Services (DNS), stated they would expect Resident 70s physicians' orders be updated to reflect the current WCS recommendations and treatment plan.<br><br><Resident 73><br><br>Review of the quarterly MDS, dated [DATE], showed Resident 73 diagnoses included adult failure to thrive (when overall health has been compromised and a prognosis is poor), muscle weakness, depression, and nicotine dependence. Resident 73 was assessed to have no problems making their needs known.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Heartwood Extended Healthcare | | STREET ADDRESS, CITY, STATE, ZIP CODE 1649 East 72nd Tacoma, WA 98404 | |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation and interview on 4/08/2024 at 2:32 PM, Resident 73 stated they used to smoke and recently started to crave cigarettes due to smelling nicotine odors in their room, from their roommate, so they got a patch today. Resident 73 revealed a Named Brand nicotine patch (a medication used for the treatment of smoking cessation) affixed to their skin on their right upper chest, with the handwritten date of 4/8/24.<br><br>Review of Resident 73's March 2024 and April 2024 Medication Administration Records (MAR) showed a POs for a nicotine patch discontinued on 03/12/2024 but no POs after 03/12/2024 to restart the nicotine patch.<br><br>During an interview on 04/12/2024 at 10:28 AM, Staff R, Registered Nurse (RN), Residential Care Manager, stated Resident 73 should not have a nicotine patch on unless there was an active PO, verified there was no active PO, and validated the medication error.<br><br>During an interview on 04/12/2024 at 10:45 AM, Staff Q, Assistant Director of Nursing Services (ADON) stated that it was their expectation that all medications required a valid PO prior to administration.<br><br>WEIGHT MONITORING (Residents 52, 6, 36, & 69):<br><br>POLICY<br><br>Review of the facility's Weight Assessment and Intervention policy, revised March 2022, residents were weighted on admission and at intervals established by the Interdisciplinary Team (IDT). Weights would be documented in the clinical record. Any weight change of 5% or more since the last weight measurement would be retaken the next day for confirmation and if verified, nursing would immediately notify the dietician in writing. Unless notified of a significant weight change, the dietician would review all the resident's weight record monthly to follow individual weight trends over time. Undesirable weight changes would be reviewed by the IDT team to determine level of significance, review status to identify potential contributing factors for the weight change. The resident's individualized CPs would be reviewed and updated to include the identified change in status, identified causes, goals/benchmarks for improvement, and timeframes/parameters for monitoring and reassessment.<br><br><Resident 52><br><br>Review of the 03/12/2024 Quarterly MDS showed Resident 52 was dependent on staff for nutrition through a stomach tube and their weight was 140.<br><br>Review of the nutrition CP, revised 09/07/2023, showed Resident 52 was at risk for nutritional problems and a goal for gradual weight gain until their ideal body weight of 110 pounds was reached. An intervention dated 09/07/2023 directed staff to weigh Resident 52 as ordered.<br><br>Review of Resident 52's POs showed no order for routine weights.<br><br>Review of Resident 52's weight record showed no weights documented for February 2024, November 2023, October 2023, September 2023, August 2023, or July 2023. Further review showed Resident 52 met their CP goal for gradual weight gain on 04/07/2023 when their weigh measured 117 pounds. Since then, they have exceeded their goal weight by 30 pounds.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 04/11/2024 at 10:15 AM, Staff S stated residents should be weighed routinely unless they were on comfort care or hospice and chose not to have weights obtained. Resident's whose weights were stable or if they received artificial nutrition, should be weighted at least monthly. If they were monitored for weight changes, then they should be weighed at least weekly, and the frequency of their weight monitoring should be noted in the CP.<br><br><Resident 6><br><br>Review of the 2/01/2024 Quarterly MDS showed Resident 6 diagnoses included obesity.<br><br>Review of the nutrition CP, revised 02/29/2024, showed Resident 6 was at risk for nutritional related problems due to diabetes and obesity. A goal, revised 08/24/2023, showed Resident 6 would have no significant weight changes in 30-days, 90-days, or 180-days and a goal revised 08/24/2024 to deter weight gain, a gradual weight loss with a body mass index less than 40 was desirable. A 10/28/2022 intervention directed staff to weigh Resident 6 as ordered or directed by the nurse.<br><br>Review of Resident 6's POs showed no order for frequency of weights.<br><br>Review of Resident 6's weight record showed a weight was measured nine times in 18-months.<br><br><Resident 36><br><br>Review of Resident 36's HER showed they admitted to the facility on [DATE] and their weight was measured five times in 13 months.<br><br><Resident 69><br><br>Review of the Nutrition CP revised 02/01/2024 showed Resident 69 was at risk for nutrition problems due to a failure to thrive, malnutrition, diabetes, and had multiple wounds. Resident was identified to have weigh loss and the goal, revised 03/21/2024 was they would maintain their weight and not have a further significant weight loss. The intervention, dated 10/27/2023, directed staff to obtain weight measurements, but no frequency was provided.<br><br>Review of the high blood pressure CP, dated 10/31/2023, showed an intervention to weigh Resident 69 monthly and as needed.<br><br>Review of Resident 69's weight record showed the last weigh documented was on 10/31/2023.<br><br>Further Review of Resident 69's record did not provide documentation to show they refused weight monitoring.<br><br>In an interview on 04/11/2024 at 9:46 AM, Staff S stated the frequency of each resident's weight monitoring schedule should be documented in the CP and on the Kardex and/or Tasks for the care staff to reference.<br><br>HEART FAILURE CARE (Resident 51):<br><br>POLICY<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the facility's Heart Failure-Clinical Protocol policy, revised November 2018, showed the physician would help to identify individuals with a history/diagnosis of heart failure (HF) and clarify as much as possible their severity and underlying cause. The physician would help identify individuals at risk for cardiac decompensation (acute decline / change in condition)- (for example because of a heart rhythm problem or chronic lung disorders). The physician would make recommendations for the nursing plan of care including symptoms monitoring, edema and weight measurement frequency, lab monitoring, and provide parameters for when to report findings, consistent with relevant protocols and professional standards: such as those from the American Heart Association and the American Medical Directors Association.<br><br>Review of the American Heart Association (Vol.8, No.3) Heart Failure Management in Skilled Nursing Facilities, published 04/08/2015, recommended for residents who were higher risk for decompensation (and with the admission goal to rehabilitate and discharge home), the nursing care plan should adhere to daily weight monitoring (same time of day-preferrably first thing in the morning after the first toileting) and fluid volume evaluations. A weight gain of three to five pounds over three to five days should alert licensed staff to perform an advanced assessment of volume status, vital signs, and oxygen saturation, then promptly notify the physician with the findings. Routine daily symptom monitoring should occur for any degree of edema, abnormal lung sounds, cough (especially when lying down), JVD (jugular vein distention-a buldging of major veins in the neck and a key symptom of HF), difficulty breathing: at rest, when lying flat, and/or at night. Monitoring for symptoms along with routine weights at the same time every day helped catch decompensation of HF early and minimized re-hosptialization.<br><br><Resident 51><br><br>Review of the 04/04/2024 quarterly MDS showed Resident 51 readmitted to the facility on [DATE], was not assessed to have HF, edema, or be on diuretic medication (medication that removes excess fluid from the blood). Resident 51's weight was not assessed.<br><br>Review of Resident 51's CP did not show a CP for HF, edema, or fluid volume overload.<br><br>Review of Resident 51's April 2024 MAR showed they received more than one diuretic medication as well as other anti-hypertensive medications used to treat HF.<br><br>In an interview on 04/10/2024 at 11:14 PM, Resident 51 stated they were not weighed routinely and had problems with edema. Resident 51 stated they recently returned from a hospital stay because they had too much fluid on their body. Resident 51 stated they had heart failure and a chronic lung disease, and daily experiened difficulty breathing while lying flat. They required a non-invasive mechanical ventilator (BiPAP) for their lung problems at night, but they wore it all the time, and only removed it to eat or when they got up in the wheelchair.<br><br>Review of Resident 51's weight record showed their 01/20/2023 admission weight measured 449 pounds. After admission the facility documented a measured weight eight times before they discharged to the hospital in respiratory distress, on 03/13/2024 (14 months after admission).<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the hosptial Cardiology Consultation note, dated 03/19/2024 (Day five of their hospital stay), showed Resident 51 diagnoses included HF, acute/sudden respiratory failure from fluid volume overload and acute worsening of their chronic lung disease. The documentation showed Resident 51 displayed JVD and had an increase in oxygen requirements. The cardiologist documented Resident 51's weight reading was 493 pounds on 03/16/2024. Resident 51 reported to the cardiologist their goal was to rehabilitate and dishcharge to the community. The cardiologist documented they were a full code and had a poor prognosis.<br><br>Review of the hosptial Discharge Summary, dated 03/28/2024, showed issues requiring specific attention after discharge were the need for an action plan to minimize re-hospitalization . Resident 51's weight on 03/28/2024 measured 454 pounds.<br><br>Review of Resident 51's current weight record showed no weight documented for the date of readmission, no daily weight monitoring. The only weight on record after readmission showed Resident 51 weighed 469 pounds on 04/03/2024, an increase of 15 pounds in six days (based on the hospital discharge weight of 454 pounds on 03/28/2024).<br><br>In an interview on 04/10/2024 at 1:09 PM, Staff S stated there were no residents on daily weights monitoring. Staff S stated residents who had problems with edema or heart failure and were not stable, should be weigh more frequently (daily usually) and the doctor should be notified if there is an increase in weight of three pounds in two days or five pounds in seven days. Residents who become short of breath or have worsening edema should be assessed for fluid volume overload and it should be reported to the doctor without delay.<br><br>REFERENCE WAC 388-97-1620(2)(b)(i)(ii).<br><br>46472 |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>46472<br><br>Based on observations, interviews, and record review the facility failed to provide the care and assistance with activities of daily living (ADLs) they required to maintain good grooming, oral hygiene, and toileting for 2 of 6 Residents (Residents 52 and 69) plus 2 supplemental residents (Resident 60 and 7) reviewed for ADLs. These failures placed the residents at risk for unmet care needs, poor oral health, skin impairment, medical complications, and diminished quality of life/quality of care.<br><br>Findings included .<br><br><Resident 52><br><br>Review of the 03/12/2024 Quarterly Minimum Data Set (MDS-assessment tool) showed Resident 52 was dependent on staff for eating, oral hygiene, toileting, personal hygiene, and transfers. Resident 52 was assessed to be always incontinent of bowel and bladder. Resident 52 received feeding through a stomach tube and had no dental problems.<br><br>Review of Resident 52's Kardex on 04/08/2024 showed Resident 52 required extensive toileting assistance by staff, staff were directed to turn and reposition Resident 52 every two hours whether they were in their wheelchair or in bed. The Kardex directed CNA staff to perform oral care with an oral swab (but did not indicate how often) and Licensed Nurses performed toothbrushing with the use of oral suctioning. The Kardex directed staff to provide one-on-one feeding assistance with small bites, one bite at a time, to feed slowly and stop if Resident 52 began coughing. Staff were also directed to apply lotion to dry areas, ensure the call light is within reach prior to leaving the room.<br><br>Oral care:<br><br>Review of Resident 52's Kardex on 04/08/2024 directed CNAs to perform oral care with an oral swab (but did not indicate how often) and Licensed Nurses were directed to perform oral care using a toothbrush with oral suctioning.<br><br>Review of a Physician Order (PO) dated 06/06/2022 showed nurses were to provide oral hygiene using cold water every shift, which each nurse signed as completed every shift.<br><br>During an observation and interview on 04/08/2024 at 10:48 AM, Resident 52's teeth were observed to be unclean, in covered in a thick white plaque build-up along the gum line. Resident 52 reported staff did not always brush their teeth. Resident 52 lips were dry/peeling, and their hair was uncombed/un-styled. Observation of Resident 52's nightstand showed it was unkept and a new standard toothbrush was unopened at the bottom of the drawer. There were no oral swabs in the drawer.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 04/10/2024 at 7:00 PM, Resident 52's Collateral Contact (CC) stated they did not think Resident 52 received adequate oral care and describe it as a constant concern. CC stated they provided Resident 52 with an electronic toothbrush but was doubtful it was still there. CC stated Resident 52 enjoyed getting their hair done and they tried to come weekly to help with that but could not always make it. CC stated frequently when they did come to visit, Resident 52's hair was a mess.<br><br>During a constant observation on 04/09/2024 from 8:10 AM until 11:45 AM, Resident 52 was not observed to receive oral care or assistance with their hair.<br><br>An observation and interview on 04/11/2024 at 9:15 AM, Resident 52 teeth were unclean. Resident 52 reported their teeth were not brushed. Observation of Resident 52's nightstand drawer showed no electronic toothbrush.<br><br>In an interview on 04/11/2024 at 9:32 AM, Staff T, Certified Nursing Assistant (CNA), stated Resident 52 was provided oral care every day using a toothbrush. Staff T was asked to show which toothbrush but had difficulty finding it at the bottom of the drawer. The toothbrush was in its package, unopened, and no toothpaste was observed. Staff T stated they did not use oral swabs.<br><br>In an interview on 04/11/2024 at 9:48 AM, Staff X, Licensed Practical Nurse (LPN) stated Resident 52 was provided oral care every day using a toothbrush by the CNA's and sometimes the nurses.<br><br>Toileting/Repositioning:<br><br>Review of Resident 52's Kardex on 04/08/2024 showed Resident 52 required extensive toileting assistance by staff, staff were directed to turn and reposition Resident 52 every two hours whether they were in their wheelchair or in bed.<br><br>Review of Resident 52's April 2024 Treatment Administration Record (TAR) showed a PO, dated 02/21/2023, that directed staff to assist with toileting assistance after meals and at bedtime (scheduled for 9:00AM, 1:00 PM, 6:00 PM and 9:00 PM) which was signed as completed at each scheduled time.<br><br>During an observation and interview on 04/08/2024 at 10:48 AM, showed Resident 52 was seated in their wheelchair, with the brakes in the locked position, pushed up against their bed, facing their wall and their back toward the doorway. Resident pointed to their perineal area and stated yes, when asked if they had to use the bathroom. Their call light was no within reach, it was on the floor at the foot of their bed.<br><br>During constant observations on 04/09/2024 from 8:10 AM until 11:45 AM, Resident 52 sat in their wheelchair, facing the wall, with their back away from the door. The call light was in the same position as the previous day, on the floor at the foot end of the bed. Resident 52 was not observed to be repositioned or offered toileting assistance.<br><br>In an interview on 04/10/2024 at 7:00 PM, CC stated they did not think Resident 52 received adequate toileting assistance frequently enough which they believed to be the source of several falls in the past. CC stated, they just wait until she starts yelling out for help or she will try to do it for herself.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 04/11/2024 at 9:32 AM, Staff T, stated Resident 52 was continent of bladder and they used the toilet in the bathroom for toileting. Staff T stated Resident 52 let them know when they needed to use the toilet by yelling out for help. Staff T was asked if they ensured Resident 52 had their call light with each encounter so if they needed to use the bathroom they could ring for help. Staff T was not aware of the position of the call light and stated they never used the call light.<br><br>In an interview on 04/12/2024 at 9:48 AM, Staff S, Licensed Practical Nurse, Resident Care Manager stated the NACs should provide oral care at least twice daily with their electronic toothbrush and could use the oral swabs as needed. Staff S verified Resident 52 did not have an electronic toothbrush. Staff S stated they expected staff to offer toileting assistance every three to four hours and at the scheduled toileting times during the night and they should always have their call light within reach. Staff S verified the call light was on the floor at the end of the bed, and then provided the call light to Resident 52 who demonstrated their ability to use the call light.<br><br><Resident 69><br><br>Review of Resident 69's April 2024 Medication Administration Record (MAR) showed a PO, dated 10/27/2024, directing nurses to provide diabetic nail care every seven days. The documentation showed the nurse signed the nail care as done on 04/06/2024.<br><br>In an observation and interview on 04/10/2024 at 11:30 AM, Resident 69 was observed to have long nails that curved over the tips of their fingers. Resident 69 stated they were not provided nail care weekly by the nurses and could not remember the last time their nails were trimmed.<br><br><Resident 60><br><br>Review of the 02/06/2024 quarterly MDS showed Resident 60 was dependent on staff for personal hygiene and oral care.<br><br>An observation on 04/08/2024 at 10:50 AM showed a toothbrush with dried toothpaste on the bristles, sitting in a small basin. The toothbrush had no name on it. The small pink basin sat inside a larger bath basin that was sitting on the sink. Hanging on the side of the basin was a black sock. An observation of Resident 60's teeth condition showed their teeth were unclean.<br><br>An observation on 04/09/2024 at 9:48 AM showed the exact same toothbrush with dried toothpaste sitting on the bristles, in the same basin, and the same black sock in the same place. An observation of Resident 60's teeth showed they were unclean.<br><br>In an observation and interview on 04/09/2024 at 9:35 AM, Staff T stated Resident 60 was provided oral care every day using the toothbrush was over by the sink. Staff T grabbed the toothbrush that had the dry, crusted toothpaste stuck to the bristles and said that was Resident 60's toothbrush.<br><br><Resident 9><br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation and interview on 04/08/2024 at 11:11 AM showed Resident 9, sitting in their wheelchair in the hallway. Their hair was uncombed, and they had multiple white whiskers on their chin. Resident 9 stated sometimes the staff helped them with combing their hair and they did not like have whiskers on their chin.<br><br><Resident 7><br><br>An observation on 04/08/2024 at 11:05 AM showed Resident 7 sat in their wheelchair dozing off in front of their sink. A toothbrush stood upright in their closet on the top shelf, the bristles were dry. Resident 7 had food particles from breakfast in their teeth, and their hair was uncombed.<br><br>An observation on 04/09/2024 at 10:15 AM showed Resident 7's toothbrush in the same position, dry, and their hair was uncombed. Resident 7 was asked about their oral care, and they stated they did not have a toothbrush.<br><br>REFERENCE WAC 388-97-1060(2)(C). |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>46472<br><br>Based on observations, interview, and record review the facility failed to ensure residents were provided resident-centered activity programs that incorporated their interests, hobbies, and cultural preferences for 1 of 2 Residents (Resident 52) plus 3 supplemental Residents (Residents 60, 57, and 7) reviewed for activities. The failure to provide independent and/or community activities that met each resident's physical, mental, and psychosocial needs placed residents at risk for social isolation, boredom, decreased sense of security/identity/meaning, and a diminished quality of life.<br><br>Findings included .<br><br><Resident 52><br><br>Review of the 03/12/2024 Quarterly Minimum Data Set (MDS-assessment tool) showed Resident 52 was assessed to have adequate hearing, unclear speech, usually made themselves understood, and usually understood others. Resident 52 had moderate vision impairment without corrective lenses and diagnoses included brain injury from lack of oxygen, dementia, and anxiety. Resident 52 has no behaviors or rejection of care, required a wheelchair for mobility and was dependent on staff for long-distance locomotion. Resident 52's daily preferences they considered important were music, pets, going outside for fresh air, and religious activities.<br><br>Review of the activity care plan (CP) revised 06/07/2022 showed Resident 52 had leisure activity preferences that included 'watching TV, listening to music, etc.', and required assistance. Resident 52's goal was to be active with leisure activity of preference and to participate in independent activities each day. The CP showed interventions dated 10/13/2022 for: 1:1 visit, Cognitive group (reminisce, trivia, news), music, sensory group, and visitors. The CP showed no person-centered, individualized preferences such as music genre, topics of interest, past hobbies, sensory stimulation they find comforting, or scheduled visitors.<br><br>Review of Resident 52's Activity Task record (for the previous 30 days) on 04/09/2024 at 11:30 AM showed the only activity attended was a Leisure Check Monday-Friday. No Leisure Checks were documented on weekend days. The activity provided no documentation to show Resident 52 attended/was offered/invited to: exercise, family/visitors, music/radio, one-on-one visits, patio/outdoors, pet visits, sensory groups, or special events.<br><br>In an interview on 04/10/2024 at 10:30 AM, Staff W stated Leisure Checks were when they went room to room to check on each resident and provide them with the daily activity events packet that included, puzzles, trivia, or coloring pages. Staff W stated for the residents who had trouble with vision or unable to read, they checked in with the resident to see if they needed anything.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An observation and interview on 04/08/2024 at 10:48 AM, showed Resident 52 seated in their wheelchair, with the brakes in the locked position, pushed up against their bed, facing their wall and their back toward the doorway. Their call light was on the floor, five feet from their reach, at the foot of the bed. On the wall facing them were three pictures of wildlife, removed from calendars, that were ripped an in ill repair. There was a small black radio on the nightstand (unplugged from the outlet) and their TV was out of their view, and unplugged. There were no personal items in the room to define who Resident 52 is, no family pictures, homelike decorations, or items of past personal interests. On the floor, under the bed was a doll that was pinned under the bedframe. Resident 52 reported they did not have things to do, was bored, and sometimes felt lonely.<br><br>During constant observations on 04/09/2024 from 8:10 AM until 11:45 AM, Resident 52 sat in their wheelchair, facing the wall, with their back away from the door. The TV and radio were still unplugged. The call light was still on the floor at the foot of the bed. No activities or interactions were observed, and Resident 52 never left the room.<br><br>In an interview on 04/10/2024 at 7:00 PM, Resident 52's Collateral Contact (CC) stated they were not satisfied with Resident 52's activity program and stated the facility just puts [Resident 52] in their wheelchair and leaves them parked in their room all day. CC stated they notified the facility before of their dissatisfaction but it never improved. CC stated Resident 52 enjoyed getting their hair done, lotion/massage/nail care, listening to stories, music events, puzzles or sensory touch activites they could do with their hands (fidget gadgets).<br><br>In an interview on 04/11/2024 at 9:32 AM, Staff T, Certified Nursing Assistant (CNA), stated they placed Resident 52 in the position against the bed, facing the wall because they though it helped them relax. Staff T stated they locked the brakes because otherwise Resident 52 would wheel themselves out into the hallway. Staff T stated they did not know what Resident 52's activity CP preferences were or if they were scheduled to attend any routine activities.<br><br>Similar findings were observed during multiple observations of Resident 52 on 04/10/2024, 04/11/2024, and 04/12/2024. There were no in-room activities provided, the TV and radio remained unplugged, and no 1:1 visits were observed. During multiple scheduled facility events, Resident 52 was in their room in the same position with their feet on the bed, facing the wall, and their back to the door.<br><br>In an interview on 04/09/2024 at 9:53 AM, Staff W, Activity Director, stated some of the activities they had for residents who were dependent on staff to attend included Sensory, and balloon ball which was also a sensory activity. Staff W stated they also had activity items like crayons and color books or puzzles to use if the resident wanted. Staff W stated the Certified Nursing Assistants were responsible to ensure residents were transported to the activities which were generally held in the main dining room, by following their activity plan in the tasks/Kardex of the resident's electronic record. Staff W stated they also had Activity calendars on each of the units for residents and staff to reference.<br><br><Resident 60><br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Heartwood Extended Healthcare | 1649 East 72nd<br>Tacoma, WA 98404 |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the 02/06/2024 quarterly MDS showed Resident 60 was non-verbal, rarely was understood others, and had vision problems. Resident 60 had no behaviors or rejection of care. Resident 60's activity preferences that were important to them included listening to music, pet visits, fresh air, and religious activities. Resident 60 diagnoses included a sever neurological developmental disorder and was dependent for transfers and mobility.<br><br>Review of the activity CP revised 08/22/2022 showed Resident 60 required assistance with leisure activities. The CP goal showed Resident 60 would respond to various sensory stimuli such as touch. CP interventions dated 08/02/2022 included: accepting 1:1 visit, leisure check, music, TV, and would respond to touch/voice during visits. The CP did not include personalized preferences.<br><br>Review of a Level II PASRR (Pre-Admission Screening process used to help identify special needs and services for individuals with serious mental illness or developmental disabilities) evaluation summary, dated 11/04/2022 showed the following recommendations: Resident 60 would benefit from photographs of family and personal items to provide a sense of stability and comfort. Resident 60 suffered from grief from the loss of their mother who was their primary care provider. Engage Resident 60 while in their room/bed with sensory stimulation and soft/gentle physical touch activities that Resident 60 finds comforting.<br><br>Review of Resident 60's Activity Task record (for the previous 30 days) on 04/09/2024 at 11:45 AM provided no documentation to show Resident 60 received Leisure Checks, family/visitors, music/radio, one-on-one visits, patio/outdoors, pet visits, sensory groups, or special events.<br><br>During an observation on 04/08/2024 at 10:50 AM, showed Resident 60 lying in bed with their right side of the bed against the wall. On the wall were three pictures of wildlife, removed from calendars, that were ripped an in ill repair. Their TV was on playing cartoons. There were no personal items in the room to define who Resident 60 is, no family pictures, homelike decorations, or items of past personal interests.<br><br>During constant observations on 04/09/2024 from 8:10 AM until 11:45 AM, Resident 60 sat in their wheelchair, facing the TV/window, with their back towards the door. The TV was on a station playing cartoons. No interpersonal contact was observed.<br><br>Similar findings were observed during multiple observations of Resident 60 on 04/10/2024, 04/11/2024, and 04/12/2024. There were no in-room sensory type activities observed except for the TV that continuously played cartoons. During scheduled facility events, Resident 60 was in their room.<br><br><Resident 57><br><br>Review of the 02/01/2024 Annual comprehensive MDS showed Resident 57 spoke a different language and required an interpreter for communication with staff. Resident 57 diagnoses included dementia, depression, and anxiety. Resident 57 had no problems with hearing or vision and was usually understood and understood others. Resident 57 had no behaviors. The MDS showed Resident 57's cognition and mood were not assessed. Resident 57's activity preferences that were important to them included: listening to music, pet visits, group activities, and fresh air.<br><br>(continued on next page) |

