

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505329	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/12/2024
NAME OF PROVIDER OR SUPPLIER Buena Vista Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 151 Buena Vista Drive Colville, WA 99114	
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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 47328 Based on observation, interview, and record review the facility failed to assess and care plan for safe self-medication administration for 1 of 1 sampled residents (Resident 28), reviewed for medication administration. This failure placed residents at risk of medication errors, adverse side effects, and diminished quality of life. Findings included . Review of the facility policy titled, Self-Administration of Medication revised 09/2017, documented if a resident desired to self-administer medications the facility would complete a self-medication evaluation before the resident was able to self-administer medications. The assessment would be reviewed quarterly or upon a change of condition. The policy instructed nursing staff to obtain a provider order for self-administration for the specific medications, initiate a self-medication administration care plan, initiate a bedside self-medication administration record, determine whether medication would be stored at the nursing station or at bedside, and obtain and initiate proper safety mechanisms if medications were to be stored at the resident's bedside. According to the 01/29/2024 admission assessment, Resident 28 had diagnose which included hyponatremia (low sodium levels), and Transient Ischemic Attack (TIA- temporary stroke like symptoms). Resident 28 was cognitively intact and able to make their needs known. On 04/08/2024 at 10:48 AM, Resident 28 was observed to have a large semi translucent bottle half full of colorful TUMS (an over-the-counter antacid) on their nightstand next to their bed with 7 TUMS tablets sitting outside of the bottle on the nightstand. Similar observations were made on 04/08/2024 at 3:29 PM, 04/09/2024 at 9:00 AM and 1:53 PM, 04/10/2024 at 8:43 AM, and 04/11/2024 at 6:19 AM. Review of providers orders showed no documentation Resident 28 self-administered medications and/or stored them at their bedside. Resident 28 had an order dated 01/17/2024 for TUMS 500mg every 4 hours as needed for indigestion. Review of Resident 28's medical record showed no documentation a self-medication evaluation had been completed. Review of the 01/18/2024 care plan showed no documentation Resident 28 self-administered medications and/or stored them at their bedside. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/11/2024 at 6:19 AM, Resident 28 was asked about the bottle of TUMS that was on their nightstand. Resident 28 stated they took the TUMS as needed for indigestion. Resident 28 stated staff had not spoken with them about the antacids. Resident 28 acknowledged they did not inform staff when they self-administered the TUMS. During observation and interview on 04/11/2024 at 6:30 AM, Staff C, Licensed Practical Nurse, stated they were unsure why Resident 28 had a bottle of TUMS at their bedside. Staff C removed the bottle from the bedside and noted the bottle was labeled as Ultra Strength 1000mg tablets. Staff C reviewed Resident 28's provider orders and acknowledged Resident 28's TUMS order was for 500mg not the ultra-strength 1000mg tablets. Staff C stated the facility did not allow for self-medication administration and medications were typically locked up in the medication cart. In an interview on 04/11/2024 at 1:04 PM, Staff B, Director of Nursing, stated if a resident chose to self-administer medications an assessment would be done, and it would need to be care planned. Staff B further stated if medications were kept at the resident's bedside, they needed to be locked up for safety to ensure all other residents did not have access to them. Reference WAC: 388-97-0440, 1060 (3)(I)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 46033 Based on observation, interview and record review, the facility failed to provide assistive cups as care planned for 1 of 3 sampled residents (Resident 17) reviewed for activities of daily living (ADL's). This failure placed the resident at risk for continued swallowing difficulties and decreased fluid intake. Findings included . A review of the 03/04/2024 comprehensive admission assessment documented Resident 17 had diagnoses which included kidney stones and an enlarged prostate. The resident had moderate cognitive impairment and required set-up/clean-up assistance for eating. Resident 17 had loss of food from their mouth when eating and held food in their mouth or cheeks after eating. The baseline care plan dated 02/27/2024 showed Resident 17 required set-up/clean-up assistance for eating and was to use a sippy cup (has a spout and two handles to aid drinking and prevent spillage) for all liquids and could also use a straw. The nutritional care plan documented Resident 17 was to have aspiration precautions (interventions that prevented inhaling foods and drinks when eating such as sitting upright for example.) Resident 17's current Individual Service Plan (ISP, staff instructions for providing the resident's care) active at the time of the survey documented the resident was to use sippy cups for all fluids. On 04/10/2024 at 12:22 PM, Resident 17 was observed in the dining room seated in their wheelchair. At this time, the resident was provided water in a light green clear plastic juice-size glass. At 12:26 PM, tomato juice was provided in the same type of juice glass. The juice glasses did not have lids, handles, or a straw. Resident 17 drank from them without coughing. On 04/11/2024 at 7:44 AM, Resident 17 was seated in the dining room for breakfast. The resident had water in a sippy cup, and coffee in a coffee mug that had a lid and straw. Resident 17 stated they used both hands to eat because food slid off their silverware. They did not like larger silverware but liked the cups with handles because they were able to drink from them easier. On 04/11/2024 at 12:11 PM, Resident 17 was provided water in a plastic juice glass, and coffee in a mug with a lid and straw during lunch. At 12:17 PM, the resident was provided cranberry juice and milk in sippy cups. The resident alternated drinking from the water, juice, milk and coffee during their lunch. At 1:02 PM, Resident 17 took a drink of milk, then started to cough. The cough was very quiet, and staff in the dining room did not hear it. At 1:10 PM, Resident 17 was no longer coughing and scooted in their wheelchair out of the dining room. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 04/11/2024 at 1:10 PM, Staff F, Nursing Assistant, stated they guessed Resident 17 was able to use either type of drinkware-a plastic juice glass or a sippy cup. Staff F stated Resident 17 used the regular juice glasses when they were in their room. Staff F was unsure why the resident needed the sippy cup and who determined what assistive devices a resident was to use. Staff F stated they looked on a resident's meal ticket when they were unsure what assistive devices a resident needed. On 04/12/2024 at 8:23 AM, a plastic juice glass half full of water was observed on Resident 17's overbed table in their room. When interviewed on 04/12/2024 at 12:25 PM, Staff G, Speech Therapist, stated they had worked with Resident 17 regarding their ability to swallow when the resident was first admitted . Staff G stated a recommendation was made for Resident 17 to use a sippy cup because the resident spilled fluids from their mouth when they drank; the cup was easier for the resident to hold, and there was less spillage. When interviewed on 04/12/2024 at 01:12 PM, Staff H, Nursing Assistant Registrant, stated a resident's meal ticket usually showed what assistive devices a resident used. They were unsure if that information was on the care plan. Resident 17's meal ticket was observed at this time and did not instruct staff to use sippy cups for the resident. When interviewed on 04/12/2024 at 04:51 PM, Staff B, Director of Nursing, stated they included speech therapy recommendations when they entered in a resident's diet order and this information was also on a resident's ISP. Staff B stated they expected staff to follow the residents care plans; not doing so might put a resident at risk of aspiration or other complications. Reference: WAC 388-97-0860(2)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 47328 Based on interview and record review the facility failed to identify, report, and thoroughly investigate a potential incident of neglect as required for 1 of 4 sampled residents (Resident 33) reviewed for accidents. Failure to identify, report, and thoroughly investigate an unwitnessed fall that resulted in serious bodily injury, placed the resident at risk of further injury, potential neglect, and diminished quality of life. Findings included . Review of the facility policy titled, Freedom from Abuse, Neglect . Mistreatment . and Exploitation revised 10/2022, showed neglect occurred when the facility was aware of goods or services required by a resident necessary to avoid physical harm, but the facility failed to provide them resulting in physical harm, pain, mental anguish, or emotional distress. The policy defined serious bodily injury as extreme physical pain, loss, or impairment of function of body requiring medical intervention such as hospitalization or surgery. The policy further showed the facility was to immediately report all suspected and/or allegations of abuse, neglect, mistreatment, and injuries of unknown source in accordance with State and Federal law. Review of The Purple Book: Nursing Home Guidelines for Prevention, Protection, Incident Identification, Investigation and Reporting revised 10/2015, defined neglect as a failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Page 59 defined injuries of unknown source as an injury sustained by a resident where the source of the injury was not directly observed by staff; or the resident was not able to report/inform how the injury occurred; or not identified through the process of a through investigation for a substantial injury. The purple book further showed substantial injuries of unknown source, even if they do not appear to be due to abuse or neglect, must be reported to the department; because the injuries may have resulted from the failure to take preventative measures. All fractures were identified as a substantial injury. According to the 10/25/2023 quarterly assessment, Resident 33 had diagnoses which included cervical spinal stenosis (narrowing of the spinal canal in the neck that may cause pain, tingling, numbness, and muscle weakness below the area of narrowing), and dementia (loss of thinking, remembering, and reasoning that interferes with a person's daily life and activities). Resident 33 had range of motion impairment to both upper extremities and required moderate assistance of staff for bed mobility. Review of the October 2023 through April 2024 facility incident log documented an 11/15/2023 fall entry for Resident 33 with the injury listed as a fracture. The entry was not marked as being reported to the State Agency. