STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505344	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury House	502 29th Street Southeast Auburn, WA 98002

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44295 Based on interview and record review the facility failed to ensure 1 of 3 residents (Resident 1) reviewed for nutrition maintained acceptable parameters of nutritional status. Failure to ensure consistent, timely weights and re-weights, identify significant weight changes timely, notify interested parties timely, and implement Registered Dietician's (RD) recommendations placed the residents at risk for delayed identification of interventions to prevent continued weight loss and decreased quality of life. Findings included . Review of the facility policy titled, Weights, revised on 10/12/2023, showed weighing criteria included obtaining a weight on the day of admission then weekly for one month. The policy showed guidelines for residents who may need to be weighed weekly due to; food intake declined and persisted, slow trending weight loss or gain, significant weight loss or gain, multiple stage two Pressure Ulcers (PU, injury to the skin and underlying tissue resulting from prolonged pressure on the skin) and any stage 3 PU (full thickness loss of tissue) or stage 4 PU (full thickness skin loss that extended to the muscle, bone and tendons). The policy showed any weight with a five pound variance would be re-weighed within 24 hours and recorded on the permanent weight record. When the significant variance was actual after the re-weigh, the staff would document in the resident's record, revise the Care Plan (CP), refer the resident to the Nutrition Hydration Skin Committee (NHSC), notify the physician and responsible party, and document this data. <Resident 1> Review of the quarterly Minimum Data Set (MDS, an assessment tool), dated 02/07/2024, showed Resident 1 admitted to the facility on [DATE], had severe impairments to their decision making, highly impaired vision, and behaviors of rejecting care. The MDS showed Resident 1 had medically complex conditions including fracture, dementia, and muscle weakness. The MDS showed Resident 1 had a weight loss of five percent or more in the last month, was not on a prescribed weight loss program, had no swallowing issues, and was on a therapeutic diet. The MDS showed Resident 1 had an unhealed stage 3 PU that required PU care. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's baseline CP, dated 11/20/2023, showed Resident 1 required staff supervision for meals and staff assistance to the dining room for all meals. Review of a Nutrition Risk CP, dated 09/05/2023, showed Resident 1 was at increased nutritional risk related to being prescribed a therapeutic diet, decreased body mass index (a measure of body fat based on height and weight), variable food intake by mouth, assistance needed with meals, medical conditions, and PU's. The CP directed staff to refer Resident 1 to the facility RD as appropriate and weights per the facility policy. Review of an actual alteration in skin integrity CP, dated 02/08/2024, showed Resident 1 had a stage 3 PU to their mid back and a Deep Tissue Injury (DTI, deep red or maroon areas of skin caused by underlying damage to skin tissue and extent of injury is not visible) to their right heel. Review of Resident 1's Physician Orders (PO) dated from 08/11/2023 through 03/26/2024, showed no PO to weigh Resident 1. Review of Resident 1's weight record showed no weight was obtained on 08/11/2023, the day of admission. On 08/12/2023 Resident 1 weighed 90 pounds. Resident 1 readmitted to the facility on [DATE] no weight was documented on the weight record until the next day on 08/22/2023 when Resident 1 weighed 92 pounds. Review of the weight record showed on 08/29/2023 Resident 1 weighed 90.9 pounds, and no weights were found for the following three weeks after re-admission to the facility. Review of Resident 1's weight record showed on 09/20/2023 Resident 1 weighed 82.9 pounds, a weight loss of eight pounds, from the previous weight of 90.9 pounds on 08/29/2023. The weight record showed no re-weigh were obtained within 24 hours but one weight was obtained two days later on 09/22/2023 that showed Resident 1 weighed 82.5 pounds demonstrating additional weight loss. Review of a Nutritional Evaluation, dated 09/05/2023, showed Resident 1 had no PU's, was on a no added salt diet, with regular textured foods, thin liquids, and a supplemental shake ordered three times daily. The evaluation showed Resident 1 required assistance with eating, and dined in their room. The evaluation showed the goal was for Resident 1 to have no unplanned weight loss or gain and directed staff to monitor Resident 1's weight, intake by mouth, and nutrition related labs as needed. Review of a NHSC review form, dated 09/20/2023, showed Resident 1 was being reviewed due to a PU. The form showed Resident 1's most recent weights of 90 pounds on 08/12/2023, 90.9 pounds on 08/29/2023. Staff documented there were no weight changes. The form did not include Resident 1's most recent weight on the same day of the NHSC review on 09/20/2023 at 82.9 pounds. The NHSC review form showed Resident 1 had four PU's, one to the mid-back, a DTI to the sacrum (tailbone) and both heels. The form included recommendations to continue current interventions as