

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505344	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/04/2024
NAME OF PROVIDER OR SUPPLIER  Canterbury House		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47836</b></p> <p>Based on interview and record review the facility failed to ensure residents had the appropriate Advanced Directive (AD) in place for 2 (Residents 16, &amp; 32) of 10 residents reviewed for ADs. The facility failed to provide information indicating residents were informed, educated, or offered assistance to formulate an AD. This failure placed residents at risk of losing their right to have their stated preferences/decisions honored regarding medical treatment and end-of-life care.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility policy titled, Advance Directive, revised April 2023, the Admission's Director would educate and offer assistance on formulating an Advance Directive (AD) to residents that did not have one upon admission to the facility. The policy showed the facility would review and discuss AD's during resident care conferences.</p> <p>&lt;Resident 16&gt;</p> <p>According to the 08/07/2024 Admission Minimum Data Set (MDS -an assessment tool), Resident 16 admitted to the facility on [DATE] and was severely cognitively impaired. Resident 16 had diagnoses of non-Alzheimer's dementia, anxiety disorder, and depression. The MDS showed Resident 16 was unable to respond and the Resident Representative (RR) participated in assessment and goal planning.</p> <p>Review of Resident 16's records showed no AD. Resident 16's records showed no AD was offered or discussed with the RR upon admission. There was no AD care plan and no review of ADs at the care conferences with Resident 16 and RR's on 08/06/2024, 08/30/2024, or 09/13/2024.</p> <p>In an interview on 09/29/2024 at 7:20 PM Resident 16's RR stated the facility staff did not discussed or offered assistance to formulate an AD. Resident 16's RR stated the facility had been utilizing them to guide Resident 16's care and goals.</p> <p>In an interview on 10/02/2024 at 12:28 PM Staff D (Social Services Director) stated they did not offer, educate, or discuss ADs with Resident 16 or their RR. Staff D stated they usually discuss AD during CC's, but they did not with Resident 16's RR.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>50511</p> <p>&lt;Resident 32&gt;</p> <p>Review of Resident 32's records showed an electronically signed form dated 05/24/2021, titled Authorizations and Designations that indicated the resident did not provide an AD to the Facility.</p> <p>Review of Resident 32's notes from the following Care Conferences; 01/10/2024 (admission), 02/01/2024 (quarterly), 04/26/2024 (annual), and 07/29/2024 (quarterly), showed the box indicating a review of Annual and Admission paperwork reviewed with resident for AD was not marked for any of the care conferences, indicating a review was not completed with the resident. Review of Resident 32's records showed no AD.</p> <p>According to the 09/07/2024 Quarterly MDS, Resident 32 was understood, had clear comprehension, had multiple medically complex conditions and was admitted to the facility on [DATE].</p> <p>In an interview on 10/02/2024 at 1:21 PM, Staff D stated AD should be provided to residents on admission and social services should follow up every quarter with the resident for changes. Staff D stated it was very important to know the resident's wishes so the facility could follow the resident's directives. Staff D stated the facility should have checked on this quarterly for Resident 32, but did not.</p> <p>REFERENCE: WAC 388-97-0280 (3)(c)(i-ii).</p> <p>42203</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>50511</p> <p>Based on observation, interview, and record review the facility failed to implement their Grievance policy for 3 of 3 residents (Resident 54, 70, &amp; 53) reviewed for Grievance reporting. The failure to report, initiate, investigate, and log grievances placed residents at risk for not having grievance resolution delayed or incomplete, feelings of frustration, and a diminished quality of life.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>Review of a facility policy titled, Grievance Procedure, updated November 2016, showed residents had the right to voice grievances orally regarding their care and treatment, interactions with other residents, and other concerns during their stay. Staff would be trained at orientation and periodically on the center's grievance procedure which included the need to take grievances seriously, what to do with grievances, when to put grievances in writing, and when to report to their supervisor.</p> <p>&lt;Resident 54&gt;</p> <p>According to the 07/18/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 54 was understood, had clear comprehension, and had no cognitive impairment.</p> <p>On 09/29/2024 at 12:44 PM, Resident 54 stated the resident next to his room (Resident 69) crawled into their room, naked from the waist down, and bleeding during the night. Resident 54 stated Resident 69 emitted a blood curdling scream when they came into their room. Resident 54 stated they pushed their call light and screamed for help from night staff, but staff did not arrive right away. When the nurse arrived for the next shift during the day, Resident 54 stated the nurse on duty talked to them and made them feel like the event did not happen at all. Resident 54 stated the event was very stressful as they were asleep at the time of the event. Resident 54 stated the staff did not do anything about that incident and Resident 69 continues to scream. Resident 54 stated they don't believe the event was resolved and no other staff have talked to them about the event. Resident 54 stated they let the nursing staff know they were not very happy about the event.