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of November 2023 progress notes showed that on 11/11/2023 Resident 33 had increased confusion, accusatory and paranoid behaviors towards staff. On 11/13/2023 staff collected a urine sample to attempt to determine the root cause of their increased behaviors, but it was negative for infection. Staff documented they would continue to monitor behaviors and implement interventions as indicated. No progress notes were found for Resident 33 between 11/13/2023 and 11/15/2023. On 11/15/2023 Resident 33 was found on the floor and complained of hip pain. Resident 33 was transferred to the hospital for further evaluation and found to have a right hip fracture that required surgery. Review of the 11/15/2023 facility fall incident report documented Resident 33 had an unwitnessed fall out of bed at 10:35 PM, and was last seen by staff at 9:30 PM (1 hour and 5 minutes prior to their fall). The incident report summary documented the resident had some unusual behaviors the previous week, a urine sample was collected on 11/13/2023 but was negative for infection. Resident 33 had no recent medication changes or acute illness observed. The incident report summary further showed the fall appeared to be an isolated incident, no abuse or neglect was noted, staff education was completed, and the care plan had been updated. The facility incident report contained no resident or staff interviews and did not indicate how abuse or neglect was ruled out. Review of Resident 33's care plan documented they required maximal assistance of one staff for bed mobility. A behavioral care plan initiated 10/31/2017 identified Resident 33 had occasional delusions with an intervention for staff to monitor behavioral episodes and attempt to determine the underlying cause. No new behavioral interventions were added in November 2023 for Resident 33's increased confusion, paranoia, suspicious or accusatory behaviors. The care plan further documented Resident 33 had cognitive loss, short term memory issues, confusion, and was disoriented at times. The pain care plan initiated 10/30/2017 documented the resident had limited range of motion to their right arm and an artificial elbow joint with an intervention for staff to monitor for increased risk for falls. The falls care plan initiated 10/31/2017 documented the resident was at risk for falls related to confusion, deconditioning, and inability to walk with interventions for staff to anticipate the resident needs, ensure the call light was within reach, quarterly fall evaluations, and to follow the facility fall protocol. No new fall interventions were added since October 2021. Review of the 11/16/2023 hospital progress notes documented Resident 33 had advanced dementia and was essentially noncommunicative. In an interview on 04/12/2024 at 3:35 PM, Staff B, Director of Nursing, stated they ruled out abuse and neglect by asking the resident, but if the resident was not alert or oriented then they would look for potential signs of abuse and/or neglect such as bruising or change in behaviors. Staff B further stated staff and resident interviews were done for falls with significant injury to rule out abuse and documented in the investigation summary note. Staff B reviewed Resident 33's medical record. Staff B stated Resident 33's fall was unwitnessed but Resident 33 was alert enough to tell staff what happened so abuse was ruled out. Staff B further stated they reviewed the Purple Book to determine the incident should not be reported. Reference WAC 388-97-0640 (5)(a)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 46033 Based on observation, interview and record review, the facility failed to ensure nail care was provided for 2 of 3 sampled residents (Resident 17 and 29) reviewed for activities of daily living (ADLs). Specifically, two residents used their fingers to help scoop food onto their eating utensils and to pick up food from their plates and their nails had dark matter under them. This failure placed the residents at risk of contracting bacterial and diarrheal illnesses. Findings included . <Resident 17> A 03/04/2024 comprehensive admission assessment documented Resident 17 had diagnoses including spinal stenosis (narrowing of the spaces in the bones that can put pressure on the spinal cord) and enlarged prostate requiring indwelling urinary catheter. Resident 17 was moderately impaired cognitively, required set-up/clean-up assistance for eating and personal hygiene and lost food from their mouth when eating and drinking. The care plan dated 02/27/2024 instructed staff to provide set-up/clean-up assistance to the resident for eating and personal hygiene, keep fingernails short to protect skin integrity, and the resident was to have large-handled utensils for eating but they preferred regular silverware. The undated Individual Service Plan (ISP, care instructions for staff) had no instructions regarding hand hygiene or nail care for Resident 17. On 04/10/2024 at 9:08 AM, Resident 17 was observed returning to their room in their wheelchair. Their fingernails were long and had dark tan and brown matter under them. On 04/10/2024 at 12:07 PM, Resident 17 was observed seated in the dining room eating from a bowl containing strawberries and whipped cream. The resident was able to slowly get food on their spoon and used their left thumb and index finger to help get berries on the spoon and prevent them from falling off the side of the bowl. When the lunch arrived, Resident 17 used their fingers on their left hand to push a beef and broccoli mixture on to their fork. The resident held an egg roll in both hands to steady it, so they could then take bites of it. They ate in this manner during the meal service. At the end of the meal, Resident 17 was provided a wet washcloth and they used it to wipe their mouth, then left the dining room. On 04/11/2024 at 7:34 AM, Resident 17 was in the dining room. When asked about their eating utensils, Resident 17 stated they did not like the large-handled ones; it was harder for them to use and food slid off of them. Resident 17 stated they used both hands to eat and demonstrated how they held their fork. Resident 17 was observed to have brown matter under their fingernails. At 7:47 AM, Resident 17 was using a piece of toast to help push eggs on to their fork, the eggs fell off the plate and the resident used their fingers to pick them up and place them back on the plate. At 7:56 AM, Resident 17 used their thumb and index finger to push fruit cocktail on to their spoon to eat and ate in this manner until they finished their meal. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/11/2024 at 12:06 PM, Resident 17 was in the dining room and had brown matter under their fingernails. The resident ate meatballs in sauce and fries using their fingers to help put food on their eating utensils. 46115 <Resident 29> A 03/25/2024 significant change assessment documented Resident 29 had diagnoses including stroke, ataxia (impaired coordination) and anemia (a condition in which the body does not have enough healthy red blood cells). Resident 29 was moderately cognitively impaired, required partial to moderate assistance with eating and set up/clean up assistance with personal hygiene and lost food from their mouth when eating and drinking. The care plan dated 01/25/2024 instructed staff to provide set-up/clean-up assistance to Resident 29 for personal hygiene and to keep fingernails short to protect skin integrity. On 04/08/2024 at 11:24 AM, Resident 29 was observed in their room seated in their wheelchair. Their fingernails had been painted and had brown matter under them. Subsequent observations of Resident 29's nails being unclean with brown matter under them occurred on 04/09/2024 at 2:04 PM, 04/10/2024 at 12:16 PM, 04/11/2024 at 7:59 AM and 1:32 PM. On 04/10/2024 at 12:47 PM, Resident 29 was observed seated in the dining room attempting to cut up their egg roll with their spoon. Resident 29 was unable to cut up the egg roll and had picked it up with their hands. Resident 29 had brown matter under their fingernails and was not assisted to wash their hands or under their nails after the meal. On 04/11/2024 at 7:59 PM, Resident 29 was observed seated in the dining room eating a piece of toast. [NAME] matter was still present under their fingernails and the resident was not assisted to wash their hands or under their nails after the meal. In an interview on 04/11/2024 at 1:59 PM, Staff N, Nursing Assistant, stated nail care was completed by the aides, unless the resident was diabetic. Staff N stated nail care entailed trimming, filing and cleaning under the resident's nails. In an interview on 04/12/2024 at 9:10 AM, Staff B, Director of Nursing, stated if a resident used their fingers to eat with, their nails should have been cleaned daily to prevent the risk of bacteria. Reference: WAC 388-97-1060 (2)(c)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46115 Based on interview and record review the facility failed to implement bowel management protocol when indicated for 2 of 5 sampled residents (Resident 26 and 31), reviewed for constipation. In addition, the facility failed to monitor and implement interventions for edema (swelling) management for 1 of 3 sampled residents (31), reviewed for edema. These failures placed residents at risk for complications, worsening conditions, and diminished quality of life. Findings included . Review of the facility policy titled, Bowel Protocol, revised 03/2018, documented nursing staff was to review a resident's bowel monitor daily. The policy instructed nursing staff to implement the bowel program if a resident did not have a bowel movement (BM) for three days. The policy showed nursing staff was to administer Milk of Magnesia (MOM) on day four, a laxative suppository was to be administered the next shift if no results from MOM, an enema was to be administered the next shift if no results from the suppository, and the provider was to be notified if there were no results from the enema. Bowel Management <Resident 26> According to the 02/15/2024 quarterly assessment, Resident 26 required maximal to total assistance for most activities of daily living including dressing, transfers, and toileting. Resident 26 was incontinent of bowel. The assessment further showed Resident 26 had severe cognitive impairments and was able to make their needs known. Review of the 02/20/2023 bowel and bladder care plan documented interventions for Resident 26 to have an unobstructed path to the bathroom and have a bowel/bladder evaluation completed upon admission and quarterly. The care plan instructed staff to monitor, document, and report possible causes of incontinence such as constipation, as needed. Review of Resident 26's medical record documented a bowel evaluation had been completed on 08/15/2023, which documented no constipation. Review of Resident 26's provider orders documented active orders for: - 10/23/2023 Prune juice to be given twice daily as needed for bowel care - 10/23/2023 Miralax (powder laxative mixed with water) to be given twice daily as needed for constipation - 10/23/2023 Bisacodyl (stimulant laxative) tablet to be given twice daily as needed for constipation (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 10/23/2023 MOM (liquid laxative) to be given as needed on day four if the resident did not have a bowel movement for three days - 10/23/2023 Bisacodyl suppository to be given as needed the following shift, during waking hours only, if there were no results from MOM - 12/25/2023 Bisacodyl tablet to be given every 12 hours as needed for constipation Review of Resident 26's physician orders, documented the resident was not on routine medication for constipation. Review of Resident 26's January 2024 through April 2024 bowel record showed resident had no bowel movements (BM) on the following days: 01/01/2024 through 01/05/2024 (5 days with no BM) 01/07/2024 through 01/12/2024 (6 days with no BM) 01/16/2024 through 01/20/2024 (5 days with no BM) 01/29/2024 through 02/02/2024 (4 days with no BM) 02/04/2024 through 02/10/2024 (7 days with no BM) 02/12/2024 through 02/16/2024 (5 days with no BM) 02/18/2024 through 02/21/2024 (4 days with no BM) 02/23/2024 through 02/26/2024 (4 days with no BM) 02/28/2024 through 03/04/2024 (6 days with no BM) 03/20/2024 through 03/23/2024 (4 days with no BM) 03/26/2024 through 03/29/2024 (4 days with no BM) Review of Resident 26's January 2024 through April 2024 Medication Administration Record (MAR) showed bowel medications were not administered when needed for constipation, as ordered. Review of the facilities paper bowel program flow sheet tool January 2024 through March 2024 showed no documentation of bowel interventions for Resident 26. In an interview on 04/12/2024 at 4:28 PM, Staff K, Registered Nurse reviewed Resident 26's bowel pattern and stated the resident should have been given the as needed bowel medications to assist with their constipation. In an interview on 04/12/2024 at 4:30 PM, Staff P, Regional Nurse, stated the expectation was for nursing staff to administer the bowel medications as indicated to prevent impaction. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	47328 <Resident 31> Bowel Management According to the 02/07/2024 admission assessment, Resident 31 required moderate up to maximal assistance for most activities of daily living including dressing, transfers, and toileting. Resident 31 was frequently incontinent of bowel and bladder. The assessment further showed Resident 31 had moderate cognitive impairment and was able to make their needs known. Review of the 02/05/2024 bowel and bladder care plan showed interventions for Resident 31 to have an unobstructed path to the bathroom and have a bowel/bladder evaluation completed upon admission and quarterly. The care plan instructed staff to monitor, document, and report possible causes of incontinence such as constipation, as needed. The 02/05/2024 fluid maintenance care plan instructed staff to administer medications as ordered, monitor and document bowel sounds and frequency of BM. Review of Resident 31's medical record showed no bowel evaluation had been completed. Review of Resident 31's provider orders showed active orders for: - 01/24/2024 Prune juice to be given twice daily as needed for bowel care - 01/24/2024 Miralax (powder laxative mixed with water) to be given twice daily as needed for constipation - 01/24/2024 Bisacodyl (stimulant laxative) tablet to be given twice daily as needed for constipation - 01/24/2024 MOM (liquid laxative) to be given as needed on day four if the resident did not have a bowel movement for three days - 01/24/2024 Bisacodyl suppository to be given as needed the following shift, during waking hours only, if there were no results from MOM - 01/24/2024 Fleet enema (liquid laxative inserted rectally) to be given as needed the following shift, during waking hours only, if there were no results from the suppository. Notify provider if no results from enema. Review of Resident 31's February 2024 through April 2024 bowel record showed no BM on the following days: 02/09/2024 through 02/11/2024 (3 days with no BM) 02/13/2024 through 02/18/2024 (6 days with no BM) 02/22/2024 through 03/03/2024 (11 days with no BM) (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	03/05/2024 through 03/07/2024 (3 days with no BM) 03/16/2024 through 03/21/2024 (6 days with no BM) 04/05/2024 through 04/08/2024 (4 days with no BM) Review of Resident 31's February 2024 through April 2024 Medication Administration Record (MAR) showed bowel medications were not administered when needed for constipation, as ordered. Review of the facilities paper bowel program flow sheet tool December 2023 through March 2024 showed no documentation of bowel interventions for Resident 31. In an interview on 04/11/2024 at 12:04 PM, Staff B, Director of Nursing, reviewed Resident 31's medical record. Staff B acknowledged Resident 31 went from 02/21/2024 until 03/04/2024, 12 days without a BM. Staff B further stated staff should have implemented the bowel protocol but did not. Edema Management Review of the 01/24/2024 admission nursing evaluation showed Resident 31 had 3+ (on a scale of 1 to 4 with 4 being the most severe) pitting (indentation to skin after pressure is applied) edema to bilateral lower extremities. Review of January 2024 through April 2024 progress notes documented a single note dated 01/24/2024, that identified Resident 31 had some edema to bilateral feet. No further description, assessment, monitoring, or intervention documentation was found. Review of Staff D, Medical Doctor, provider note dated 01/25/2024, documented Resident 31 had edema to the top of their feet that extended to their shins. Review of Resident 31's provider orders found no provider orders for edema management. Review of the 02/05/2024 care plan showed no documentation of interventions for edema management. Review of Staff E, Physician Assistant, provider note dated 02/06/2024, showed Resident 31's edema was unchanged from 01/25/2024. On 04/08/2024 at 11:03 AM, Resident 31 was observed sitting up in their wheelchair with 3+ edema to both legs that extended from their feet up to middle thighs, both legs were in a dependent position, and no compression stockings were being worn. Similar observations were made on 04/08/2024 at 2:30 PM, 04/09/2024 at 8:57 AM and 1:56 PM, 04/10/2024 at 3:04 PM, 04/11/2024 at 11:18 AM. On 04/11/2024 at 2:45 PM, Resident 31 was observed sitting up in their wheelchair with 4+ edema to both legs that extended from their feet up to middle thighs, both legs were in a dependent position, shiny, and again no compression stockings were being worn. In an interview on 04/11/2024 at 9:45 AM, Staff A, Administrator, stated the facility had no edema management policy but edema management fell under their weight management policy. The weight management policy was requested on 04/11/2024 at 9:45 AM and by 2:25 PM, no policy had been provided. (continued on next page)		

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/11/2024 at 11:38 AM, Staff C, Licensed Practical Nurse, stated edema was monitored by nursing staff and should be documented in the progress notes. Staff C further stated typical edema interventions consisted of compression stockings and elevation of the legs. Staff C acknowledged Resident 31 had edema for some time that was increasing and was unsure if there were interventions in place. In an interview on 04/11/2024 at 11:58 AM, Staff B, Director of Nursing, stated if a resident had significant edema they would be placed on alert for further monitoring. Staff B stated typical edema interventions consisted of elevation of the legs, diuretic medication (medication that helps the body get rid of excess fluid), and compression stockings. Staff B reviewed Resident 31's medical record and acknowledged Resident 31 had edema and no edema interventions had been implemented. Reference WAC 388-97- 1060 (1)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 46115 Based on observation, interview, and record review the facility failed to implement interventions to prevent pressure ulcer/injuries for 1 of 3 sampled residents (8). Resident 8 experienced harm when they developed avoidable pressure ulcers. This failure placed other residents at risk for development of pressure ulcers, medical complications, and unmet care needs. Findings included . <Resident 8> Review of the facility's policy titled Skin Integrity updated October 2022, documented if a resident admitted with or developed a skin ulcer/pressure ulcer/wound, care would be provided to treat, heal, and prevent, if possible further development of skin ulcers/pressure ulcers/wounds. Review of the annual assessment, dated 02/16/2024, showed Resident 8 had diagnoses which included dementia, contractures (a permanent tightening of the muscles, tendons, skin, and nearby tissues that caused joints to shorten and become very stiff) to the left and right knees and a contracture to the right ankle. The assessment documented Resident 8 was identified as being at risk of developing pressure ulcers and had a Stage II pressure ulcer (a shallow open ulcer with a red or pink wound bed) on their right great toe. Review of Resident 8's care plan dated 11/14/2019, documented Resident 8 was high risk for skin breakdown related to limited mobility, contractures to bilateral feet, left second toe abrasion and fragile skin. The care plan had been updated to reflect a pressure ulcer to Resident 8's second toe on 11/23/2023 and a pressure ulcer to their third toe on 02/28/2024. Review of the care plan showed no interventions specific to Resident 8's care needs were documented regarding treatment and prevention of pressure ulcers to their toes. Review of a progress note dated 11/23/2023 at 10:23 AM, documented a pressure ulcer was found on Resident 8's right great toe due to the second toe being pressed up against it. Review of the 11/23/2023 Braden assessment, (an assessment that explains the risk of getting skin breakdown) documented a score of 13, which indicated Resident 8 was a high risk for skin breakdown. Review of a progress note dated 12/09/2023 at 10:40 AM, documented Resident 8's right great toe was observed to have an indentation from pressure placed on it from direct contact of the second toe. No documentation was found to show that interventions were implemented to prevent further skin breakdown. Review of a progress note dated 12/17/2023 at 10:11 AM, documented Resident 8's right great toe did not have an open wound, but an indentation was present due to continuous pressure against the second toe. The note documented the left side of the second toe was red with no broken skin. No documentation was found to show that interventions were implemented to prevent further skin breakdown. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a progress note dated 12/31/2023 at 10:44 AM, documented Resident 8 had a bandage on their right great toe to provide a cushion against pressure caused from the second toe, and the left side of the second toe had a very thin scab. Review of a progress note dated 01/14/2024 at 1:25 PM, documented the area between Residents 8's the right great toe and second toe was dark red, and a double layer of foam dressing had been applied. Review of a progress note dated 01/25/2024 at 11:35 AM, documented Resident 8's right great toe had a foul smell, drainage and yellow slough (a yellowish, moist, stringy substance that can delay wound healing) inside the indentation where the second toe had pressed into the side of the great toe. Review of a progress note on 02/25/2024 at 9:07 AM, documented Resident 8's right great toe, second and third toes had pressure wounds. The wounds were between the toes and were the result of the toes curling up and putting pressure on the insides of the toes, which created open oozing wounds. Review of a progress note dated 02/28/2024 at 2:05 PM, documented two new pressure areas to Resident 8's toes during weekly skin observation assessment. New areas were observed to the inside of the right second toe, and to the inside of right third toe. These areas were caused from the toes crossing over each other. Review of Resident 8's Braden assessment on 02/28/2024, documented a score of 15, which indicated they were high risk for skin breakdown. The assessment showed the resident had an increased risk for skin breakdown from the previous assessment on 11/23/2023. During an observation on 04/09/2024 at 8:55 AM, Resident 8 was sitting in their wheelchair and had socks on both feet. When asked if the nurses had placed anything between their toes prior to the development of the right toe wounds, Resident 8 stated, No, I wish they would have. During an observation of the wound with Staff K, Registered Nurse (RN), on 04/11/2024 at 9:04 AM, Resident 8 was observed with gauze between their toes. The right great toe, second and third toe were all bunched together, with the right great toe and third toe overlapping across the top of the second toe. Pressure ulcers were observed on the inside of the right great toe, inside and outside of the second toe, and on the inside of the third toe. In an interview on 04/12/2024 at 8:30 AM, Staff K, stated Resident 8 had pressure ulcers between their toes and non-adherent strips were placed between them. Staff K added that toe spacers had been ordered but had not yet arrived. Staff K stated nothing had been placed between Resident 8's toes until they had complained about the issue, and a shower aide had reported the resident had breakdown between their toes. In an interview on 04/12/2024 at 11:26 AM, Staff B, Director of Nursing, stated they had many interventions in place for skin breakdown, but not for Resident 8's toes. Staff B added it would have been helpful to have put an intervention in place prior to the skin breakdown. Reference: WAC 388-97-1060 (3)(b)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 47328 Based on interview and record review the facility failed to consistently implement effective preventative measures for falls, by evaluating the effectiveness of current interventions and the need for increased supervision for 4 of 4 sampled residents (Residents 31, 33, 36, and 51), reviewed for accidents. Resident 51 experienced harm when they sustained a hip fracture requiring hospital treatment and Resident 36 experienced a pattern of frequent falls. These failures placed residents at risk for repeat falls, major injury, and diminished quality of life. Findings included . Review of the facility titled Fall Evaluation and Management dated 02/2000, showed the facility was to implement a fall management plan based on the resident's medical history and resident evaluation. The policy instructed nurses to complete a Morse fall scale (assessment that scored a residents fall risk) assessment upon admission, with each fall, and with a significant change in condition. A score greater than 45, identified the resident as a high potential for falls and staff should implement appropriate safety interventions for fall management. A score less than 45, identified the resident as a low to moderate potential fall risk and the interdisciplinary team was to determine if safety interventions were needed. The policy further showed nursing staff was to review and update a resident's care plan with newly identified interventions as needed after a fall was sustained. <Resident 51> Review of the admission assessment, dated 03/10/2024, showed Resident 51 admitted to the facility on [DATE]. Resident 51 had diagnoses including dementia and recent thoracic spine fusion (surgical procedure where two or more spine bones are joined together to eliminate movement between them). Resident 51 had moderate cognitive impairment and was able to make their needs known. Review of Resident 51's baseline care plan, dated 03/08/2024, showed they were alert but confused and forgetful. Resident 51 required moderate up to substantial assistance for bed mobility and moderate assistance of one staff for transfers using a front wheeled walker. Falls or risk for falls or fall interventions were not documented on the baseline care plan. Review of the March 2024 through April 2024 facility incident log showed a 03/10/2023 fall entry for Resident 51 with the injury listed as a fracture. Review of Resident 51's progress notes showed they had high anxiety about their admission to the facility, wanted to leave and had family at bedside the first two days. On 03/10/2024 Resident 51 called out for help and was found alone down on the floor lying on their right side. They complained of right hip pain and guarded their hip while grimacing. Resident 51 was then transferred to the hospital for further evaluation and was found to have a right hip fracture. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the 03/10/2024 facility fall incident report showed Resident 51 had an unwitnessed fall at 12:45 PM. Resident 51 was found on the floor parallel to their bed lying on their right side while they moaned and complained of right hip pain. Weakness, forgetfulness, admission within the last 72 hours after a spinal procedure were listed as predisposing factors. Resident 51 was noted to have significant complaints of right hip pain, right leg was externally rotated and appeared shorter than the left leg. Staff then used the Hoyer lift to transfer the resident off the floor. Resident 51 was then sent to the hospital for further evaluation and was found to have a right hip fracture. Review of the Interdisciplinary team (IDT) fall review showed Resident 51 overestimated their own ability to self-transfer, attempted to transfer from their recliner and fell on to the floor. Resident 51 had dementia and was adjusting to their new surroundings. The assessment showed the fall on 03/10/2024 was the first fall since their admission to the facility two days prior and the need for initial interventions would be evaluated once the resident returned to the facility. Review of Resident 51 nursing progress note, dated 03/11/2024, showed they did not return to the facility after their hospitalization for right hip fracture. In an interview on 04/12/2024 at 3:35 PM, Staff B, Director of Nursing, stated baseline care plans typically included how much assistance a resident required for their activities of daily living (ADL), but a falls care plan was typically not initiated until the comprehensive care plan was completed (up to 21 days after admission) and the resident's fall risk was determined by completing the Morse fall assessment. Staff B further stated staff had up to five days to implement and re-evaluate safety interventions after a fall occurred. Staff B acknowledged if a resident had increased complaints of pain or showed possible signs and/or symptoms of a fracture such as increased pain, inward or outward limb rotation or limb shortening they should not be moved. Staff B reviewed Resident 51's medical record. Staff B acknowledged Resident 51 was not cognitively intact and had an unwitnessed fall two days after their admission that resulted in a right hip fracture. Staff B further stated that Resident 51 did not return to the facility after they sustained their fracture. <Resident 36> Review of the comprehensive admission assessment dated [DATE] documented Resident 36 had diagnoses including stroke with hemiplegia and hemiparesis (paralysis and weakness) on the left non-dominant side. Resident 36 was cognitively intact, had limited range of motion in both upper and lower extremities on both the left and the right, and required partial/moderate assistance for transferring from a lying to sitting position, sitting to standing, transferring to a chair, toileting, and walking 10 feet. The resident used a walker and wheelchair for ambulation and had no history of falling prior to admission. Review of the baseline care plan, dated 10/26/2023, showed Resident 36 needed minimal/moderate assistance of one staff to move from lying to sitting, transferring to the toilet, moving from sitting to standing, and transferring from the bed to the wheelchair. Review of the care plan, revised on 11/02/2023, showed Resident 36 had a potential ADL performance deficit related to stroke with left-side weakness. Staff were instructed to make sure shoes were comfortable and not slippery, encourage the resident to use the call bell and wait for assistance, and physical and occupational therapy were to evaluate and treat. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the facility Incident logs documented the following for Resident 36: -a fall on 11/06/2023 at 10:30PM, -a fall on 11/18/2023 at 4:50PM, -a fall on 11/22/2023 at 10:30PM, -a fall on 11/23/2023 at 5:00PM, -a fall on 11/30/2023 at 2:45AM, -an incident on 12/12/2023 at 10:00AM that resulted in a fracture, and -a fall on 12/22/2023 at 2:00AM. A nursing progress note, dated 11/06/2023 at 10:25 PM, showed Resident 36's call light was activated. The resident was on the floor beside their bed and stated they attempted to self-transfer to brush teeth, then slipped and fell . There was no injury. An IDT fall review completed on 11/07/2023, showed the cause of the fall was Resident 36's mood or mental status; the resident over-estimated their ability to safely transfer without assistance. On 11/06/2023, the care plan was updated to include Resident 36 was high risk for falls related to left sided weakness and gait/balance problems. Staff were instructed to anticipate and meet the resident's needs, make sure the call light was in reach and encourage the resident to use it, the resident needed prompt response to requests for assistance, educate the resident about safety reminders, encourage the resident to participate in activities that promote exercise, strength and mobility, ensure the resident was wearing appropriate footwear, fall evaluation on admit, quarterly and as needed by the licensed nurse, and physical therapy evaluate and treat. An IDT fall review completed on 11/18/2023 documented Resident 36 fell in their room again. The cause of fall was attributed to the resident's mood/mental status; the resident over-estimated their own ability and slid off their bed to the floor. The review documented that the team determined the resident was going to continue to self-transfer, the resident was educated to use their call bell with understanding and the care plan was updated. On 11/20/2023, the fall risk care plan was updated and instructed staff to educate Resident 36 on the importance of using the call light and waiting for assistance, already part of the care plan. Review of Resident 36's nursing progress notes November 2023 through December 2023 showed the following: (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	There was no nursing progress note related to the fall on 11/18/2023. On 11/21/2023, it was noted the resident was to be discharged on [DATE]. On 11/22/2023 at 10:10 PM, the resident was found on the floor next to their wheelchair after they fell out of their wheelchair and complained of left hip pain. On 11/23/2023, the resident continued to complain of left hip pain and refused their shower. They told the shower aide they thought they broke their hip when they fell. When questioned, Resident 36 declined to go to the hospital for further treatment. At 5:29 PM, Resident 36 was found on the floor leaning against their nightstand. They reported they