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| | 505326 | A. Building<br>B. Wing | 04/12/2024 |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the activity CP, revised 05/10/2023, showed Resident 57 showed a goal to attend group activities when they chose to. The CP included active leisure of choice, leisure check, sensory group, attend one out of room activity per week, 1:1 visit, watching TV, and arts and crafts. The CP did not show personalized preferences or cultural interests.<br><br>Review of Resident 57's Activity Task record (for the previous 30 days) on 04/09/2024 at 12:22 PM showed the only activity attended was a Leisure Check Monday-Friday. No Leisure Checks were documented on weekend days. Resident 57 was offered sensory on 03/26/2024 and 04/04/2024. Resident 57's activity task record did not provide documentation to show they attended or were offered/invited to attend: arts and crafts lotion/nails, music, that activities were offered, watching TV, crosswords/coloring, or special events.<br><br>Multiple observations of Resident 57 on 04/08/2024, 04/09/2024, 04/10/2024, and 04/11/2024 showed Resident 57 sat in their wheelchair, self-propelling from one end of the hallway to the other. Resident 57 was observed at times putting their hand out to people who passed by, sometimes they acknowledged Resident 57 and sometimes they did not.<br><br><Resident 7><br><br>Review of the 02/16/2024 quarterly MDS showed Resident 7 had problems with cognition, required assistance with mobility, and diagnoses included dementia and depression. Resident 7's activity preferences that were important to them included: reading, pets, fresh air, and religious activities.<br><br>Review of the activity CP, revised 09/27/2022, showed Resident 7 preferred to watch TV and listen to music. Resident 7 required staff assistance with attending activities. The CP showed the generic- system generated activity interventions: 1:1 visit, leisure of choice, leisure check, music, TV, and sensory. The CP did not provide personalized-resident centered interventions or preferences.<br><br>Review of Resident 7's Activity Task record (for the previous 30 days) on 04/09/2024 at 12:00 PM showed the only activity attended was a Leisure Check Monday-Friday. No Leisure Checks were documented on weekend days. Resident 7's activity task record had no documentation to show they attended/offered/were invited to: exercise, family/visitors, music/radio, one-on-one visits, patio/outdoors, pet visits, sensory groups, memory games, outings, phone visits, reading, or coloring.<br><br>An observation on 4/08/2024 at 11:08 AM showed Resident 7 sitting in their wheelchair in the center of their room, asking what they should do. The shades were closed. Their hair was uncombed.<br><br>Multiple observations of Resident 7 on 04/09/2024 showed at 8:15 AM they sat in the wheelchair in their room, dozing off; at 11:48 AM they sat in their wheelchair in their room, in the doorway trying to get staff attention, at 2:10 PM showed they were sitting in their wheelchair in their room, dozed off, and a cup of water was on the floor in front of them.<br><br>REFERENCE WAC 388-97-0940 (1).<br><br>. |