</p> <p>Review of a 09/01/2024 progress note showed Resident 69 crawled out of bed and all the way to their door.</p> <p>Review of Resident 54's progress notes did not show an entry for the event on 09/01/2024.</p> <p>Review of the facility's grievance log did not show a grievance report for Resident 54 for the event that occurred with Resident 69.</p> <p>In an interview on 10/01/2024 at 1:55 PM, Staff J (Resident Care Manager) stated they reviewed the incident report for Resident 69 but did not have a grievance report for Resident 54 and did not believe the event occurred in Resident's 54 room. Staff J stated the Director of Nursing would have a full investigation of the occurrence.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 10/04/2024 at 9:39 AM, Staff B (Director of Nursing) stated they were told Resident 69 never left their room, they did not know that Resident 54 had a grievance. Staff B stated they would expect staff to report the grievance when it occurred.</p> <p>43642</p> <p>&lt;Resident 70&gt;</p> <p>According to a 08/09/2024 Admission MDS, Resident 70 had clear speech, was understood, and able to understand others. This MDS showed staff assessed Resident 70 to have no memory impairment.</p> <p>In an interview on 09/30/2024 at 11:08 AM, Resident 70 stated they were frustrated about some missing clothes. Resident 70 stated they told staff, about a week ago, but they had not located the missing clothes yet. Resident 70 stated they were missing their underwear and a t-shirt.</p> <p>In interviews on 10/01/2024 at 8:53 AM and 10/04/2024 at 9:17 AM, Resident 70 stated the items were still missing, they kept asking staff, but nobody was able to find them yet.</p> <p>Review of an 08/06/2024 Personal Inventory form for Resident 70 showed the resident brought one shirt and one pair of underwear upon admission to the facility.</p> <p>Review of the grievance log on 10/01/2024 showed no grievance reports were logged for Resident 70 regarding their missing clothes.</p> <p>In an interview on 10/04/2024 at 2:55 PM, Staff N (Certified Nursing Assistant - CNA) stated they had just found Resident 70's underwear this morning. Staff N stated Resident 70 reported the missing clothes a few weeks ago and indicated the resident stated at that time, the clothes were already missing for about two weeks. Staff N stated they found Resident 70's shirt last week but was unable to find the underwear until today.</p> <p>&lt;Resident 53&gt;</p> <p>According to a 09/02/2024 Admission MDS, Resident 53 had clear speech, was understood, and able to understand others. This MDS showed staff assessed Resident 53 to have no memory impairment.</p> <p>In an interview on 09/29/2024 at 10:31 AM, Resident 53 stated they had some clothes come up missing that was not resolved. Resident 53 stated they were still really mad about it. Resident 53 stated when staff were assisting them to get ready for a recent doctor appointment, the staff had to run and try to find the resident's shirt and pants. Resident 53 stated staff found their pants but were unable to locate their shirt and hoodie. Resident 53 was unable to identify which staff members, but reported it was different staff assisting them with getting ready, and one that rode with them to the appointment. Resident 53 stated they asked a lot of different staff about the missing clothing.</p> <p>In an interview on 10/04/2024 at 9:26 AM, Resident 53 stated they were still missing the clothes, and they had several staff go look for the items without locating them. Resident 53 stated staff did not offer to assist them to file a grievance and stated, it's really a bummer the clothes were missing.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an 08/28/2024 Personal Inventory form for Resident 53 showed the resident brought one shirt and one hoodie upon admission to the facility.</p> <p>Review of the grievance log on 10/01/2024 showed no grievance reports were logged for Resident 53 regarding their missing clothes.</p> <p>In an interview on 10/04/2024 at 2:55 PM, Staff N stated Resident 53 told them a couple of days ago they were missing a black zipper sweater and a t-shirt. Staff N stated they let laundry know, but did not report it to anyone else. Staff N stated they do not complete grievance forms when a resident reports missing items and indicated they give it a week or so to keep looking around.</p> <p>In an interview on 10/02/2024 at 1:30 PM, Staff D (Social Service Director) stated their expectation was for a grievance to be completed and on the log, when a resident reports missing items and clothing. Staff D stated a report of missing items should be addressed at least within 72 hours and followed up by staff to assure resolution.</p> <p>In an interview on 10/04/2024 at 3:20 PM, Staff A (Executive Director) stated the facility process was for staff to fill out a grievance form anytime they hear of missing clothing. Staff A stated the CNA or any staff notified of the missing clothes, should complete a grievance form, turn it in to the social services department, who will log it, and assign it to staff for follow-up and resolution with the resident. Staff A stated their expectation was for the grievance form to be completed and addressed timely.