were afraid to go home and did not know what they would do if they fell at home. On 11/24/2023 at 2:22 AM, Resident 36 refused transfers with one assist as care planned and stated they were afraid they would fall. The resident complained of left hip pain rated 9 out of 10, the pain was worse with movement, and they winced when returning to bed. At 9:10 AM, the resident again slipped out of bed and did not want to go home and was notified they would not be going home. At 8:29 PM, Resident 36 was reluctant to transfer on their own and did not get out of bed that shift. An IDT fall review completed on 11/23/2023 regarding the fall on 11/22/2023 at 10:10PM documented Resident 36 was forgetful of their left-side deficit from their stroke, the resident was educated to use their call bell for assistance, and the care plan was updated. Review of Resident 36's record showed there was no evaluation done to determine the need for additional interventions after the Resident fell on [DATE], 11/23/2023, and 11/24/2023. The fall on 11/24/2023 was not entered on the facility incident log. On 11/27/2023, Staff B, Director of Nursing entered a progress note that Resident 36 requested an x-ray related to pain in their hip, possibly from the fall that occurred on 11/23/2023. The x-ray was negative for a fracture and concluded Resident 36 had degenerative changes and osteoarthritis of the left hip. Review of a nursing progress note, dated 11/30/2023, documented Resident 36 fell in their bathroom at 2:45AM, hit their arm on the sink which caused an abrasion and landed on their left hip. The resident then crawled to the door and was found by a nursing assistant. This note was struck out (a line drawn through the entry) on 12/04/2023 and noted as incorrect documentation. A 12/02/2023 nursing progress note documented Resident 36 had adequate safety awareness but appeared to backslide recently and had several falls from over-estimating their abilities. They were encouraged to get up and ambulate only when staff were present. On 12/04/2023 at 8:08 AM, a nursing progress note documented Resident 36 fell in their bathroom, hit their arm on the sink that caused an abrasion and landed on their left hip. An IDT fall review completed on 12/04/2023 regarding the fall that occurred on 11/30/2023 documented the resident fell in their room. The cause again was that Resident 36 over-estimated their ability to safely ambulate without assistance. Resident 36 was again encouraged to use their call light and wait for staff assistance. The care plan was updated to include 1:1 activities related to the resident not wanting to leave their room. The IDT team concluded the resident was alert and oriented and would likely continue to self-transfer. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 12/12/2023 at 3:56 AM, the nursing progress note showed the resident asked for an early dose of pain medication for pain rated 10 of 10 (on a scale of zero to 10, zero being no pain and 10 being the worst pain), then requested to go to the emergency room for pain medication. Resident 36 was told there was less than one hour before their next dose of pain medication was due, and the resident stated they would tough it out until the next dose. The resident was told to put on their call light if they wanted to go to the hospital. On 12/12/2023 at 1:01 PM, Staff B documented Resident 36 continued to complain of left hip pain and had several falls, the last one occurred on 11/30/2023. When assessed, the resident's left leg was externally rotated and this was not new, but the resident grimaced when attempts were made to straighten or move the left leg. An Xray of the left hip and femur were to be obtained. On 12/13/2023 at 10:24 AM, a nursing progress note showed Resident 36 had an acute fracture of their left femur at the neck (top part of the thigh bone.) The resident was transferred to the local hospital. An incident report completed on 12/13/2023 showed Resident 36 stated they thought they slept wrong, and my legs kind of slid off the bed and I felt a pop at the same time. Predisposing factors for the incident included the resident had a history of self-transfers and had been previously educated to not self-transfer. Under other information, it was documented there had been no immediate fall noted since 11/30/2023, the resident states that likely occurred the night of 12/07/23 or 12/08/23. There were no witnesses. The investigation documented that when interviewed, Resident 36 stated that on 12/11/2023, they had tried sleeping on their left side and in doing so, their legs slid off the mattress and they felt a pop at that time. There were no entries on the incident log for Resident 36 on 12/07/2023 or 12/08/2023 and no nursing progress notes. Review of a nursing progress note, dated 12/21/2023, showed Resident 36 returned from the hospital after surgical repair of their hip fracture. A 12/22/2023 at 2:00AM nursing progress note showed Resident 36 was found on the floor sitting against the door frame after a fall. Resident 36 stated they got up themselves because no one answered their call light. Resident 36 stated they caught the wheel of their walker on a chair, started to fall, the guided themselves to the floor and scooted to their door. An incident report dated 12/22/2023 showed Resident 36 was notified they required two staff and a gait belt to assist them when being transferred. When asked why they were up without assistance, Resident 36 reported they were independent when at the hospital and thought they were also independent at the facility. The report documented the care plan was reviewed and updated, the current plan of care would continue, and interventions would be implemented as indicated. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on 04/12/2024 at 2:56 PM, Staff G, Nursing Assistant Registered, stated residents that were at risk for falls had a laminated star sign that was placed on their door and that was how they were aware of a resident's fall risk. Other residents might have a sign in their bathroom that instructed staff to not leave a resident unattended in the bathroom. They stated they had access to each resident's care plan, and there might be communication on the board in the breakroom if there were changes for a resident. Staff G stated they remembered Resident 36 and believed most of their falls occurred on the evening shift. Staff G stated they did not remember being told to do anything different after Resident 36 kept falling, they just remembered the resident being forgetful and thinking they were able to do more than they were capable of. In an interview on 04/12/2023 at 3:35PM, Staff B stated care plans were usually reviewed the next day after a resident fell , but they had five days to do so. Staff B stated Resident 36 had initially been doing well working with therapy, but when discussions about discharge started it seemed that was when the resident began falling and did not use their call bell. The resident's care plan was updated on 11/30/2023, to include 1:1 activities in their room to distract them from falling. Staff B stated they had not been notified that Resident 36 had increased pain and that the resident had told staff they thought they broke their hip after the 11/22/2023 fall. Staff B expected staff to notify them when any resident had increased pain after a fall. Staff B stated they did not consider the incident when the resident heard a pop on 12/12/2023 a fall; the resident repositioned themselves in their bed, their legs came off the bed and they heard a pop. When asked if the resident's care planned interventions were reassessed after Resident 36's falls, Staff B stated there would not be documentation showing care plan interventions were reassessed. <Resident 33> According to the 10/25/2023 quarterly assessment, Resident 33 had diagnoses including cervical spinal stenosis (narrowing of the spinal canal in the neck that may cause pain, tingling, numbness, and muscle weakness below the area of narrowing), and dementia (loss of thinking, remembering, and reasoning that interferes with a person's daily life and activities). Resident 33 had a range of motion impairment to bilateral upper extremities and required moderate assistance of staff for bed mobility. The assessment further showed Resident 33 had a memory problem but was able to verbalize their needs. Review of the October 2023 through April 2024 facility incident log showed a 11/15/2023 fall entry for Resident 33 with the injury listed as a fracture. Review of Resident 33's nursing progress notes showed: - 11/01/2023 at 3:08 PM, Resident 33 had slight to moderate range of motion limitation in their elbows and moderate range of motion limitations in their shoulders. Resident 33 required extensive verbal/visual cueing and prompting to stay on task. - 11/11/2023 at 10:40 AM, Resident 33 showed increased confusion, accusatory and paranoid behaviors towards staff. Staff would obtain a urine sample to determine the root cause of the behaviors. - 11/13/2023 at 8:45 AM, Resident 33 showed unusual paranoid and suspicious behaviors times two. A urine sample was collected that morning and was negative for a bladder infection. Staff would continue to monitor behaviors and implement interventions as indicated. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	- 11/15/2023 at 10:25 PM, yelling was heard from Resident 33's room. Resident 33 was found on the floor next to their bed and complained of right hip pain. Resident 33 was assisted to their bed with use of the Hoyer mechanical lift (machine that allows a person to be lifted and transferred with minimal physical effort). Resident 33 continued to complain of right hip pain and was unable to straighten out their right leg due to pain. Resident 33 was then transported to the hospital for further evaluation. - 11/16/2023 at 2:28 AM, a call was received from the hospital which stated Resident 33 had a right hip fracture and required surgery. There were no nursing progress notes or other monitoring documentation found for Resident 33 between 11/13/2023 8:45 AM and 11/15/2023 10:25 PM. Review of the 11/15/2023 facility fall incident report showed Resident 33 had an unwitnessed fall out of bed at 10:35 PM. Resident 33 was found on the floor and complained of right hip pain, no lower extremity inward or outward rotation was noted at that time. Staff transferred Resident 33 back to bed using a Hoyer lift and reassessed them for injuries. Resident 33 was now unable to straighten their right leg due to hip pain and winced in pain if their right hip was touched or right leg was repositioned. Resident 33 was then sent to the hospital for further evaluation and was found to have a right hip fracture. The facility incident report contained no resident or staff interviews. The investigation showed Resident 33 had their call light within reach, but it had not been activated and was last seen by staff at 9:30 PM (one hour and five minutes prior to their fall). The incident report summary showed the fall appeared to be an isolated incident, and staff were educated on positioning residents in bed, completing a post fall assessment and showed the care plan had been updated. Review of Resident 33's care plan, dated 10/30/2017, showed they required maximal assistance of one staff member for bed mobility. A behavioral care plan initiated 10/31/2017 identified Resident 33 had occasional delusions with an intervention for staff to monitor behavioral episodes and attempt to determine the underlying cause. The 10/31/2017 behavioral care plan did not show any new behavioral interventions were added for Resident 33's increased confusion, paranoia, suspicious or accusatory behaviors which occurred November 2023. The Dementia care plan further showed Resident 33 had cognitive loss, short term memory issues, confusion, and was disoriented at times. A pain care plan initiated 10/30/2017 showed Resident 33 had limited range of motion to their right arm and an artificial elbow joint with an intervention for staff to monitor for increased risk for falls. The falls care plan initiated 10/31/2017 showed Resident 33 was at risk for falls related to confusion, deconditioning, and inability to walk with interventions for staff to anticipate the resident needs, ensure the call light was within reach, quarterly fall evaluations, and to follow the facility fall protocol. Review of the care plan showed no new fall interventions were added since October 2021. Review of a 11/16/2023 hospital progress note showed Resident 33 had advanced dementia and was essentially noncommunicative. The notes documented Resident 33 sustained a fall out of bed that resulted in right hip pain and imaging confirmed a right hip fracture. In an interview on 04/12/2024 at 3:35PM, Staff B reviewed Resident 33's care plan and acknowledged staff education was the only intervention completed for their unwitnessed fall that resulted in a right hip because Resident 33 already had several fall interventions in place prior to their fall on 11/15/2023. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	<Resident 31> Review of the admission assessment, dated 02/07/2024, showed Resident 31 admitted to the facility on [DATE] and required moderate up to maximal assistance for most activities of daily living including dressing, transfers, and toileting. The assessment showed Resident 31 had a history of falls prior to admission and sustained two or more falls since their admission to the facility. Resident 31 had moderate cognitive impairment but was able to make their needs known. Review of the 01/24/2024 Morse fall assessment identified Resident 31 as a high fall risk related to a history of falls, weakness, and overestimates/forgets limitations. Review of the 01/24/2024 baseline care plan showed Resident 31 was a high fall risk related to a history of fainting and falls, with interventions of a perimeter mattress and bed against the wall initiated. The baseline care plan further showed Resident 31 required moderate assistance of two staff for toileting and transfers. Review of the 01/25/2024 Staff D, Medical Doctor, progress note showed Resident 31 was hospitalized after they sustained a fall at home on 01/17/2024 and was down about 24 hours. Review of the January 2024 through April 2024 facility incident log showed the following entries for Resident 31: - 01/28/2024 fall at 8:07 PM - 01/30/2024 fall at 5:00 AM - 01/31/2024 fall at 12:57 PM - 02/01/2024 fall at 2:45 PM - 02/03/2024 fall at 6:00 PM - 02/07/2024 fall at 4:30 AM - 02/16/2024 fall at 9:52 AM Resident 31 had seven falls listed on the incident log in 19 days. Review of January 2024 through April 2024 nursing progress notes showed Resident 31 was confused, forgetful and safety education was ineffective related to poor cognition: - 01/28/2024 at 7:40 PM, was found on the floor in front of their wheelchair when they attempted to self-transfer into bed. Resident 31 did not call for staff assistance. - 01/30/2024 at 7:48 AM, was found sitting on the floor undressed with a soiled brief rolled up under them. Resident 31 stated they needed to use the bathroom and had not activated their call light. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	- 01/31/2024 at 12:55 PM, sitting on the floor in the dining room. Fall unwitnessed by staff in the dining room. - 02/01/2024 at 3:45 PM, was found sitting on the floor in their room. - 02/03/2024 at 6:14 PM, Resident 31 self-propelled out of the dining room and fell in the hallway. Resident 31 stated they slipped out of their wheelchair. - 02/07/2024 at 5:18 AM, Resident 31 was found sitting on the floor leaning against their bed wrapped in blankets with wet clothing sitting next to them. Resident 31 stated they slid to the floor to remove their wet clothing. - 02/07/2024 at 1:32 PM, a nursing assistant observed resident slide to the floor from bed without hitting their head. - 02/09/2024 at 9:50 PM, was found sitting on the floor in the bathroom. Resident 31 stated they slid to the floor from their wheelchair. Staff educated not to leave resident unattended in the bathroom. - 02/14/2024 at 11:30 PM, found sitting on the floor with back against the bed. - 02/16/2024 at 9:43 AM, found sitting on floor next to wheelchair. Resident 31 stated they needed to use the bathroom. Resident 31 was found on the floor 10 different times in 19 days. Review of facility fall incident reports showed incident reports completed for seven of 10 falls: - 01/28/2024 at 8:07 PM, Resident 31 was found on floor with their back against wheelchair, attempted to self-transfer into bed. Memory deficit, confusion, gait imbalance, and impaired memory listed as predisposing factors. Was previously educated to not self-transfer. The call light was within reach but not activated. The care plan was updated to add frequent visual checks for safety. - 01/30/2024 at 5:00AM, Resident 31 was found on the floor with a soiled brief behind them and stated they needed to void. Confusion, impaired memory, incontinence, overestimation of physical abilities and only 1 wheelchair break locked was listed as predisposing factors. The care plan was updated to add nonskid socks while in bed. - 01/31/2024 at 12:57 PM, Resident 31 slid off their wheelchair onto the floor in the dining room. Noisy environment and impaired memory were listed as predisposing factors. Resident 31 thought their legs got tangled up which caused them to slide to the floor. Velcro was added to wheelchair cushion to keep it from sliding. - 02/01/2024 at 2:45 PM, Resident 31 was found sitting on the floor in their room and stated they slid down when they tried to reach for something. Confusion, impaired gait/memory, weakness/fainting were listed as predisposing factors. Falling star was placed outside of room to help staff identify as a high risk for falls. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	- 02/03/2024 at 6:00PM, Resident 31 slid out of their wheelchair and sustained a large abrasion to their back. The wheelchair was assessed. - 02/07/2024 at 4:30 AM, Resident 31 slid off the bed while it was in a low position, found wrapped in blankets and stated they wanted to take their wet clothes off. The call light was within reach but had not been activated. - 02/16/2024 at 9:52 AM, Resident 31 was found sitting on the floor next to their wheelchair and stated they needed to use the bathroom. The call light was within reach but had not been activated, neither wheelchair brake was locked, and the resident was barefoot. Review of Resident 31's care plan, dated 01/29/2024, showed they were a high fall risk related to poor balance, poor communication, poor comprehension, and unsteady gait. The facility identified seven non injury falls and implemented the following interventions: 01/29/2024- frequent visual checks, 01/30/2024- nonskid socks on while in bed, 01/31/2024- provide activities that promote exercise and strength, 02/12/2024- bring to nurses station for safety monitoring if up in wheelchair, 02/05/2024- pharmacy consult to evaluate medications, falling star placed outside of room to help staff identify hall fall risk, ensure call light is within reach when in room, proper footwear when up for the day and nonskid socks on when in bed as allowed. A 02/05/2024 intervention showed Resident 31 would sometimes sit or lay on the floor for comfort and instructed staff to allow them to stay on the floor if they were found sitting and appeared safe and uninjured. Review of Resident 31's nursing progress notes from January 2024 through April 2024 showed: - Resident 31 was very confused and is only oriented to self, has very poor safety awareness and has fallen here several times with no injuries. Resident will most likely continue to fall as they do not believe they have any mobility issues. - Resident 31 was very confused and needs monitoring, does not redirect well, does not use call light appropriately. - Resident 31 does not remember the redirection after just a few minutes, needs almost constant supervision, tries to transfer by self very quickly, education is not effective, and collapses to floor without warning during transfers. - Resident 31 was a fall risk and tried to self-transfer many times during a 24-hour period, does not participate well during transfers, loses concentration and folds to the floor during transfers. - Resident 31 was noncompliant/unable to understand the call light system. - Resident 31 was unable to use call light appropriately, attempts to self-transfer and ends up sitting on the floor. - Resident 31 overestimating their abilities and has poor balance resulting in high fall risk, with several falls since admit. In an interview on 04/11/2024 at 8:40 AM, Staff B, Director of Nursing acknowledged there were no fall incident reports for Resident 31 for the 02/09/2024 or 02/14/2024 falls. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on 04/11/2024 at 11:43 AM, Staff C, Licensed Practical Nurse, stated a fall occurred when there a resident had a change in plane (change in position resulting in coming to rest on the ground or at a lower level) and a fall packet should be filled out. Staff C further stated that a new intervention should be implemented, and care planned right after a fall occurred because the same incident could reoccur if a new intervention was not added. In a follow up interview on 04/11/2024 at 12:10 PM, Staff B, stated any change in plane was considered a fall and they expected staff to complete a fall packet each time that occurred. Staff B further stated they expected staff to implement a new fall safety intervention as soon as possible after a fall. Reference WAC 388-97-1060 (3)(g) 46033		