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| NAME OF PROVIDER OR SUPPLIER Heartwood Extended Healthcare | | STREET ADDRESS, CITY, STATE, ZIP CODE 1649 East 72nd Tacoma, WA 98404 | |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46472<br><br>Based on observation, interview, and record review, the facility failed to accurately assess and develop/implement a care plan (CP) for the management of chronic heart problems and failed to timely identify/assess/implement interventions for a related change in condition for 1 of 3 sampled Residents (Resident 51) reviewed for hospitalization . The facility also failed to consistently monitor and document bowel movements (BMs) and implement the bowel program when needed for 2 of 3 sampled residents (Residents 16 and 66) reviewed for bowel management. Resident 51 experienced harm when they had a significant fluid volume overload (too much fluid in the body causing difficulty breathing, increased weight and swelling/edema) and a delay in respiratory interventions resulting in an emergency transfer to the hospital for respiratory failure. The failure placed residents at risk for further decline in their conditions, discomfort, and a diminished quality of life/quality of care.<br><br>Findings included .<br><br>Review of the facility's Weight Assessment and Intervention policy, revised March 2022, residents were weighted on admission and at intervals established by the Interdisciplinary Team (IDT). Weights would be documented in the clinical record. Any weight change of 5% or more since the last weight measurement would be retaken the next day for confirmation and if verified, nursing would immediately notify the dietician in writing. Unless notified of a significant weight change, the dietician would review all the resident's weight record monthly to follow individual weight trends over time. Undesirable weight changes would be reviewed by the IDT team to determine level of significance, review status to identify potential contributing factors for the weight change. The resident's individualized CPs would be reviewed and updated to include the identified change in status, identified causes, goals/benchmarks for improvement, and timeframe/parameters for monitoring and reassessment.<br><br>Review of the facility's Heart Failure-Clinical Protocol policy, revised November 2018, showed the physician would help to identify individuals with a history/diagnosis of heart failure (HF) and clarify as much as possible their severity and underlying cause. The physician would help identify individuals at risk for cardiac decompensation (acute decline / change in condition)- (for example because of a heart rhythm problem or chronic lung disorders). The physician would make recommendations for the nursing plan of care including symptoms monitoring, edema and weight measurement frequency, lab monitoring, and provide parameters for when to report findings, consistent with relevant protocols and professional standards: such as those from the American Heart Association and the American Medical Directors Association.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Review of the American Heart Association (Vol.8, No.3) Heart Failure Management in Skilled Nursing Facilities, published 04/08/2015, recommended for residents who were higher risk for decompensation (and with the admission goal to rehabilitate and discharge home or was uncertain), the nursing care plan should adhere to daily weight monitoring (same time of day-preferably first thing in the morning after the first toileting) and fluid volume evaluations. A weight gain of three to five pounds over three to five days should alert licensed staff to perform an advanced assessment of volume status, vital signs, and oxygen saturation, then promptly notify the physician with the findings. Routine daily symptom monitoring should occur for any degree of edema, abnormal lung sounds, cough (especially when lying down), JVD (jugular vein distention-a bulging of major veins in the neck and a key symptom of HF) symptom of too much water in the blood system ), difficulty breathing at rest, when lying flat, and/or at night along with routine weights at the same time every day helped determine exacerbations in HF.<br><br><Fluid Volume Overload: Weights and Edema><br><br><Resident 51><br><br>In an interview on 04/10/2024 at 11:14 PM, Resident 51 stated they were not weighed routinely and had problems with edema. Resident 51 stated they recently returned from a hospital stay because they had too much fluid on their body. Resident 51 stated they had heart failure and a chronic lung disease, and experienced daily difficulty breathing while lying flat. They required a non-invasive mechanical ventilator via bilevel or continuous positive airway pressure (BiPAP/CPAP: machines that assists with breathing) for their lung problems at night, but they wore it all the time, and only removed it to eat or when they got up in the wheelchair.<br><br>Review of the Annual Minimum Data Set (MDS), an assessment tool, dated 02/02/2024, showed Resident 51's diagnoses included respiratory failure, diabetes, high blood pressure, fluid volume overload, and swelling to both lower legs. The MDS did not include Resident 51's diagnosis of HF and assessed them as not having a problem with breathing when laying flat. Resident 51 was assessed to require Bipap/Cpap and did not receive oxygen therapy. Resident 51 was assessed to weigh 475 pounds but was not assessed to have a significant weight gain.<br><br>Review of Resident 51's respiratory CP, dated 01/23/2023, showed they had obstructive sleep apnea (repeatedly stop and start breathing while asleep), COPD (chronic obstructive lung disease), respiratory failure, and the goal was to decrease episodes of respiratory distress with nursing interventions. The CP showed interventions dated 1/23/2023: Bipap/Cpap per physician orders (not personalized with prescription or parameters), oxygen as ordered (not personalized with prescription), and weight per facility protocol-Notify physician of significant weight fluctuations.<br><br>Review of Resident 51's electric health record (EHR) showed no provider order for routine weight monitoring or frequency.<br><br>Review of Resident 51's nutritional CP, revised 01/08/2024, showed they were at nutritional risk due to fluid overload and edema including a 01/30/2023 intervention that directed nursing staff to monitor and evaluate for signs or symptoms of significant weight changes or trends and obtain weights as ordered or directed by the licensed nurse. An additional intervention, dated 03/28/2024, read weights and did not specify further.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Review of Resident 51's weight record showed they were not weighted consistently since their initial admission on 01/22/2023. Resident 51's recorded weights were: 08/31/2023-415 pounds, 10/17/2023-440 pounds, and 01/25/2024-474 pounds (an 8% weight gain in three months and a 14% weight gain in four months). There were no weights recorded for September 2023, November 2023, or December 2023. Review of the corresponding Progress Notes showed no identification of the significant weight change.<br><br>Review of the Vascular Specialist consult note, dated 02/19/2024, showed the provider ordered medical grade lower extremity compression therapy (Unna boot) and elevation therapy for the management of chronic lower extremity edema and recurrent venous stasis ulcers (chronic and recurrent wounds of the lower legs, a result of venous insufficiency- the condition of poor blood circulation from the legs back to the heart).<br><br>Review of the February 2024, March 2024, and April 2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) showed no order for weight monitoring frequency or parameters for physician notification, no edema monitoring (except for two days, 03/11/2024 and 03/12/2024), and no medical grade compression therapy was never initiated.<br><br>In an interview on 04/12/2024 at 1:15 PM, Staff S, Licensed Practical Nurse, stated when residents go to their specialist appointments, they made a point to try to review the consult orders and/or ensure they were reviewed by the provider and expected the orders provided by the specialists to be implemented. Staff S was unable provide documentation to show medical grade compression therapy was started for Resident 51. Staff S stated residents were expected to be weighed monthly unless otherwise specified in their orders or care plans. Staff S stated if a resident had heart failure and problems with edema, their edema should be monitored routinely (daily or weekly) which would include frequent and routine weight monitoring (typically daily, or two to three times per week, depending on the resident's condition), and have parameters for physician notification. Staff S could not provide documentation to show how often Resident 51 should have been weighed to monitor their fluid volume status or how often their edema should have been monitored.<br><br><Change in Condition: Respiratory Failure><br><br>Review of provider order, dated 01/19/2024, showed oxygen via nasal canula was ordered for 2 liters per minute (lpm) as needed to maintain oxygen saturations above 89%.<br><br>Review of a Provider Progress Note (PPN), dated 03/01/2024, showed Resident 51's weight was 475 pounds (using the weight from 01/25/2024) with a warning triggered for significant increase in weight. The PPN showed Resident 51's room air oxygen saturation was 89% which triggered for being below 90%. The PPN showed Resident 51 had mild edema on both lower legs. The provider documented Resident 51's COPD was stable and their oxygen sats were greater than or equal to 90%. The documentation showed no adjustments were made to the resident's medical plan.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Review of a Nurse Progress Note (NPN), dated 03/11/2024 at 9:53 PM, showed Resident 51's oxygen saturation was around 80% at PM (almost six hours prior to the writing of the NPN). Staff L, Registered Nurse, documented they gave an emergent puff of their inhaler and called the on-call doctor. Staff L did not document a respiratory assessment or an assessment of fluid volume status. Staff L documented Resident 51 did not want the oxygen on [they] wanted to wear their BiPap. Staff L documented the on-call physician requested Resident 51's primary care provider adjust their BiPap prescription to maintain oxygen saturation greater than 90%. Staff L documented Resident 51 reported breathing difficulty earlier in the morning, but now complained of difficult breathing and chest tight. Staff L documented Resident 51's oxygen saturation was between 78% and 86%. The NPN did not document the provider was contacted to report the previous interventions were ineffective at keeping Resident 51's oxygen saturation greater than 90% and that the oxygen saturations were decreasing. Staff L documented Continue to monitor and endorse accordingly.<br><br>Review of the electronic health record (EHR) showed Resident 51 was not sent to the emergency room at this time (03/11/2024) for evaluation of their low oxygen levels, new onset of increase demand for oxygen, or chest pain.<br><br>In an interview on 04/12/2024 at 2:15 PM, Staff B, Director of Nursing, stated the facility had a system to help identify and monitor for a change of condition that included the SBAR form (SBAR stands for Situation, Background, Assessment, and Recommendation) for non-emergent concerns. If the concerns were more emergent the nurses were expected to evaluate the resident's condition and call the provider (or on-call) to report their findings. Staff B stated the provider should have been called after there was no improvement in Resident 51's respiratory status on 03/11/2024 and their oxygen saturation persisted below 90% with interventions.<br><br>Review of a NPN, dated 03/11/2024 at 11:23 PM showed the nurse wrote an SBAR to the provider for the adjustment of the level of the BiPap.<br><br>Review of new verbal provider order, dated 03/12/2024, written by nursing, showed oxygen two to three lpm to maintain oxygen saturations above 92%.<br><br>Review of the NPN, dated 03/12/2024 at 1:47 PM showed Resident 51 was on 3 lpm of continuous oxygen with a mask. The nurse documented the Provider would see Resident 51 today.<br><br>Review of the NPN, dated 03/12/2024 at 11:16 PM showed Resident 51's oxygen saturation was 90% on 3 lpm of oxygen, sometime that evening. After dinner, Resident 51 reported they felt like they could not get enough air and requested to switch to their BiPap. The nurse documented they put both the nasal canula (with oxygen set at 3 lpm) and the BiPap together and their oxygen saturation was 84%-88%. They would continue to monitor and endorse accordingly. There was no documented respiratory evaluation or assessment of fluid volume status. There was no documentation to show they contacted the provider to report the abnormal oxygen saturations readings that were below the ordered parameters.<br><br>Review of Resident 51's Progress notes did not show a provider note for 03/11/2024 or 03/12/2024, or any new order changes were made.<br><br>Review of the NPN, dated 03/13/2024 at 6:00 AM showed Resident 51 was sent to the ED at 3:45 AM in respiratory distress and their oxygen saturation was between 84% and 88% that was below the ordered parameters.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Review of the hospital Emergency Department (ED) Encounter note, dated 03/13/2024 at 4:38 AM, showed Emergency Medical Services reported to the provider Resident 51's oxygen saturation was 69% at the facility on 4 lpm of oxygen (although the order was for two to three lpm). Resident 51 reported they were short of breath for several days, had worsened lower extremity edema, and chest pain/tightness which would come and go.<br><br>Review of the SBAR, dated 03/11/2024, regarding Resident 51's situation showed He would like to see a provider for increased coughing and congestion for a few days now. The nurse documented an assessment: no fever, no increased sputum production, wheezing on and off. The nurse made the recommendation to please see the patient today. Next to the Orders section of the SBAR, the Physician wrote patient sent to hospital and signed and dated 03/13/2024 (two days later).<br><br>Review of the Advanced Heart Failure Consultation note, dated 03/19/2024, showed Resident 51 weight readings from their previous encounters were: 1/17/2023- 466 pounds and 3/16/2024- 493 pounds. The cardiologist consult showed Resident 51 had acute on chronic heart failure with fluid volume overload, removed a total of 15 liters of fluid over the course of six days, started an additional diuretic medication, and increased a blood pressure medication.<br><br>Review of the hospital discharge summary, dated 3/28/2024, showed Resident 51's weight on 3/28/24 was 454 pounds, a decrease of 39 pounds since 03/13/2024 (expected weight loss from the removal of excess fluid).<br><br><Fluid Volume Overload: Post Change in Condition><br><br>Review of the quarterly MDS, dated [DATE], showed Resident 51 readmitted to the facility on [DATE] after a hospitalization . Resident 51's diagnoses included pneumonia (a lung infection), respiratory failure, and oxygen dependence. The MDS did not include the diagnosis of HF. Resident 51 was assessed to require non-invasive mechanical ventilation but did not receive oxygen therapy. Resident 51 was assessed to weigh 433 pounds and inaccurately documented Resident 51 did not have a recent significant weight increase.<br><br>Review of Resident 51's comprehensive CP on 04/08/2024 did not show a CP was developed for cardiac or edema problems after readmitting from the hospital visit.<br><br>Review of Resident 51's current weight record showed no weight documented for the date of readmission, no daily weights monitoring. The only weight on record showed Resident 51 weighed 469 pounds on 04/03/2024, an increase of 15 pounds in six days based on the hospital discharge weight of 454 pounds on 03/28/2024.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | In an interview on 04/09/2024 at 10:13 AM, Resident 51 stated they were not weighted routinely, and their edema was less that it had been because they just got out of the hospital after having a bunch of fluid removed from their body. Resident 51 stated before the hospitalization , they kept telling the staff they could not breathe but no one would listen. Resident 51 stated they did have wounds on their lower legs that come and go and get worse when their edema flares. Resident 51 stated they felt like they were starting to have more swelling. Resident 51 stated their lower legs were not routinely wrapped with compression dressings to help manage their edema and vascular problems. Resident 51 stated before the hospitalization they did not routinely use oxygen, only when they needed it connected to their BiPap at night. During the interview, Resident 51 lower legs were observed to not have medical grade compression. Resident 51 was wearing their BiPap with no oxygen connected, and the oxygen concentrator and tubing was sitting under the sink, not in use.<br><br>34567<br><br><BOWEL MONITORING><br><br>POLICY<br><br>Review of the facility's Bowel (Lower Gastrointestinal Tract) Disorders - Clinical Protocol policy, dated September 2021, showed the staff and provider would identify individuals with gastrointestinal problems, which included alterations in bowel movements. [BM]. The licensed nurse (LN) would assess and document/report the presence of stool impaction and the onset, duration, frequency, and severity of signs and symptoms. The facility would monitor the individual's response to interventions, including frequency and consistency of bowel movements. The provider would adjust based on identification of causes and the resident's response to treatment.<br><br><Resident 16><br><br>During an interview on 04/08/2024 at 2:14 PM, Resident 16 stated they experienced constipation (inability to have a bowel movement naturally) that sometimes lasted longer than three days, throughout their stay at the facility.<br><br>Review of Resident 16's electronic health record (EHR) BM report showed staff documented no BM on the following dates: 03/12/2024, 03/13/2024, 03/14/2024 with a BM documented on 3/15/2024 at 9:17 PM. Additional dates included 04/06/2024, 04/07/2024 with a BM on 04/08/2024 at 8:53 PM.<br><br>Review of Resident 16's EHR showed several bowel management provider orders dated 02/24/2024 within the resident's March and April 2024 medication administration records (MAR). The BM protocol showed that the LNs were to administer the following orders, as needed, for the resident without a BM: Dulcolax (a laxative that stimulates bowel movements/used to treat constipation), on the evening of the 3rd day, Milk of Magnesia suspension (a laxative) on the morning of the 4th and Dulcolax suppository (in the evening of the 4th day for no BM. The MAR also showed in the evening of the 4th day that the LN had an order for a Fleet enema (a laxative) to be administered to the resident without a BM. The MARs showed an order for Polyethylene Glycol (a medication used in the management and treatment of constipation) to be administered as necessary for constipation. The March and April 2024 MARs showed no documentation that any of the providers orders were administered or documented.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Heartwood Extended Healthcare | | STREET ADDRESS, CITY, STATE, ZIP CODE 1649 East 72nd Tacoma, WA 98404 | |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Review of Resident 16's care plan dated 02/24/2024 showed resident was ordered a psychotropic (a medication used to affect the brain and causes changes in mood, awareness, thoughts, feelings, and behavior), related to a disease process daily. Interventions included LNs to monitor and document side effects to include constipation.<br><br><Resident 66><br><br>During an interview on 04/08/2024 at 2:14 PM, Resident 16 stated they had constipation at times during their time at the facility.<br><br>Review of Resident 66's electronic health record (EHR) showed documentation within the point of care (POC) task section whereas staff had documented longer than three days Resident 16 was without a BM. The staff documented lack of a BM on the following dates: 03/15/2024, 03/16/2024, 03/17/2024, 03/18/2024, 03/19/2024, 03/20/2024 and with a BM not documented until 03/21/2024 at 07:00 PM. Additional dates included 03/22/2024, 03/23/2024, 03/24/2024 03/25/2024, with a BM documented on 03/26/2024 at 07:01 PM. On 03/27/2024 to 03/31/2024 no BM was documented until 04/01/2024.<br><br>Review of Resident 66's EHR showed several bowel management provider orders dated 02/24/2024 within the resident's March and April 2024 medication administration records (MAR). The BM protocol showed that the LNs were to administer the following orders, as needed, for the resident without a BM: Dulcolax (a laxative that stimulates bowel movements/used to treat constipation), on the evening of the 3rd day, Milk of Magnesia suspension (a laxative) on the morning of the 4th and Dulcolax suppository (in the evening of the 4th day for no BM. The MAR showed in the evening of the 4th day that the LN had an order for a Fleet enema (a laxative) to be administered to the resident without a BM.<br><br>During an interview on 04/10/2024 at 10:04 AM, Staff R, Registered Nurse/Residential Care Manager (RN/RCM) stated that it was their expectation that the staff start the bowel protocol as ordered by the provider for residents who had constipation for greater than 3 days.<br><br>During an interview on 4/10/2024 at 10:08 AM, Staff Q, Assistant Director of Nursing (ADON) stated that it would be their expectation that the LNs administer the bowel protocol as ordered for the resident's constipation.<br><br>Reference WAC 388-97-1060(1)(2)(3)(b)(c). |