</p> <p>REFERENCE: WAC 388-97-0460(2).</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47836</p> <p>Based on observation, interview, and record review the facility failed to report significant injury of unknown origin for 1 of 1 resident (Resident 16) reviewed. The facility's failure to report a large hematoma of unknown origin on Resident 16's right calf, placed Resident 16 and all residents at risk for repeated incidents and unidentified abuse and/or neglect.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>Review of the facility policy titled, Abuse Reporting and Response, published September 2017, showed staff would immediately report all alleged or suspected violations to the supervisor and Executive Director (ED). The policy showed the ED or designee would report injuries of unknown source to the state agency immediately, but no later than two hours. This policy showed the facility would identify the staff responsible for implementation of corrective actions, expected date of implementation, and those responsible for monitoring. The policy showed failure to report potential abuse/neglect timely by staff would result in disciplinary action.</p> <p>Review of the facility policy titled, Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation, revised October 2022, showed an injury was classified as an injury of unknown source if the injury was not observed, the source of the injury could not be explained by the resident, and the injury was suspicious because of the extent of the injury. This policy showed an injury of unknown source could indicate potential abuse.</p> <p>Review of the facility policy titled, Abuse Identification, revised October 2022, showed staff would identify and report indicators of abuse such as an injury that is suspicious because the source of the injury was not observed, or the extent or location of the injury was unusual.</p> <p>&lt;Resident 16&gt;</p> <p>According to the 08/07/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 16 admitted to the facility on [DATE] and was severely cognitively impaired. Resident 16 had diagnoses of paraplegia, non-Alzheimer's dementia and chronic pain syndrome. The assessment showed Resident 16 was taking blood thinner medications during the assessment period. The MDS showed no hematomas or other non-pressure skin concerns were identified at time of the assessment.</p> <p>In an interview on 09/29/2024 at 6:56 PM, the Resident Representative (RR) for Resident 16 stated they found a large hematoma on Resident 16's right calf on 08/10/2024. The RR stated they reported to the nurse on duty on 08/10/2024. The RR stated they reported the hematoma to Staff B (Director of Nursing) on 08/13/2024.</p> <p>In an interview on 10/02/2024 at 1:47 PM Staff B stated the RR reported the hematoma on 08/10/2024. Staff B stated they did not report the significant injury of unknown origin to the state agency.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 10/04/2024 at 10:33 AM Staff A (ED) stated they should have reported Resident 16's significant injury of unknown origin to the state agency within two hours, but they did not.</p> <p>Refer to F610 - Investigate Abuse.</p> <p>Refer to F684 - Quality of Care.</p> <p>REFERENCE: WAC 388-97-0640(2).</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47836</b></p> <p>Based on interview and record review, the facility failed to thoroughly investigate and rule out abuse/neglect for 2 of 12 sampled resident's (Resident 16 &amp; 4) reviewed for investigations. Facility failure to complete thorough investigations placed residents at risk for potential abuse and other negative health outcomes.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>Review of the facility policy titled, Abuse Investigation, revised October 2022, showed the facility maintained complete and thorough documentation of the investigation. The policy showed the facility would determine, through investigation, if the abuse/neglect had occurred, the extent, and the cause of the injury.</p> <p>&lt;Resident 16&gt;</p> <p>According to the 08/07/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 16 admitted to the facility on [DATE] and was severely cognitively impaired. Resident 16 had diagnoses of paraplegia, non-Alzheimer's dementia, and chronic pain syndrome. The assessment showed Resident 16 was taking blood thinner medications during the assessment period. The MDS showed no hematomas or other non-pressure skin concerns were identified at time of the assessment.</p> <p>In an interview on 10/02/2024 at 1:47 PM Staff B (Director of Nursing) provided investigation documents that showed an incomplete incident report, dated 08/13/2024 with a completion date of 08/26/2024, eight days outside of the five-day regulatory requirement. The incident report showed no injuries observed at time of incident, no pain assessment, no skin assessment, no mental status assessment for Resident 16, no predisposing environmental factors were checked, no predisposing physical factors were checked, no predisposing situation factors were investigated, and no resident interviews were included. The investigation summary showed Resident 16's Resident Representative (RR) called Staff B to notify them of Resident 16's large hematoma to their right calf on 08/13/2024. The summary stated the RR questioned the cause of the hematoma and suggested the hematoma may have happened during a transfer for a shower on the previous day, 08/09/2024. The summary showed Staff B interviewed the shower aide who reported Resident 16 was not transferred for a shower but received a bed bath and they did not see a bruise on 08/09/2024. Staff B determined that abuse/neglect was ruled out.