Resident 1's wounds and meal intake were improving and did not identify Resident 1's eight pound weight loss. Review of Nursing Progress Notes (NPN), dated 09/20/2023-09/28/2023 showed no documentation that staff informed the physician or the resident representative of Resident 1's weight loss. A NPN, dated 09/29/2024, nine days later, showed Resident 1's representative was informed of a significant weight loss of 12.3% in one month and 11.4% in three months. The NPN showed that Resident 1 had complained of pain upon readmission to the facility, meal intake was reduced, and pain was now well managed and the resident's intake by mouth had improved. The NPN showed the physician was informed and a new PO was received for a second nutritional supplement three times a day with meals. Review of a NPN, dated 10/06/2024, showed staff informed Resident 1's representative that the resident's weight continued to decrease. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's weight record showed on 11/15/2023, Resident 1 weighed 76.6 pounds and on 11/23/2023 weighed 72.6 pounds, an additional four pounds weight loss. The weight record showed on 12/06/2023 Resident 1 weighed 73.5 pounds and on 12/13/2023 weighed 71.7 pounds, an additional 1.8 pounds. Review of the weight record showed no weights were documented between 01/16/2024-02/27/2024. Review of the weight record showed on 03/06/2024 Resident weighed 71 pounds, a loss of 4.1 pounds. Review of a NPN, dated 11/27/2024, showed staff documented that Resident 1 had a significant weight loss of 6.2% in one month and 20.1% in three months. Staff documented that Resident 1's oral intake varied. Review of a wound provider note, dated 01/10/2024, showed Resident 1's mid-back PU re-opened, required wound care and follow up from the wound provider. A wound provider note, dated 01/17/2024 showed Resident 1 was found with a re-opened wound to their tailbone and on 01/24/2024 a wound provider note showed Resident 1's tailbone was now healed. Additional wound provider notes dated 01/31/2024 through 03/24/2024, date of discharge Resident 1 still had the PU to their mid-back. Review of a Nutritional Note, dated 02/21/2024, showed the facility RD recommended Resident 1 be started on an appetite stimulant. Review of NHSC documentation in Resident 1's record showed no documentation that Resident 1 was reviewed in the committee between 12/20/2023 through 03/20/2024, although Resident 1 had current PU's, continued weight loss, and was identified by the RD with continued weight loss. Review of NPN's, dated 02/21/2024-03/26/2024, showed no documentation to support that facility staff implemented the RD's recommendations, or informed the physician or the resident representative about the RD's recommendation. In an interview of 04/26/2024 at 10:20 AM Resident 1's Collateral Contact (CC) stated they visited Resident 1 daily during the week. the CC stated the resident needed supervision and encouragement with meals, but staff would just bring the meal tray in, leave, and they would not try to assist Resident 1. The CC stated Resident 1 lost twenty pounds in six months, a female staff member talked to them about Resident 1's weight loss and stated the resident might need a feeding tube (a flexible tube placed into the stomach and used to administer artificial nutrition). The CC stated when they asked about the feeding tube they were told by a staff member that Resident 1 had not lost enough weight, after four more pounds lost another staff member told the CC a doctor has to give the order for a feeding tube. The CC stated they wanted Resident 1 to have a feeding tube, expected them to get one, and was asked by facility staff to review Resident 1's POLST (Physicians Orders for Life-Sustaining Treatment) form and think about changing Resident 1 to a DNR (Do not resuscitate), which would include no feeding tube. The CC stated the facility mentioned something about an appetite stimulant but never started one which is when they moved Resident 1 to another care facility. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/29/2024 at 3:35 PM Staff B (Director of Nursing) stated the NHSC meet weekly. Staff B stated, resident's with PU's were reviewed weekly and the RD created the list of residents to be reviewed. Staff B stated the resident's weight records were used to ensure the correct weights were reviewed in the NHSC meeting. Staff B stated they were not sure why Resident 1's 09/20/2023 weight was not used as part of the assessment during the 09/20/2023 NHSC meeting and during that meeting Resident 1's eight pound weight loss was not identified. Staff B sated when a resident admitted to the facility staff were expected to weigh the resident weekly for one month and weekly when a resident had a PU. Staff B stated they would have to look to see if additional weights were obtained after Resident 1 readmitted to the facility. Staff B provided no additional information. Staff B stated they were not sure why weekly weights were not completed between 01/16/2024 through 02/27/2024 and stated if the resident had a PU, they should be weighed weekly. Staff B stated they were not sure why Resident 1 was dropped from the weekly NHSC meetings, had no nutrition notes from 12/20/2024-03/2024, and would have to ask the RD. Again, no additional information as provided. REFERENCE: WAC 388-97-1060(3)(h).