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| Heartwood Extended Healthcare | 1649 East 72nd<br>Tacoma, WA 98404 |

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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** 46472

Based on observation, interview, and record review the facility failed to provide an environment free of accidents/hazards for 3 of 9 residents (Residents 13, 66, and 27) and 2 of 2 smoking areas (on the property and on the street sidewalk-adjacent to the facility property) reviewed for accidents. The failure to re-assess Residents 13 and 66 after unsafe smoking incidents and provide adequate supervision and/or assistance for smoking safety compliance, equally enforce the facility smoking policy for all residents, visitors, and staff; ensure smoking receptacles were available for safe and sanitary collection of cigarette refuse; and ensure a re-assessment and care plan (CP) update occurred for Resident 27 after a fall. These failures placed the residents at risk for further accidents, smoking related injuries, unsanitary environment, and diminished quality of life.

Findings included .

SMOKING

<POLICY>

Review of the facility's Admission Agreement Packet, Notice of Smoke-Free Center Policy, revised November 2016, showed smoking, including the use of electronic (e-cigarettes) was prohibited in all buildings, exterior grounds, and vehicles parked on the premises for everyone including residents, employee's, visitors, volunteers, consultants, contractors, and government representatives. All residents were required to sign the Acknowledgement of Center Smoking Policy upon admission. Violations of the facility smoking policy could result in an involuntary discharge. Education on smoking cessation programs would be provided for residents and responsible upon request. The policy did not cover how or when the facility would assess each resident for smoking safety and ensure residents who were unsafe to smoke independently received assistance if they required it; to develop and implement a smoking plan.

<Resident 13>

Review of the 01/02/2024 annual comprehensive Minimum Data Set (MDS-an assessment tool) showed Resident 13 had some difficulty with hearing, no cognition problems, and diagnoses included seizure disorder, arthritis (painful deformity of joints), dementia, anxiety, and bipolar disorder (a major depression disorder). Resident 13 was assessed to be independent in their wheelchair for mobility.

Review of the tobacco use care plan (CP), dated 03/20/2024 showed Resident 13 would adhere to the facility smoking policies. The CP showed an intervention, dated 03/28/2024, that Resident 13 would secure their smoking paraphernalia in a locked box, however the cp did not indicate the location of the lock box and an intervention, dated 03/20/2024, intervention that directed staff to conduct a smoking safety evaluation on admit and as needed, educate on the smoking policy, and offer cessation. The CP did not show whether Resident 13 required supervision with smoking, required the use of a smoking apron or other safety modalities while smoking, of if they had any previous unsafe smoking behaviors or incidents of non-compliance to the smoking policy.