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. 47309 Based on observation, interview, and record review the facility failed to provide cueing and meal assistance, monitor for significant weight loss, and risk of skin integrity for nutrition for 1 of 1 sampled residents (29). The resident experienced harm when they had an unplanned severe weight loss, nutritional decline, and breakdown of skin integrity with wound development. This failure placed other residents at risk for unplanned weight loss, medical complications, and unmet care needs. Findings included . <Resident 29> Review of the 03/25/2024 significant change assessment, showed Resident 29 had diagnoses which included stroke, anemia, and ataxia (impaired coordination). The assessment also documented Resident 29 had moderate cognitive impairments, required partial to moderate assistance from staff with eating, had experienced significant weight loss, and was at risk for developing pressure ulcers. Review of skin care plan, the 01/25/2024, showed Resident 29 was at risk for skin breakdown related to incontinence, and low body weight. The care plan documented on 03/10/2024, the resident had suspected deep tissue injuries (SDTI, purple or maroon localized areas of discolored intact skin or a blood-filled blister caused from pressure) to the coccyx, and moisture associated skin damage (MASD, inflammation or skin erosion caused by prolonged exposure to moisture such as urine or stool). An air mattress was added as an intervention on 03/11/2024. Review of nutrition care plan, dated 01/11/2024, showed Resident 29 was a nutritional risk and the interventions instructed nursing staff to give a substitute meal or a supplemental drink if less than 50% of meal consumed. Review of the nutrition/hydration review, dated 03/13/2024, documented Resident 29 had two SDTI's on their coccyx (tailbone) and that an air mattress had been added. Resident 29 was consuming 45 percent (%) of their meals and the cause of the pressure ulcers was decreased nutritional intake and decreased mobility. Resident 29's weight was 97.8 pounds (lbs.) on 02/13/2024 and on 03/06/2024 89lbs, a 9.0 % loss. No additional nutritional interventions were implemented. The weekly skin evaluation on 03/19/2024 documented the area to Resident 29's tailbone was changed from SDTI's to MASD. A review of the weight record for Resident 29 documented the following: 01/07/2024 102lbs. 01/11/2024 95lbs. 02/13/2024 89lbs. 12.75% loss in one month 03/05/2024 90.5lbs. 11.2% loss in two months (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	04/02/2024 88.5lbs. 13.2% loss in three months Review of Resident 29's medical record found no nutritional interventions had been implemented for the significant weight loss until 04/09/2024. On that date a liquid supplement was added to be given twice daily. During an observation of the wound on 04/09/2024, with Staff K and Staff L, Nursing Assistant, Staff K stated Resident 29 had a stage III pressure ulcer (an ulcer that extends through the skin into deeper tissue and fat, but does not reach the muscle, tendons, or bone). The pressure ulcer contained slough and was approximately the size of a pea, the surrounding tissue was red and blanched. During an observation of a meal service on 04/10/2024 showed the following: 12:29 PM, Resident 29 attempted to take a bite of their food with their fork and was unable to do so independently. The resident attempted to use spoon and fork and was unable to get the food onto their utensils. There were two aides at this table assisting residents to eat their meal. This table was used for residents who needed assistance with their meals. 12:32, the resident had taken a bite of their beets and was now trying to use a butter knife to eat with. 12:36 PM, the resident was unable to take a bite of their food and attempted to use the butter knife again. Resident 29 put the knife down and ate a piece of meat with their fingers. 12:39 PM, The resident was able to take a bite of rice with their fork. When the resident attempted to take a bite of their egg roll, they were unable to and began eating bites of broccoli with their fork. 12:42 PM, the resident attempted to cut up their egg roll with a spoon. 12:47 PM, the resident picked up their egg roll and put it down. The resident was not cued or assisted during the meal service. 12:54 PM, Resident's spouse gave them a bite of their egg roll, 25 minutes after the meal had begun. Resident 29 ate approximately 40% of their food and was not cued or helped during the meal service and was not provided a liquid supplement as instructed on their tray card. During an observation of the breakfast meal on 04/11/2024 showed the following: 7:59 AM, Resident 29 was in the dining room and had toast, eggs, fruit juice and water. Resident 29 consumed bites of their toast. 8:02 AM, Resident 29 attempted to take a bite of their eggs with their fork and dropped the fork on the table, picked up the fork and attempted to get a bite and was unsuccessful. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	8:05 AM, Resident 29 continued trying to use their fork for their eggs and decided to take a bite of toast instead. 8:08 AM, Resident 29 tried to use their fork again and put it down and drank some juice. 8:16 AM, Resident 29 was able to take some bites of their eggs. The resident then decided to use their spoon for their eggs and was unable to. Resident 29 consumed a piece of toast, half of their eggs and three quarters of a cup of their juice. Resident 29 was not cued or helped during the meal service. In an interview on 04/12/2024 at 8:40 AM, Staff L stated they reported to the nurse if the resident did not consume any of their meal or supplement, otherwise the nurse could look at the meal intake that was charted. Staff L stated if a resident had poor intake an alternate meal or supplement would have been offered. Staff L added that Resident 29 required supervision and cueing with their meals as they were confused and became distracted with their utensils. In an interview on 04/12/2024 at 9:10 AM, Staff B, Director of Nursing, stated Resident 29 was underweight upon admission to the facility, and had been doing well until they had a stroke, and now required more assistance. Staff B stated the initial assessment showed the wound was MASD but has developed into a pressure ulcer. In an interview on 04/12/2024 at 12:34 PM, Staff O, Speech Therapist, stated Resident was confused and would benefit from cueing and supervision with meals. In an interview on 04/12/2024 at 12:57 PM, Staff M, Registered Dietician, stated once a resident had poor intake or weight loss, nutritional interventions would be added to increase the resident's protein. After discussion of Resident 29's pressure ulcer and weight loss, Staff M stated the resident's weight was significantly down on 03/05/2024, and it would have been helpful to have added protein. In an interview on 04/12/2024 at 2:15 PM, Staff B stated when a resident had significant weight loss or wounds, the Registered Dietician (RD) is notified via email. Staff B stated the RD had access to place orders into the system and can do so at any time. Staff B stated the expectation was for interventions to be placed the same week that a change had occurred. Staff B added that Resident 29 was in the hospital from 03/15/2024 through 03/19/2024 and it would have been helpful for the supplement to have been initiated earlier to assist with weight loss and skin breakdown. Staff B stated nursing was also able to initiate a supplement and did not have to wait for the RD to do so. Reference: WAC 388-97-1060(3)(h).		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46115 Based on observation, interview, and record review, the facility failed to ensure oxygen delivery equipment was maintained in a clean manner for 1 of 1 sampled residents (Resident 26) reviewed for respiratory care. These failures placed the residents at risk for respiratory complications and infection. Findings included . Per the 02/15/2024 quarterly assessment, Resident 26 had diagnoses which included pericardial effusion (the buildup of extra fluid in the space around the heart), sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts) and needed oxygen due to those conditions. Review of the physician orders documented on 08/15/2023, the resident had been prescribed oxygen to be used as needed to maintain oxygen saturations greater than 90 percent, due to the diagnoses listed above. The orders also documented to change the filter monthly and to change the oxygen tubing as needed if damaged or unable to have been cleaned. Review of Resident 26's care plan found there was no respiratory care plan in place to instruct staff what the resident's care needs related to oxygen were. On 04/08/2024 at 2:13 PM, Resident 26 was observed asleep in bed. An inspection of the oxygen concentrator in the resident's room showed the concentrator was unclear with thick dust stuck to the filter and the nasal cannula was lying on the floor. Subsequent observations of the filter being dirty with dust debris and the nasal cannula lying on the floor were made on 04/09/2024 at 1:59 PM, 04/10/2024 at 08:43 AM, 2:25 PM and 3:25 PM. On 04/11/2024 at 9:20 AM the filter of the concentrator was observed to still be dirty with dust debris, but the nasal cannula had been placed in a bag on the side of the concentrator During an interview on 04/11/2024 at 10:25 PM, Staff K, Registered Nurse, stated oxygen tubing, which included the nasal cannula, was to be stored in a bag on the side of the concentrator. Staff K added that a nasal cannula lying on the floor could have caused a respiratory infection. During an interview on 04/11/2024 at 11:09 AM, Staff B, Director of Nursing, stated oxygen tubing was to be stored in a bag on the side of the concentrator or in a bag on the wheelchair. Staff B added dirty oxygen equipment could have increased the risk of a respiratory infection. Reference: WAC 388-97-1060 (3)(j)(vi)		

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46115 Based on interview and record review, the facility failed to ensure dietary staff had the proper qualifications. Failure to ensure the dietary manager had the proper certification placed all residents at risk for nutritional deficits, unmet nutritional needs, and diminished quality of life. Findings included In an interview on [DATE] at 1:32 PM, Staff Q, Dietary Manager, stated their license had expired and they were in the process of getting certified as a dietary manager. On [DATE] at 9:32 AM, Staff A, Administrator, confirmed the Dietary Manager for the facility was not certified as a dietary manager. Reference (WAC) [DATE] (1)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46115 Based on observation and interview, the facility failed to maintain appropriate dishwasher temperatures, date and dispose of expired foods and failed to prepare food in a sanitary manner. These failures placed the residents at risk for food borne illnesses and decreased quality of life. Findings included . <Dishwasher temperatures> During an observation of the kitchen on [DATE] at 12:42, Staff Q, Dietary Manager, stated the dishwasher was a low temperature dishwasher, which must sanitize the dishes at 120 degrees or above. Staff Q stated that maintenance was informed each time the dishwasher was below 120 degrees, and the temperature was fixed. Staff Q was unable to provide documentation showing the temperature had been fixed and what the new temperature was afterward, and the maintenance person was on vacation. During an observation on [DATE] at 12:50 PM, Staff R, Dietary Aide, had ran two loads of trays though the dishwasher and the trays reached a temperature of 117 degrees, not 120 degrees as required. Staff R had put those trays away and continued washing the next load. Staff R stated if the temperature did not reach 120 degrees, they needed to notify the dietary manager. No notification to the dietary manager was observed. In an interview on [DATE] at 12:51 PM, Staff Q stated they kept the dishwasher running until it reached the required temperature of 120 degrees and would notify maintenance if there were any issues with the machine. In an interview on [DATE] at 1:15 PM, when told of the earlier observation, Staff Q stated the expectation for staff was to have notified them if the dishwasher was not working correctly and that the dishes would not have been put away. <Expired and undated food> During an initial tour of the kitchen on [DATE] at 9:58 AM, the pantry contained two loaves of raisin bread