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 13's Smoke-Free Center Policy Acknowledgement showed they signed it on 02/16/2024.<br><br>Review of the Smoking Safety Screen, dated 03/07/2024, showed Resident 13 had no cognitive loss or dexterity problems, but did have vision problems. Resident 13 smoked 1-2 times per day typically in the afternoon, did not require use of a smoking apron (used to protect the resident form ash droppings or burns), and required the facility to store their smoking paraphernalia. The Interdisciplinary Team (IDT) decision showed Resident 13 was aware of the smoking hazards, understood the facility's non-smoking policy, and was assessed to be safe to smoke without supervision because they could get in and out of the facility independently and had no dexterity or neurological conditions that would hinder their safe use of a lighter. The evaluation did not show Resident 13 was assessed on how they managed their ashes, how they extinguished their cigarettes, or how they navigated the busy parking lot in their wheelchair.<br><br>Review of the Assumption of Risk Consent Form, signed by Resident 13 on 03/21/2024, showed Resident 13 was informed of smoking alternatives available to them, the risks/consequences of smoking related injuries and respiratory disease, and by signing they acknowledged they accepted they may imperil their health and suffer the adverse consequences listed at their own risk. The list of risks/consequences did not include the potential of being struck by a motor vehicle or becoming a victim of a criminal act due to the number of homeless people in the area.<br><br>An observation, on 04/09/2024 at 8:50 AM, showed Resident 13, sitting in their wheelchair alone, in the parking lot between two cars, smoking a cigarette. The lit cigarette was propped between their lips, with an ash trail on the end of the cigarette that measured approximately one inch long, and about to fall on their lap. On their lap was three items of crocheted garments. Resident 13 grabbed the cigarette from their lips and knocked the ashes off the end of the cigarette using the metal hand bar of their right wheelchair wheel (which had many small round black spots on it). Resident 13 took two more puffs, and then extinguished the cigarette in the same manner, on the metal hand bar of their wheelchair wheel. Resident 13 held the extinguished butt in their hand during the interview. Resident 13 stated they always smoked in that spot, and they were told by the facility they had to be at least 25 feet from the front entrance to smoke. Resident 13 stated they were going to hold on to the extinguished butt of the cigarette until they got back to the front entrance, and then would put the butt in the garbage can. Resident 13 put the extinguished butt under a white sugar packet that sat inside a black, plastic cup holder attached to their wheelchair.<br><br>Review of a Nurse Progress Note (NPN), dated 02/21/2024 at 3:03 PM, showed Resident 13's bathroom was found to smell like cigarette smoke. Social Services was notified. No further follow-up was found in the record.<br><br>Review of NPNs, dated 03/06/2024 at 2:20 PM and 4:00 PM, showed Resident 13 had smoked in their bathroom and facility administration was notified. Resident 13 was re-educated on the smoking policy, risks of not following the policy, and consequences of breaking the policy, which included potential notice of intent to discharge. The facility staff reviewed smoking storage requirements with Resident 13. A smoking detector was put in Resident 13's room as an additional monitoring mechanism.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of a NPN, dated 03/08/2024 at 11:50 AM, showed Resident 13's bathroom smelled like smoke. The facility staff searched Resident's belongings and found Resident 13 had two packs of cigarettes and a lighter in their room, unsecured. The paraphernalia was removed from their room and secured on the nurse's cart.<br><br>In an interview on 04/12/2024 at 3:00 PM, Staff B, Director of Nursing, stated the facility was aware of the challenges surrounding smoking residents, and had an active Performance Improvement Plan (PIP) to ensure residents who smoked were identified, assessed by both clinical and rehabilitation services, safety needs were identified, and care plans updated. Staff B's expectation was that any newly identified smoking concerns be evaluated and if resident specific, should be part of their care plan.<br><br>34567<br><br><Resident 66><br><br>Review of the quarterly MDS, dated [DATE], showed Resident 66 admitted on [DATE], diagnoses included lung and kidney disease, was dependent on kidney hemodialysis (a treatment that removes wastes and extra fluid form the blood), and was able to make their needs known.<br><br>Review of the Smoke-Free Center Policy Acknowledgement, signed by Resident 66 on 02/14/2024, showed [they] acknowledged understanding of the facility's non-smoking policy, which included e-cigarettes, and failure to adhere to the policy could result in discharge from the facility in accordance with applicable state and federal laws. The document showed that prohibiting smoking on the campus preserved everyone's right to breathe clean, smoke free air.<br><br>Review of the Assumption of Risk Consent Form, signed by Resident 66 on 03/21/2024, showed [they] were offered smoking cessation alternatives (such as nicotine patches or gum) and if they did not choose cessation alternatives, they assumed responsibility for the risks/consequences that could occur.<br><br>During an interview on 04/09/2024 at 9:09 AM, Resident 66 stated they used a Vape (also known as vaping-inhaling of a liquid nicotine product that is heated until it becomes an aerosol mist using a battery-operated e-cigarette or other vaping device) several times throughout the day.<br><br>During an interview, on 04/08/2024 at 2:32 PM, Resident 73 (Resident 66's roommate) stated they had a history of smoking and recently began to crave a cigarette due to smelling nicotine odors from Resident 66, especially when they Vaped in their room. Resident 73 stated the craving was so strong, they now desired a nicotine patch. Resident 73 stated that Resident 66 vaped using the E-cigarette all the time and the facility staff were aware.<br><br>During an interview on 04/10/2024 at 9:37 AM, Staff R, Registered Nurse/ Residential Care Manager (RN/RCM) stated their expectation was Resident 66 not use their e-cigarette in their room.<br><br>During an interview on 04/10/2024 at 9:47 AM, Staff Q, Assistant Director of Nursing (ADON), stated it was not acceptable for Resident 66 to use their e-cigarette in their room, within the facility.<br><br><Facility Grounds><br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An observation of the front entrance garbage can, on 04/09/2024 at 10:45 AM, showed a cigarette butt easily visible at the bottom of the trash liner. On top of the plastic garbage can cover were small circular black areas where cigarette butts were extinguished. The other garbage receptacle smelled heavily of cigarette smoke.<br><br>An observation on 04/09/2024 at 10:50 AM of the facility grounds where staff were known to congregated and smoke, showed a large round bowl on the ground, with butts and garbage in it and surrounding it on the ground. Six facility staff were observed sitting on the picnic table next to the smoking debris on the ground. An anonymous staff member commented This is not a true designated smoking area and two staff got up, finished their last puff of their cigarette, tossed their butts onto the pile of butts on the ground, and walked away from the area.<br><br>An observation on 04/09/2024 at 11:00 AM of the facility grounds toward the street sidewalk (where smoking was approved) showed the ground littered with cigarette butts on and off the property.<br><br>In an observation and interview on 04/09/2024 at 11:03 AM, on the street sidewalk, Resident 74 was smoking a cigarette. Resident 74 stated they felt it was unfair the facility expected the little old ladies in the wheelchairs to wheel themselves across the parking lot, over to the street, without assistance to smoke a cigarette, while staff smoked on the property, leaving the mess they did. Resident 74 stated sidewalk area is not a safe area and felt the facility should provide a nice, safe, covered space-somewhere where they can smoke safely, with and a receptacle to place their butts when they were done. Resident 74 stated they often picked up used butts (not theirs) while they were out smoking to help keep the area clean. Resident 74 stated they extinguished their cigarettes, made sure they were completely out and kept them in their pocket until they got to the front entrance where they put the butts in the garbage can. Resident 74 stated Where else am I supposed to put them?<br><br>In an interview on 04/12/2024 at 3:12 PM, with Staff A, Administrator, Staff C, Regional Director of Operations, and Staff Y, Regional Director of Clinical Operations, Staff C stated the facility was still a non-smoking campus and expected all staff, visitors, and residents to comply with the policy. Staff C confirmed there currently was no cigarette receptacle on or around the facility grounds to collect used cigarette butts safely. Staff C stated they would explore other options and/or ideas on how to ensure resident safety to and from the smoking area (on the street sidewalk), and how to manage the smoking refuse on and off the property. Staff Y stated the facility purchased smoking receptacles, but they were never put out for use.<br><br>38344<br><br>FALLS<br><br><Resident 27><br><br>Review of the quarterly MDS, dated [DATE], showed Resident 27 readmitted to the facility on [DATE], diagnoses included muscle weakness, reduced mobility, and was able to make needs known.<br><br>Review of the facility incident investigation report, dated 11/21/2023, showed Resident 27 was found on the floor, face down, next to the bed in their room. The intervention to prevent reoccurrence showed, Care plan revised. Belongings in reach, staff to ensure that [Resident 27] has not dropped anything when they provide care.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 27's fall CP, dated 11/15/2023, showed no documentation of a new intervention initiated/implemented related to the fall that occurred on 11/21/2023.<br><br>In an interview on 04/12/2024 at 9:50 AM, Staff S, Licensed Practical Nurse/Resident Care Manager, stated Resident 27's 11/21/2023 incident report showed the CP was to be updated with a new intervention to prevent another fall; however, that did not happen. Staff S stated they should have updated Resident 27's care plan with the new intervention, as documented in the 11/21/2023 incident report but did not.<br><br>During an interview on 04/12/2024 at 10:04 AM, Staff B Director of Nursing Services (DNS) stated the facility should have updated Resident 27's care plan with the new intervention documented in the 11/21/2023 incident report investigation; however, that did not happen, and this did not meet expectations.<br><br>Reference WAC 388-97-1060 (1)(2)(3)(g). |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46472<br><br>Based on observations, interviews, and record reviews the facility failed to ensure 2 of 3 residents (Residents 69 and 70) with urinary catheters (a flexible tube inserted into the bladder to drain urine) received care and services consistent with professional standards of care. The failure to ensure routine catheter care was provided, and the catheters were properly secured and positioned placed the residents at risk for infections, skin breakdown, discomfort, and diminished quality of care.<br><br>Findings included .<br><br><Resident 69><br><br>Review of the 03/01/2024 Annual Comprehensive Minimum Data Set (MDS-assessment tool) showed Resident 69 diagnoses included paraplegia, an amputation of the left lower leg, urine retention (condition where the bladder is unable to empty all the urine), and a multi-drug resistant organism (MDRO). Resident 69 required the use of a foley catheter and was dependent on staff for toileting care.<br><br>Review of the elimination care plan (CP), revised 03/20/2024, showed: an intervention (revised 10/31/2023) to ensure the catheter tubing was secured with a leg strap to prevent the catheter from being dislodged, an intervention (initiated 03/11/2024) for foley catheter care every shift and as needed, and an intervention (revised 03/11/2024) Resident 69 required a foley catheter change according to the facility protocol or as directed.<br><br>Review of the potential for UTI (urinary tract infection) CP, revised 03/11/2024, showed Resident 69 was at risk for infections and to follow the foley catheter care plan to prevent infections.<br><br>Review of Resident 69's March 2024 Treatment Administration Record (TAR) showed: a Physician Order (PO), dated 02/13/2024 to flush the foley catheter as needed with 60 mls of normal saline, which was done once on 03/04/2024 and a PO, dated 03/15/2024, to change the foley catheter/drainage bag system as needed, and to change the drainage bag every two weeks. The March 2024 and April 2024 TARs showed the bag was only changed on 03/04/2024 when the catheter was flushed.<br><br>In an interview on 04/12/2024 at 10:00 AM, Staff S, LPN/RCM, stated Resident 69's catheter drainage bag should have been changed on 03/18/2024 and 04/01/2024 but was not documented as done. Staff S stated the facility protocol for foley catheter changing was to change the catheter system as needed and to change the drainage bag as ordered.<br><br>In an observation and interview on 04/10/2024 at 11:15 AM, Resident 69 stated they did not receive routine catheter care every shift, the catheter was not routinely secured and had been pulled out in the past during care. Resident 69 was not sure how often nursing was required to change the catheter drainage bag and believed it was only done when the wound nurse changed their catheter. An observation of the catheter system showed the catheter tubing was not secured and was hanging in a dependent position off the bed with white sediment collected in the tubing.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 04/10/2024 at 11:40 AM, Staff K, Licensed Practical Nurse/Wound Nurse, stated they sometimes changed the catheter if needed during wound care, and the floor nurses were to change the bag routinely, every couple of weeks. Staff K observed and verified the catheter was not secured to the leg and stated it should always be secured.<br><br>An observation and interview with Resident 69 on 04/11/2024 at 9:40 AM, showed Resident 69 lying on their left side and the catheter strap was secured to the catheter tubing but was not secured to the left thigh; it slid down off their left stump and was lying on the bed. The catheter tubing was hanging off the bed in a dependent position with urine collected in the middle of the tubing.<br><br>In interview on 04/11/2024 at 12:18 PM, Staff EE, Certified Nursing Assistant (CNA), stated they performed catheter care on their shift but did not know how often it was supposed to be done.<br><br>During an observation and interview on 04/11/2024 at 12:22 PM of Resident 69's catheter position, observed by Staff Z, CNA, confirmed the catheter tubing was not secured or positioned properly. Staff Z stated the facility policy for catheter care was to follow the standard of care which included all residents who had catheters required catheter care every shift by cleansing around the catheter insertion site and then cleaning down the tubing (away from the body), to ensure the catheter tubing was secured to their leg, the tubing coiled and clipped to the bed to prevent it from hanging off the bed.<br><br>In an interview on 04/12/2024 at 10:00 AM, Staff S stated Resident 69's their expectation was CNA's or nurses provided routine catheter care every shift and ensured the tubing was properly secured and positioned at all times.<br><br>46148<br><br><Resident 70><br><br>Review of the admission MDS dated [DATE] showed the resident admitted on [DATE] with a diagnosis of quadriplegia (unable to move or feel below their upper chest) and had an indwelling supra pubic catheter (a tube placed into the bladder through the abdomen to drain urine).<br><br>Review of Resident 70's electronic health record (EHR) on 04/11/2024 showed no POs, CP, or Kardex (care directives for direct care staff) directives to provide catheter care.<br><br>During an interview and observation on 04/11/2024 at 9:12 AM, Resident 70 stated did not recieve routine catheter care, and their catheter had problems with draining and leaked urine often. Resident 70 reported they recently had a bladder infection and stated, because the catheter slides in and out and if it's not cleaned, it puts that bad stuff into my bladder. An observation of the catheter tubing showed it hung off the side of the bed in a dependent position with a collection of white sediment, and the catheter drainage bag was empty.<br><br>Review of a PO, dated 12/15/2023, showed Resident 70 was ordered an antibiotic medication to treat a urinary tract infection (UTI) with a stop date of 12/22/2023.<br><br>During an interview on 04/11/2024 at 9:12 AM, Staff J, Nursing Assistant-Registered (NAR), stated that looked at the Kardex to determine resident's care needs, such as catheter care for residents.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Heartwood Extended Healthcare | 1649 East 72nd Tacoma, WA 98404 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 04/11/2024 at 9:23 AM, Staff L, Registered Nurse (RN), stated catheter care should have been in the CP/Kardex and there should have been a PO in the TAR for nursing staff to do catheter-site care.<br><br>During an interview on 04/11/2024 at 2:41 PM, Staff B, DNS, stated it was their expectation that residents with catheters had POs for catheter management, CPs/kardex for the device with interventions that included routine catheter care , and nursing staff provided catheter care every shift.<br><br>REFERENCE: 388-97-1020(2)(a) -1060(1)(2)(iii)(3). |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>34567<br><br>Based on observations, interviews, and record review the facility failed to ensure staff provided pain medication as ordered for 1 of 4 Residents (Resident 73) reviewed for pain. The failure administer a routinely scheduled anti-inflammatory analgesic (a medication to reduce swelling and pain) and accurately document the provision of acetaminophen (a mild analgesic that has potential for medical complications when taken in excess) in the clinical record placed the resident at risk for delay in care and services to treat their chronic pain condition, potential for acetaminophen toxicity, medical complications, and diminished quality of care/quality of life.<br><br>Findings included .<br><br>POLICY<br><br>Review of the facility's Pain-Clinical Protocol policy, dated March 2020, showed the provider and staff would identify residents who had pain, conduct a pain assessment, and provide treatment to relieve pain. The pain management protocol showed staff would evaluate and report the residents use of scheduled medication and PRN (as needed) medication usage. If there were more than occasional analgesic requests, the provider would consider medication adjustments of any routine medications, consider changing PRN medications to a routine administration schedule, or some other adjustments to alleviate breakthrough pain as much as possible.<br><br><Resident 73><br><br>Review of the Quarterly Minimum Data Set (MDS-assessment tool), dated 02/06/2024, showed Resident 73 diagnoses included osteoarthritis (OA-a disease of the bone and joints that can cause debilitating pain) of the knees and hip, and depression. Resident 73 was dependent on staff for activities of daily living (ADLs) and able to make their needs known.<br><br>Review of actual chronic pain care plan (CP) intervention, dated 11/20/2023, directed staff to assess characteristics of pain, location severity on a scale of 1 to 10 and assess effectiveness of PRN pain medication 30 minutes to 1 hour after administration of pain medication.<br><br>Review of the Pain Assessment evaluation, dated 03/08/2024, showed Resident 73 had chronic pain, to both lower extremities (including hips, knees, & legs). Resident 73's routine pain management regime included a Named Brand topical anti-inflammatory gel, applied to the skin on both knees and their right shoulder.<br><br>During an observation and interview on 04/08/2024 at 2:30 PM, Resident 73 was observed lying in bed, wearing a hospital gown. Resident 73 stated they had problems with pain and their physician ordered them an over-the-counter oral analgesic to take as needed, which they requested often, and was unaware of the dosage they received.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review on 04/09/2024 at 9:51 AM of Resident 73's April 2024 Medication Administration Record (MAR), showed a physician order (PO), dated 01/05/2024, for a Named Brand topical anti-inflammatory gel to be applied to both knees and right shoulder three times a day routinely (documented as administered every morning, mid-day and evening), and a PO, dated 03/13/2024, for acetaminophen extra strength every six hours PRN for OA pain, not to exceed 3,000 milligrams (mg) in 24 hours. The April Mar showed no documentation the acetaminophen was administered between 04/01/2024 and 04/09/2024.<br><br>During an observation and interview on 04/09/2024 at 1:10 PM, Staff FF, Registered Nurse (RN), delivered Resident 73 a cup with medication and stated, Here is your acetaminophen for pain. Resident 73 swallowed the medication, and Staff FF left the room without applying the Name-Brand topical anti-inflammatory gel to Resident 73's knees or hip that was scheduled for mid-day. Resident 73 stated, I must ask for acetaminophen every six to eight hours, and the nurses give it to me. When asked about when the nurses apply the anti-inflammatory gel for their knees and hip, Resident 73 stated they had not received that medication for the past several weeks.<br><br>Review of Resident 73's April MAR on 04/10/2024 showed the anti-inflammatory gel was documented as administered for the mid-day and evening dose on 04/09/2024 and there was no documentation to show Resident 73 was administered acetaminophen on 04/09/2024.<br><br>During an interview on 4/10/2024 at 9:37 AM, Staff R, Registered Nurse/Residential Care Manager (RN/RCM), stated it was their expectation that the nurses documented their administrations of PRN medications when administered and not to document something as administered if it was not provided to the resident.<br><br>During an interview on 4/10/2024 at 9:40 AM, Staff B, Director of Nursing Services (DNS) stated their expectation was to administer all medications as ordered and document the administration accurately, and if not administered, to document the rational for why and that all medications that were administered should be documented accurately on the MAR.<br><br>Reference WAC 388-97-1060 (1). |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>34567<br><br>Based on interview and record review, the facility failed to provide adequate hemodialysis (HD, a process in which blood is filtered of waste, toxins and fluid) services for 1 of 1 Residents (Resident 66) reviewed for dialysis. The facility failed to provide consistent monitoring of the dialysis documentation of communication, to the dialysis unit, to inform them of pertinent clinical information. This failure placed the resident at risk for unmet care needs, medical complications, and diminished quality of care.<br><br>Findings included .<br><br>POLICY<br><br>Review of the facility's Nursing Home Dialysis Transfer Agreement policy, dated 05/16/2013, showed the facility and the HD Center would provide each other with the necessary health information to ensure the residents received the care and services they required related to their kidney disease. The facility would ensure all appropriate medical, social, and administrative information regarding the resident would be communicated to the HD Center at the time of transfer.<br><br><Resident 66><br><br>Review of the 04/04/2024 Quarterly Minimum Data Set (MDS-assessment tool) showed Resident 66 diagnoses included lung and kidney disease, and was dependent on kidney HD. Resident 66 was able to make needs known.<br><br>Review of HD care plan, dated 03/20/2024, showed Resident 66 attended HD at a Named outpatient HD center every Monday, Wednesday, and Friday. The CP directed staff to ensure Resident 66 was ready for transporation pick-up time was 8:00 AM and they were scheduled to return to the facility at 2:15 PM. Other HD CP interventions included: collaborate with the HD center staff as needed, maintain the HD flowsheets post-dialysis, and monitor/change/remove HD access site post-hemodialysis pressure dressing per HD Center instructions, and obtain any lab records obtained at the HD center. The CP directed staff to monitor Resident 66 increased shortness of breath, increased edema (fluid accumulation), restlessness, low blood pressure, clammy skin, and notify the provider if observed.<br><br>Review of Resident 66's HD folder ([they] used to keep their health records and communications between facility/HD center when going between to and from HD) showed 12 facility Dialysis Transfer Forms (a communication tool used by both the facility and HD Center to report laboratory values, pre and post HD weights, any medication administered at the HD Center, any changes that occurred in the resident's status, Physician orders, and any issues that required follow-up) dated 01/31/2024, 02/7/2024, 02/26/2024, 03/11/2024, 03/13/2024, 03/15/2024, 03/18/2024, 03/22/2024, 04/01/2024, 04/03/2024, 04/5/2024 04/08/2024. The binder had multiple missing documents during the time Resident 66 had received HD services at the center. The forms were incomplete, omitting information regarding post HD nursing evaluations of signs of excessive bleeding, vital sign changes, HD access site status, and other post HD requirements.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 66's Electronic Health Record (EHR) did not provide documentation to show the Dialysis Transfer Forms were initiated or completed for nine HD treatment days in Februaury of 2024 and eight HD treatment days in March 2024.<br><br>During an interview on 04/11/2024 at 9:32 AM, Staff R, Registered Nurse/Residential Care Manager was asked about the missing dialysis transfer forms and/or incomplete HD transfer form documentation. Staff R stated the dialysis transfer forms were to be filled out prior to sending the resident out to the dialysis center and filled out whenever the resident returned after their appointment. Staff R, stated that if the form was incomplete or the dialysis center did not fill out their sections then it was the expectation that the facility's LNs would call the HDs centers to obtain information about the residents dialysis treatment.<br><br>During an interview on 04/11/2024 at 1:25 PM, Staff Q, Assistant Director of Nursing Services (ADON), stated that it would be their expectation that the facility's LNs ensure that the dialysis transfer form was completed by all parties (facility and dialysis center) in its entirety and that if it was not completed by the dialysis center the licensed nurses were to call the dialysis center to get the necessary information.<br><br>Reference WAC 388-97-1900 (1)(6)(a)(b)(c). |

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| F 0800<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.<br><br>46067<br><br>Based on observations, interviews, and record review the facility failed to provide food that accommodated identified resident preferences for 4 of 20 Residents (Residents 3, 62, 301, and 91) reviewed for food preferences. This failure placed residents at risk for weight loss, malnutrition, and diminished quality of life.<br><br>Findings included .<br><br>During an interview on 04/08/2024 at 12:35 PM, Resident 22 stated they disliked tomatoes, but the facility still served them tomato soup.<br><br>During an interview on 04/09/2024 at 10:18 AM, Resident 6 said, They asked me what I like and don't like, but then serve me what i don't like, so I have them take it back.<br><br>During an interview on 04/09/2024 at 9:41 AM, Resident 72 stated sometimes preferences for food choices were not followed, they had a pineapple allergy and were served pineapple. Resident 72 said they didn't eat because they were concerned the pineapple may have touched other food.<br><br><BREAKFAST TRAY LINE><br><br><Resident 3><br><br>Review of Resident 3's breakfast tray card showed one banana identified as a breakfast preference.<br><br>Observation of the breakfast tray line on 04/11/2024 at 8:17 AM, showed Staff H, Cook, served Resident 301 a donut, scrambled eggs, and a slice of ham. No banana was provided.<br><br><Resident 62><br><br>Review of Resident 62's breakfast tray card showed two bowls of rice identified as a breakfast preference.<br><br>Observation of the breakfast tray line on 04/11/2024 at 7:38 AM showed Staff H served Resident 62 one bowl of rice.<br><br><Resident 301><br><br>Review of Resident 301's breakfast tray card showed bowl of rice identified as a breakfast preference.<br><br>Observation of the breakfast tray line on 04/11/2024 at 7:51 AM showed Staff H served Resident 301 a donut, scrambled eggs, and a slice of ham. No rice was provided.<br><br><Resident 91><br><br>(continued on next page) |