dated [DATE] and had no expiration date and nine boxes of thickened orange juice that expired on [DATE]. The freezer contained no dates on two bags of french fries and one bag of tater tots had two holes in the bag, smoked ham that expired on [DATE], an undated apple pie, and pastrami that expired on [DATE]. The refrigerator contained an undated bag of brown, wilted lettuce, and undated sliced cheese. In an interview on [DATE] at 10:48 AM, Staff Q, Dietary Manager, stated the dry storage area, refrigerator and freezer was checked often (no specific timeframe was given) and expired food was discarded at that time. Staff Q acknowledged the above food items and stated they should have been dated and the expired items should have been discarded. <Sanitary practices> (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:58 AM, Staff S, Dietary Aide and Staff T, Cook were observed to have a hairnet that covered only the hair bun on the top of their head, and the rest of their hair was uncovered. Both staff members were handling food for the noon meal at the time of the observation. During a subsequent visit to the kitchen on [DATE] at 11:47 AM, Staff T was again observed wearing a hairnet that only covered a hair bun on the top of their head. During an interview on [DATE] at 08:14 AM, Staff Q stated all dietary workers should have worn a hair net that covers all hair, unless they had chosen to wear a hat to avoid contamination of the food. Reference: WAC [DATE] (3), 2980		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46115 Based on observation, interview, and record review the facility failed to ensure staff followed enhanced barrier precautions, cleaned mechanical lifts after usage, and performed hand hygiene when indicated during the meal service and wound care. These failures placed residents at risk of transmission of communicable diseases and/or healthcare associated diseases, and diminished quality of life. Findings included . Review of the facility policy titled, Handwashing/Hand Hygiene revised 03/2018, showed hand hygiene was the facilities primary means to prevent the spread of infections. The policy instructed staff to perform hand hygiene with alcohol-based hand rub or soap and water before and after direct contact with residents; before performing any non-surgical invasive procedure; before and after handling an invasive device; before handling clean or soiled dressings, before moving from a contaminated body site to a clean body site during resident care; after contact with object in the immediate vicinity of a resident; before and after handling food; before and after assisting a resident with meals; and after glove removal. The website CDC.gov - in which CDC refers to Centers for Disease Control and Prevention- with regard to hand hygiene showed, healthcare personnel should use alcohol-based hand rub or wash with soap and water for the following clinical indications: immediately before touching a patient, before performing an aseptic (free from living viruses, bacteria, and other germs that may cause disease) task, before moving from a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment and immediately after glove removal. When washing hands with soap and water rub hands together for at least 15 seconds. When using handrubs rub hands together covering all surfaces until dry. Unless hands are visibly soiled alcohol-based hand rub is preferred over soap and water in most situations due to evidence of better compliance compared to soap and water. <Enhanced barrier precautions> <Resident 10> Review of Resident 10's record, documented the resident was on enhanced precautions (an infection control intervention to reduce transmission of multidrug resistant organisms) related to the placement of a urinary catheter. Enhanced precautions required staff to wear PPE (personal protective equipment, such as gowns and gloves) when providing cares such as transfers, toileting and dressing for the resident. On the door going into the resident's room, an enhanced barrier precaution sign was present that instructed staff what PPE was required. During an observation on 04/10/2024 at 2:27 PM, Staff U and Staff V, Nursing Assistants, were in Resident 10's room transferring them from the wheelchair to the bed using a Hoyer (a mechanical lift used to transfer residents). Neither Staff U or Staff V were wearing the required PPE as instructed on the sign. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/10/2024 at 2:27 PM, Staff W, Licensed Practical Nurse read the enhanced barrier precautions sign and stated Staff U and V should have worn PPE During an interview on 04/10/2024 at 2:37 PM, Staff U stated they should have been wearing PPE prior to the resident being transferred because they had a catheter. The hoyer was placed in the hall at 2:43 PM and was not sanitized after being used for Resident 10. During an observation on 04/11/2024 at 6:17 AM, Staff X, Nursing Assistant, had used the hoyer to get a resident out of bed and placed the machine in the hallway. Staff X did not sanitize the machine after it's use. During an observation on 04/11/2024 at 6:18 AM, Staff X and Staff Y Nursing Assistants, entered room [ROOM NUMBER] to assist the resident to the toilet, neither of them were wearing PPE and an enhanced barrier precaution sign was present on the resident's door. During an observation on 04/11/2024 the hoyer was placed in the hall at 10:17 AM and was not sanitized after being used for Resident 10. <Resident 8> Resident 8 was on enhanced barrier precautions related to wounds on their toes. Staff K, Licensed Practical Nurse, entered Resident 8's room and performed a dressing change without a gown as required. During an interview on 04/11/2024 at 9:18 AM, Staff K stated they knew the resident's roommate was on precautions but did not know Resident 8 was also on precautions. Staff K stated they should have worn a gown to protect themselves from bacteria. <Catheter> According to the 02/14/2024 annual assessment, Resident 4 had diagnoses which included benign prostatic hyperplasia (prostate gland enlargement that can cause difficulty with urination), and obstructive uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow) and was moderately cognitively impaired but able to direct their care. The resident required substantial to maximal assistance for activities of daily living such as toileting and had a urinary catheter. During observations on 04/09/2024 at 9:36 AM and 04/11/2024 at 6:14 AM, Resident 4 was observed lying back in their recliner asleep, and their urinary catheter collection bag was lying on the floor without a cover over it. Review of Resident 4's record documented on 02/28/2024 the resident had a urinary tract infection and was treated with an antibiotic for seven days. During an interview on 04/11/2024 at 10:21 AM, Staff H, Nursing Assistant, stated a catheter needed to be stored in a privacy bag, and up off the floor because bacteria can travel up the catheter tubing. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/11/2024 at 11:07 AM, Staff B, Director of Nursing, stated a catheter needed to be placed in a privacy bag, not touching the floor as this could have an increased risk for an infection. <Wound care> <Resident 10> On 04/10/2024 at 2:56 PM, during an observation of Resident 10's wound on their buttocks , Staff Y, Licensed Practical Nurse, unhooked the resident's urinary catheter from the bed, and with the assistance of Staff X, Nursing Assistant, they repositioned the resident onto their side.Staff Y then removed their gloves, and without performing hand hygiene, put on new gloves and removed the resident's soiled buttock dressing. After removing the dressing, Staff Y changed their gloves, cleansed the wound, and while wearing the same gloves, grabbed more gauze out of the package, and then wiped the wound. No hand hygiene was performed between removing the soiled gloves and putting on clean gloves. After wiping the wound, Staff Y then changed gloves, measured the wound and applied ointment to the wound. Still wearing the same soiled gloves, Staff Y removed Resident 4's compression socks, and then proceeded to assist Staff X, to change the soiled incontinence brief Staff Y then discarded the soiled brief into the garbage, and without performing hand hygiene and putting on new gloves, touched the resident's legs. Staff X removed their gloves, and without performing hand hygiene, put on new gloves and assisted the resident with repositioning. During an interview on 04/10/2024 at 3:21 PM, Staff Y stated they should have used hand sanitizer after the wound was cleansed, after incontinence care was provided and the aide should have done so also. <Resident 28> During an observation of Resident 28's buttock wound on 04/12/2024 at 8:45 AM, Staff L, Nursing Assistant, performed incontinence cares, and without performing hand hygiene or changing gloves, touched the resident's leg and removed the dressing from the resident's right upper buttock. Staff K cleansed the wound, and without performing hand hygiene, changed gloves, applied ointment and a new dressing to the wound. After the buttock wound care was completed. Staff K applied a new pair of gloves, cleansed the resident's left leg wound, removed their gloves, applied new gloves and put a treatment on the wound, without hand hygiene being performed. Staff L using the same gloves that was worn during incontinence care placed a brief onto the resident and pulled up their pants. During an interview on 04/12/2024 at 8:57 AM, Staff K stated hand hygiene should have been performed before the dressing change, and every time gloves were changed during the dressing change. Staff K stated you could have encountered bacteria that could be passed on to yourself and other residents. During an interview on 04/12/2024 at 8:59 AM, Staff L stated gloves needed to be changed once they have been soiled. Staff L stated they should have performed hand hygiene and placed new gloves on prior to having touched the resident's leg and the dressing being removed because that can cause cross contamination. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/12/2024 at 4:46 PM, Staff B, Director of Nursing, stated the expectation was for staff to have worn gowns and gloves for residents on enhanced barrier precautions. Staff B stated staff were to have performed hand hygiene when going from dirty to clean areas and when their gloves were changed. Staff B added the mechanical lifts should have been wiped down after each use to prevent infections. Reference: WAC 388-97-1320 (2)(a) 47328 <Dining Room> During continuous observation of meal service on 04/08/2024 from 12:32 PM until 12:52 PM, Staff L, Nursing Assistant, passed out desserts to 11 different residents without performing hand hygiene before, in between residents, or after. Staff L then poured water into a cup, opened two straws while touching the mouthpiece, and gave a resident a sip of water. Staff L washed their hands with soap and water at the sink in the back of the dining room. Staff L then started assisting two different residents to eat their lunch, used their walkie talkie, adjusted the chair they were sitting on, and continued to assist the two residents to eat their lunch without performing hand hygiene after touching objects in the immediate vicinity of a resident or in between assisting the two different residents. Reference WAC 388-97-1320 (1)(c)		