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| F 0800<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident 91's breakfast tray card showed fresh fruit identified as a breakfast preference.<br><br>Observation of the breakfast tray line on 04/11/2024 at 8:13 AM showed Staff H served Resident 91 a donut, scrambled eggs, and a slice of ham. No fresh fruit was provided.<br><br>During an interview on 04/11/2024 at 8:45 AM, Staff H stated they were unable to accommodate the resident's preferences because they ran out of fresh fruit the day before and there was not enough rice prepared in advance to serve Residents 62 and 301.<br><br>During an interview on 04/11/2024 at 8:51 AM, Staff G, Dietary Manager, stated their expectation was staff would have prepared rice to meet the needs of residents preferences. Staff G stated they were unaware there was no fresh fruit.<br><br>During an interview on 04/11/2024 at 2:24 PM, Staff C, Regional Director of Clinical Operations, stated it was the expectation that identified resident preferences be honored.<br><br>Reference: WAC 388-97-1120 (2)(a), -1100 (1), -1140 (6). |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>46067<br><br>Based on observations, interviews, and record review the facility failed to ensure preplanned menus were followed and the appropriate portion sizes were served according to the tray card for 3 of 20 Residents (Resident 75, 76, and 92) reviewed for dietary services. These failures placed residents at risk for decreased/increased caloric intake, nutritional deficits, and a diminished quality of life.<br><br>Findings included .<br><br>Review of the preplanned breakfast menu for 04/11/2024 showed toast, scrambled eggs, ham, 2% milk, juice, and fruit.<br><br>Observation of the breakfast tray line on 04/11/2024 at 7:25 AM showed Staff H, Cook, plated a donut, scrambled eggs, and a slice of ham for the general diet and low-fat milk was added to the tray. When asked about the preplanned menu, Staff H stated they ran out of bread and 2% milk so they decided to serve donuts and low-fat milk as the alternative.<br><br><Resident 75><br><br>Review of Resident 75's breakfast tray card showed double portions.<br><br>Observation of the breakfast tray line on 04/11/2024 at 7:28 AM showed Staff H served Resident 75 one donut, one scoop of scrambled eggs, and one slice of ham. Double portions were not served.<br><br><Resident 76><br><br>Review of Resident 76's breakfast tray card showed double portions.<br><br>Observation of the breakfast tray line on 04/11/2024 at 7:56 AM showed Staff H served Resident 76 two donuts, one scoop of scrambled eggs, and one slice of ham. Double portions were not served.<br><br><Resident 92><br><br>Review of Resident 92's breakfast tray card showed double portions.<br><br>Observation of the breakfast tray line on 04/11/2024 at 8:18 AM showed Staff H served Resident 92 one donut, one scoop of scrambled eggs, and one slice of ham.<br><br>During an interview on 04/11/2024 at 8:45 AM, Staff H stated they were concerned they would not have enough food to feed all the residents if they served double portions, because they got busy and overcooked the eggs, which were not as fluffy as usual.<br><br>(continued on next page) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 04/11/2024 at 8:51 AM, Staff G, Dietary Manager, stated their expectation was staff would provide portion sizes according to the resident tray card. Staff G stated there was an issue with obtaining 2% milk from their supplier and they expected a bread order that day. Staff G agreed the eggs were overcooked and did not look appetizing.<br><br>Reference WAC 388-97-1160 (1)(a)(b). |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>46067<br><br>Based on observations and interviews, the facility failed to ensure food was prepared and served according to in accordance with professional standards. These failures placed residents at risk of foodborne illness and a diminished quality of life.<br><br>Findings included .<br><br><FIRST KITCHEN OBSERVATION><br><br>An observation on 04/08/2024 at 10:19 AM showed three packages of partially thawed ground beef, an uncovered and unlabeled container of cheese sauce, and an open can of a Named Brand Energy drink on the prep table.<br><br>During an interview on 04/08/2024 at 10:25 AM, Staff G, Dietary Manager (DM), stated the ground beef thawing on the counter, uncovered and unlabeled food and personal drinks on the counter did not meet expectations.<br><br><TEMPERATURES><br><br>An observation on 04/11/2024 at 7:50 AM, showed Staff H, Cook, added a large pitcher of hot water from the coffee maker to the oatmeal on the steam table. Observation showed no temperature was taken.<br><br>An observation on 04/11/2024 at 8:11 AM showed Staff H take a tray of ham from the oven and put it on the steam table. Observation showed no temperature was taken.<br><br>An observation on 04/11/2024 at 8:07 AM showed Staff G, Dietary Manager (DM), fill a large pitcher of hot water from the coffee maker, handed it to Staff H, who poured half of the water into the oatmeal and half into the cream of wheat. Observation showed no temperature was taken.<br><br>During an interview on 04/11/2024 at 8:45 AM, Staff H said, I knew I should have taken the temperature of the ham and oatmeal, but I was in a rush.<br><br>During an interview on 04/11/2024 at 8:47 AM, Staff G stated [they] and Staff H should have checked the temperature of the hot water from the coffee pot because it was unpredictable. Staff G stated the expectation was that food temperatures were taken before tray line, during tray line, and after tray line meal service.<br><br>During an interview on 04/11/2024 at 2:24 PM, Staff C, Regional Director of Operations, stated their expectation was staff followed temperature measurement requirements according to professional standards.<br><br><FOOD PREPARATION><br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An observation of the breakfast tray line on 04/11/2024 at 7:25 AM showed a large pot of uncovered previously-cooked shredded chicken on the prep table, unattended.<br><br>An observation on 04/11/2024 at 8:50 AM showed the pot of chicken remained uncovered, and unattended, on the prep table (85 minutes without refrigeration).<br><br>During an interview on 04/11/2024 at 8:45 AM, Staff H stated the chicken was not completely thawed out and they intended to cook it before breakfast but got preoccupied doing something else. Staff H stated they should have put it in the refrigerator to thaw.<br><br>During an interview on 04/11/2024 at 8:51 AM, Staff G stated their expectation was meats were safely thawed in the refrigerator and the meat placed on the prep table to thaw did not meet their expectations.<br><br>An observation on 04/11/2024 at 8:59 AM showed Staff H placed the pot of uncovered previously-cooked chicken that sat out for at least 85 minutes into the refrigerator.<br><br>An observation on 04/11/2024 at 10:09 AM showed Staff H placed several scoops of shredded chicken from the pot into a blender.<br><br>During an interview on 04/11/2024 at 10:10 AM, Staff H stated they cooked the shredded chicken and did not think it was unsafe to consume. Staff H was unable to provide the time the chicken was placed out on the prep table to thaw, how long it sat on the prep table without refrigeration.<br><br>During an interview on 04/11/2024 at 10:13 AM, Staff G stated the chicken was not safe for consumption and should not have been cooked after it was left out on the prep table.<br><br>During an interview on 04/12/2024 at 1:10 PM, Staff A, Administrator, stated food that was not thawed properly should be discarded. Staff A stated cooking the improperly thawed chicken with the intention to serve it did not meet their expectations.<br><br>Reference WAC 388-97-1100 (3). |

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| F 0847<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567<br><br>Based on interview and record review, the facility failed to include documentation of the Arbitration (a procedure used to settle a dispute using an independent person mutually agreed upon by both parties) Agreement to the resident and/or representative for 4 of 4 residents (Residents 81, 87, 73 and 66), reviewed for Arbitration Agreement. This failure placed the residents at risk of losing legal protections, forfeiture (loss or giving up of something) of the right to a jury or court, lack of understanding of the legal document signed, and a diminished quality of life.<br><br>Findings included .<br><br>Review of a facility's Admission Agreement for Skilled Nursing Facilities, Admission Agreement (AA)packet, dated May 2017, showed in section 9.1: Attachments / Arbitration Agreement: The Center offers the Resident Group [resident or resident representative] the option of signing an Arbitration Agreement. The Resident Group acknowledges receiving a copy of the Arbitration Agreement, being informed orally of the content of the Arbitration Agreement and given the opportunity to ask questions. In addition, Section 12: Acknowledgement of Receipt of Attachments showed that the resident acknowledged that they had all attachments which included the [NAME] Arbitration Agreement (WAA). The packet did not include the WAA in attachments.<br><br>Review of the [NAME] Arbitration Agreement, (WAA), dated September 2022, provided by Staff A, Administrator, on 04/08/2024, showed the explanation of the arbitration process and resident signature/date once they agreed. The document showed by signing, they understood their right to seek counsel, it was optional, not a precondition of admission or reciept of care and services, and they had 30 days to revoke their decision.<br><br><Resident 81><br><br>Review of Resident 81s AA and attachments acknowledgement, showed they signed it on 12/27/2023; however the WAA was not included in their AA attachments packet.<br><br>During an interview on 04/10/2024 at 1:01 PM, Resident 81 stated they signed lots of documents when they admitted but did not remember receipt of information regarding optional WAA.<br><br><Resident 87><br><br>Review of Resident 87s AA and attachments acknowledgement, showed they signed it on 01/24/2024; however the WAA was not included in their AA attachments packet.<br><br>During an interview on 04/10/2024 at 12:31 PM, Resident 87, stated they signed several documents when they admitted but did not recall any optional WAA information related to arbitration agreements.<br><br><Resident 73><br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505326 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/12/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Heartwood Extended Healthcare | | STREET ADDRESS, CITY, STATE, ZIP CODE: 1649 East 72nd Tacoma, WA 98404 | |

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| F 0847<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident 73s AA and attachments acknowledgement, showed they signed it on 10/06/2023; however the WAA was not included in their AA attachments packet.<br><br><Resident 66><br><br>Review of Resident 66s AA and attachments acknowledgement, showed they signed it on 04/25/2023; however the WAA was not included in their AA attachments packet.<br><br>During an interview 04/10/2024 at 11:54 AM, Staff M, Admissions Coordinator (AC), stated the AA information was discussed with the residents upon admission and the residents signed Section 12 of the AA to aknowlege they received the listed attachments, however [they] were just provided the optional WAA attachment (within the last week) by Staff C, Regional Director of Operations, to include in the AA packet attachments.<br><br>During an interview on 04/10/2024 at 1:42 PM, Staff A, Administrator, stated the AA packet attachments were not up to date and the optional WAA would be added to the AA packet attachments.<br><br>Refer to F848 for additional information.<br><br>No Associated Reference WAC |

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| F 0848<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide a neutral and fair arbitration process and agree to arbitrator and venue.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567<br><br>Based on interview and record review, the facility failed to include documentation of the Arbitration (a procedure used to settle a dispute using an independent person mutually agreed upon by both parties) Agreement to the resident and/or representative for 4 of 4 residents (Resident 81, 87, 73 and 66), reviewed for Arbitration Agreement. This failure placed the residents at risk of losing legal protections, forfeiture (loss or giving up of something) of the right to a jury or court, lack of understanding of the legal document signed, and a diminished quality of life.<br><br>Findings included .<br><br>Review of a facility document titled, Admission Agreement for Skilled Nursing Facilities, dated May 2017 showed section 9.1: Attachments / Arbitration Agreement. The Center offers the Resident Group [resident or resident representative] the option of signing an Arbitration Agreement. The Resident Group acknowledges receiving a copy of the Arbitration Agreement, being informed orally of the content of the Arbitration Agreement and given the opportunity to ask questions. In addition, Section 12: Acknowledgement of Receipt Attachments showed that the resident acknowledged that they had received several documents to include the [NAME] Arbitration Agreement.<br><br>Review of a separate document titled, [NAME] Arbitration Agreement, dated September 2022, provided by Staff A, Administrator (ADM) on 04/08/2024, showed documentation that discussed the Arbitration process and an area for the resident to sign once they had agreed. The document showed that by signing, the resident had understood that they had the right to consult with or seek legal counsel or the Washington State long-term ombudsman concerning the Arbitration Agreement and that it was optional and was not a precondition of admission or a condition to receive continued care. In addition, the document showed that the resident had 30 days from the execution of the Arbitration Agreement to revoke the document. The Admission Agreement documentation provided by Staff A was provided on 04/08/2024.<br><br>Review of Resident 81, 87, 73 and 66's Admission Agreement documentation showed that each resident had signed the documentation that indicated that they had received a copy of the Admission Agreement and the attachments to include the [NAME] Arbitration Agreement; however, the [NAME] Arbitration Agreement was not included in the packet. Resident 81 had signed the Agreement on 12/27/2023, Resident 87 signed on 01/24/2024, Resident 73 signed on 10/06/2023 and Resident 66 signed on 04/25/2023.<br><br>During an interview on 04/10/2024 at 11:54 AM, Staff M, Admissions Coordinator (AC) stated that the Admission Agreement for Skilled Nursing Facilities information would be discussed with the residents upon admission and that they (residents) would sign Section 11 of the document and Section 12 that they received several attachments (regarding forms, notices and policies); however, Staff M stated that they had just been provided the optional [NAME] Arbitration documentation, within the past week, by a regional administrator, and that it would now be included in the Admission Agreement documentation.<br><br>During an interview on 04/10/2024 at 12:31 PM, Resident 87, stated that they had signed off several documents when they entered the facility but did not remember any optional form related to the Arbitration Agreement.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Heartwood Extended Healthcare | | STREET ADDRESS, CITY, STATE, ZIP CODE 1649 East 72nd Tacoma, WA 98404 | |

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| F 0848<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 04/10/2024 at 1:01 PM, Resident 81 stated that the staff had them sign a bunch of documents when they were last admitted to the facility but did not remember that they had signed the optional Arbitration Agreement.<br><br>During an interview on 04/10/2024 at 1:42 PM, when presented with Resident 81, 87, 73 and 66's Admission Agreement documentation and [NAME] Arbitration Agreement that was not included in the initial admission packet, Staff A stated that the required optional documentation related to the Arbitration Agreement was just received and that the residents Admission packet needed to be updated.<br><br>Refer to F847 for additional information.<br><br>No Associated Reference WAC |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148<br><br>Based on interview, and record review the facility failed to maintain an infection prevention and control program to prevent the transmission of communicable diseases and infections by completing the collection and analyzation of infection control data, identifying trends, and completing follow-up activities in response to those trends for 2 of 3 months (February and March 2024) reviewed for Infection Control. The facility also failed to implement isolation precautions for 1 of 2 wings (Rose wing) reviewed for transmission-based precautions. These failures placed residents and staff at risk for communicable diseases and infections, poor clinical outcomes, and a decreased quality of life.<br><br>Findings included .<br><br><Tracking and Trending><br><br>Review of the facility policy titled Infection Control, revised October 2018, showed the surveillance for infections would identify both individual cases and trends to guide appropriate interventions and prevent future infections based on current standards. It showed that the Infection Preventionist would observe for trends and summarize monthly data.<br><br>February 2024<br><br>Review of the infection control line listing for the month of February 2024 showed 26 new infections; however, did not include infections that were documented in the following resident's electronic health records (EHR):<br><br>1. Resident 48 admitted to the facility on [DATE] and was prescribed gentamicin (an antibiotic) eye drops for Conjunctivitis (eye infection) on 02/23/2024.<br><br>2. Resident 16 admitted to the facility on [DATE] and was prescribed ceftriaxone (an antibiotic) for septic joint infection on 02/25/2024.<br><br>3. Resident 86 admitted to the facility on [DATE] and was prescribed ciprofloxacin (an antibiotic) eye drops for an eye infection on 02/14/2024.<br><br>4. Resident 92 admitted to the facility on [DATE] and was prescribed levofloxacin (an antibiotic) for a wound infection on 02/24/2024, completed on 03/02/2024 and restarted levofloxacin on 03/31/2024 for the same wound, no culture results were found in the medical record.<br><br>Further review of the infection control line listing for February 2024 showed no mapping of infections and no summary to identify trends or interventions to address those trends, and Multidrug resistant organisms were not identified and tracked.<br><br>March 2024<br><br>Review of the infection control line listing for the month of March 2024 showed 17 new infections; however, did not include infections that were documented in the following resident's EHR:<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1. Resident 52 admitted to the facility on [DATE] and was prescribed levofloxacin (an antibiotic) for a urinary tract infection on 03/23/2024.<br><br>2. Resident 12 admitted to the facility on [DATE] and was prescribed augmentin (an antibiotic) for a urinary tract infection on 03/17/2024 and nitrofurantoin (an antibiotic) on 03/20/2024, lab review showed this was a multi drug resistant organism.<br><br>3. Resident 91 admitted to the facility on [DATE] and was prescribed levofloxacin (an antibiotic) for a urinary tract infection on 03/21/2024.<br><br>4. Resident 18 admitted to the facility on [DATE] and was prescribed levofloxacin for a urinary tract infection on 03/17/2024.<br><br>Further review of the infection control line listing for March 2024 showed no summary to identify trends or interventions to address those trends and multidrug resistant organisms were not identified and tracked.<br><br>During an interview on 04/12/2024 at 4:07 PM, Staff Q, Assistant Director of Nursing (ADON) stated that they should have looked at all new infections daily to include new admissions with infections and tracked them on the infection control line listing and map. Staff Q said there should have been a monthly summary completed for February and March 2024, but this had not been done.<br><br><Transmission Based Precautions><br><br>Observation on 04/09/2024 at 9:34 AM showed an isolation cart outside the door of room [ROOM NUMBER] and an enhanced barrier precautions sign posted. Staff T, Certified Nursing Assistant (CNA), was providing care to Resident 52 wearing an isolation gown and gloves. Staff T adjusted the residents peg tube and undergarment, Staff T began to remove their gown and gloves by removing their left glove first, then attempted to pull their left arm out through the sleeve but was unable, so they used their ungloved left hand and grabbed the outside of the gown on their left shoulder and lifted the gown over their head with the strings still tied. They then grabbed the outside of their gown on the right arm and pulled the right sleeve and right glove off, grabbed the gown with both ungloved hands and pulled the gown off where it was tied around their waist, balled the gown up without regard for clean and dirty side, shoved it in the small garbage can next to the nightstand and pushed it down into the garbage can with their ungloved hands. They then pulled the garbage sack out, grabbed the other garbage sack and left the room without performing hand hygiene. They walked to the soiled utility room and pushed the code numbers with their unsanitized hand and opened the soiled utility room.<br><br>During an interview on 04/09/2024 at 9:45 AM, Staff T stated Resident 52 was on enhanced barrier precautions because they had a feeding tube. Staff T stated they should perform hand hygiene before giving care and when they are done providing care before they exit the resident's room, after they remove their gloves.<br><br>During an interview on 04/12/2024 at 12:48 PM, Staff DD, CNA, stated that if a resident was on isolation precautions they would follow the directions on the posted sign.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER: Heartwood Extended Healthcare | | STREET ADDRESS, CITY, STATE, ZIP CODE: 1649 East 72nd Tacoma, WA 98404 | |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation of room [ROOM NUMBER] showed an isolation cart outside the door with a posted sign for contact/enteric precautions which required the use of a gown and gloves when entering the room and hand hygiene to be performed with soap and water on exit.<br><br>Observation on 04/12/2024 at 12:46 PM, showed a male staff member stood inside room [ROOM NUMBER] at foot of the bed. The male staff member did not have on a gown or gloves and exited the room without washing with soap and water.<br><br>Observation on 04/12/2024 at 1:04 PM, Staff C, CNA entered room [ROOM NUMBER] without a gown or gloves, took the lunch tray from the bedside table, exited the room, opened the lunch tray cart, and placed the tray inside, and did not perform hand hygiene with soap and water.<br><br>During an interview on 04/12/2024 at 1:40 PM, Staff B, Director of nursing services stated their expectation was that staff who entered a room with isolation precautions would follow the directions on the sign and for residents on enteric precautions they would wear a gown and gloves when entering the room and wash their hands with soap and water on exit.<br><br>During an interview on 04/12/2024 at 1:45 PM, Staff B stated they had lost their infection preventionist a couple of months ago and had been doing their best to keep up while they find a new one.<br><br>Reference WAC 388-97 -1320 (2)(a)(b)(c) |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Implement a program that monitors antibiotic use.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148<br><br>Based on interview and record review, the facility failed to implement an effective Antibiotic Stewardship Program, to promote appropriate use of antibiotics, reduce the risk of unnecessary antibiotic use and decrease the development of adverse side effects and antibiotic resistance for 4 of 7 residents (Residents 69, 304, 56 and 305) reviewed for antibiotic stewardship. This failure placed residents at risk for potential adverse outcomes associated with the inappropriate and/or unnecessary use of antibiotics.<br><br>Findings included .<br><br>Resident 69<br><br>Review of the electronic health record (EHR) showed Resident 69 admitted to the facility on [DATE] with diagnose of infected amputation stump.<br><br>Review of the laboratory report dated 06/24/2023 showed the resident had a urinary tract infection (UTI) and identified e-choli (a bacteria) extended spectrum beta lactamase (ESBL) which was resistant to multiple antibiotics (MDRO) and also identified proteus mirabilis (a bacteria) which was not resistant to antibiotics.<br><br>The resident received the following antibiotic (ABO) therapy with eight different antibiotics since admission for UTI, pneumonia (PNA), and osteomyelitis (bone infection):<br><br>1. Vancomycin for osteomyelitis which started on 04/23/2023 and completed on 12/06/2023.<br><br>2. Ciprofloxacin for possible UTI infection started 06/20/2023 completed 06/23/2023. Review of laboratory results dated [DATE] showed the organism was resistant to ciprofloxacin.<br><br>3. Ertapenem one time a day for UTI, which started 06/23/2023 completed 6/30/2023 and for UTI which started 03/04/2024 and completed 03/14/2024.<br><br>4. Ceftriaxone for osteomyelitis which started 10/10/2023 and completed 10/24/2023.<br><br>5. Cefepime for osteomyelitis which started 11/06/2023 and completed on 12/07/2023.<br><br>6. Augmentin for wound infection, which started 01/30/2024 and was discontinued on 01/31/2024.<br><br>7. Levofloxacin for PNA which started 02/01/2024 and completed on 02/11/2024.<br><br>8. Doxycycline for osteomyelitis which started 01/08/2024 and completed on 02/19/2024.<br><br>Review of the laboratory report dated 03/03/2024 identified the organism proteus mirabilis which had become resistant to all but three antibiotic classes.<br><br>Resident 304<br><br>(continued on next page) |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the EHR showed Resident 304 admitted to the facility on [DATE] with diagnoses of diverticulitis and enterocolitis, the resident received levofloxacin (an antibiotic) for a UTI from 02/15/2024 through 02/22/2024.<br><br>Review of the laboratory results dated [DATE] showed no bacterial growth with yeast growth less than 20, 000.<br><br>Review of the EHR showed no documentation of signs or symptoms of a UTI or that the lab was reviewed by the provider for continued use of the antibiotic.<br><br>Resident 56<br><br>Review of the EHR showed Resident 56 admitted to the facility on [DATE] with diagnosis of osteomyelitis and sepsis (the body's reaction to an infection.) The resident was administered Ciprofloxacin (an antibiotic) for 5 Days which started on 04/06/2024 and completed on 04/11/2024.<br><br>Review of the laboratory results collected on 04/03/2024 showed ESBL positive organism that was resistant to ciprofloxacin.<br><br>Review of the EHR showed no documentation of signs or symptoms of a UTI or that the lab was reviewed by the provider for continued use of the antibiotic.<br><br>Resident 305<br><br>Review of the EHR showed Resident 305 was admitted to the facility on [DATE] with diagnosis of dementia. The resident was administered Cephalexin (an antibiotic) for UTI which started on 03/06/2024 and completed on 03/13/2024.<br><br>Review of the laboratory results collected 03/06/2024 showed no bacterial growth.<br><br>Review of the EHR showed no documented signs or symptoms of a UTI, or that the lab was reviewed by the provider for continued use of the antibiotic.<br><br>During an interview on 04/12/2024 at 1:11 PM, Staff BB, Licensed Practical Nurse stated that they were unaware of the criteria that constitutes active infection but that they would notify the provider when lab results were received.<br><br>During an interview on 04/12/2024 at 1:31 PM, Staff B, Director of Nursing Services stated that it was their expectation that the infection preventionist notify the provider when lab results show resistance for further orders. Staff B also stated that the lack of oversite for antibiotic stewardship did not meet their expectations.<br><br>No associated Reference WAC. |

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| | 505326 | A. Building<br>B. Wing | 04/12/2024 |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148<br><br>Based on interview and record review, the facility failed to provide Influenza and Pneumococcal vaccines for 2 of 5 residents (Resident 55 and 70) reviewed for vaccinations. This failure placed the residents at a higher risk for contracting influenza and pneumococcal infections, related complications, and a decreased quality of life.<br><br>Findings included .<br><br>Resident 55<br><br>Review of Resident 55's electronic health record (EHR) showed the resident admitted on [DATE]. A signed consent form was located in the medical record that listed influenza, and pneumococcal vaccines, there was no indication if the resident consented or declined the vaccines. Review of the administration record showed the vaccines had not been administered.<br><br>Resident 70<br><br>Review of Resident 70's EHR showed the resident admitted on [DATE], a signed consent form which indicated the resident consented to the influenza vaccine was located in the medical record dated 08/04/2023. Also, a signed consent form for the pneumococcal vaccine was located, it did not indicate if the resident declined or consented to the vaccine. Review of the resident's administration record showed the vaccines had not been administered.<br><br>During an interview on 04/12/2024 at 1:38 PM, Staff B, Director of Nursing Services stated their expectation was for residents to be educated on and offered the vaccines when they admitted , the forms should be completed fully and if they consented, the vaccines should have been ordered and administered.<br><br>Reference WAC 388-97-1340 (1), (2), (3) |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148<br><br>Based on interview and record review, the facility failed to offer and follow-up on the completion of COVID-19 immunizations for 2 of 5 residents (Residents 55 and 70) reviewed for vaccinations. This failure placed the residents at an increased risk for complications related to COVID-19 infection that could result in severe illness or death.<br><br>Findings included .<br><br>Review of Resident 55's electronic health record (EHR) showed the resident admitted on [DATE] with diagnoses of heart disease, presence of a pacemaker and asthma. There was no record of the resident receiving the Covid-19 vaccine prior to admission. A signed consent form dated 03/14/2024 was located in the medical record that listed the Covid-19 vaccine, there was no indication if the resident consented or declined the vaccine. Further review showed no record of the residents Covid-19 vaccination status and that the vaccine had not been administered since admission.<br><br>Review of Resident 70's EHR showed the resident admitted on [DATE] with diagnoses of acute respiratory failure and history of Covid-19 infection, the resident had received their 2nd dose of Covid-19 vaccine on 04/01/2021 and was due for the booster. A signed consent form which indicated the resident consented to the Covid-19 vaccine booster was located in the medical record dated 08/04/2023. Review of the resident's administration record showed the vaccine had not been administered since admission.<br><br>During an interview on 04/12/2024 at 1:38 PM, Staff B, Director of Nursing Services stated their expectation was for residents to be educated on and offered the Covid-19 vaccine when they admitted , the forms should be completed fully and if they consented, the vaccines should have been ordered and administered.<br><br>No Associated Reference WAC |