</p> <p>In an interview on 10/03/2024 at 8:40 AM Staff A (Executive Director) stated the investigation of Resident 16's right calf hematoma was not completed in five days. Staff A stated the incident report was not complete or thorough. Staff A stated they investigated the shower aide transfer which did not happen, and they did not continue the investigation to determine the root cause of the hematoma, but they should have.</p> <p>In an interview on 10/04/2024 at 10:33 AM Staff A stated they should have started the investigation immediately to rule out abuse and neglect, but they did not.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>44296</p> <p>&lt;Resident 4&gt;</p> <p>According to the 09/04/2024 Quarterly MDS, Resident 4 was assessed to require maximum assist with transfers to the toilet, used a wheelchair for ambulation, and was cognitively intact with no behaviors.</p> <p>Review of the 08/08/2024 Care Plan (CP) showed Resident 4 required a sit to stand lift (equipment that assists staff with resident transfers) for all transfers and care in pairs. The CP showed the wheelchair footrests were padded to prevent skin issues. The CP showed Resident 4 was to wear long sleeves to protect their arms for skin safety, and use caution during transfers to prevent striking arms, legs, and hands, against sharp and hard surfaces.</p> <p>Review of the 07/2024 facility incident log showed a skin investigation occurred for Resident 4 on 07/22/2024.</p> <p>An observation and interview on 09/29/2024 at 9:31 AM showed Resident 4 was sitting in a wheelchair with both feet on the elevated footrests, the footrests were padded. Resident 4 was wearing socks and pants; their lower legs were not covered. Both the lower legs were observed to have significant edema, the outside of the left lower leg had a large bruise, and both legs had red marks, scars, and scabs. Resident 4 stated the staff bangs their legs on the wheelchair footrests when they take me to the bathroom with the sit to stand lift. Resident 4 stated the staff do not remove the leg rests from the wheelchair and it caused injuries to their legs.</p> <p>Review of the 07/22/2024 facility incident investigation showed Resident 4's right shin was bumped on the wheelchair during a transfer, first aid was administered, and the medical doctor and RR were notified. The investigation conclusion was dated 08/08/2024, 18 days after the incident with injury. The conclusion summary showed Resident 4's right leg injury was consistent with contact with the wheelchair during a transfer and abuse and neglect was ruled out.</p> <p>In an interview on 10/04/2024 at 11:53 AM, Staff B stated the caregivers were not interviewed to gather a statement of how the injury occurred. Staff B stated the sit to stand lift was not considered as contributing to the injury and was not evaluated for function. Staff B stated the caregivers were not evaluated for their ability to safely transfer Resident 4 with the sit to stand lift to prevent future injuries. Staff B stated there was no assessment if the sit to stand lift continued to be a safe method to transfer Resident 4. Staff B stated the lift, transfers, and caregiver evaluation should be, but were not, included in the investigation.</p> <p>Refer to F609 - Reporting of Alleged Violations</p> <p>Refer to F684 - Quality of Care</p> <p>REFERENCE: WAC 388-97-0640(6)(a)(b).</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47836</p> <p>Based on interview and record review, the facility failed to implement a system to ensure residents received required written notices at the time of transfer/discharge for 3 (Residents 65, 16, &amp; 53) of 4 residents and notify the Office of the State Long-Term Care Ombudsman (LTCO) for 2 of 4 residents (Resident 16 &amp; 53) reviewed for hospitalizations. Failure to ensure written notification to the resident and/or the Resident's Representative (RR) of the reasons for the discharge in writing and in a language and manner they understood, placed residents at risk for a discharge that was not in alignment with the resident's stated goals for care and preferences. Failure to ensure required LTCO notification was completed, prevented the LTCO the opportunity to educate residents and advocate for them regarding the discharge process.</p> <p>Findings included .</p> <p>&lt;Resident 65&gt;</p> <p>According to the 09/25/2024 Discharge Return Anticipated Minimum Data Set (MDS - an assessment tool), Resident 65 admitted on [DATE] and had no memory impairment. The MDS showed Resident 65 was discharged to an acute care hospital on 09/25/2024.</p> <p>Review of Resident 65's records showed a nursing note stating Resident 65 discharged to an acute care hospital on 09/25/2024 at 7:30 PM. Resident 65's records showed no information about a written transfer notification being provided to the resident or RR.</p> <p>&lt;Resident 16&gt;</p> <p>According to the 08/15/2024 Modified Discharge Return Anticipated MDS, Resident 16 was severely cognitively impaired. The MDS showed Resident 16 was discharged to an acute care hospital on 08/15/2024.</p> <p>Review of Resident 16's records showed a nursing note stating they were transferred to an acute care hospital on 08/15/2024 at 5:30 PM. Resident 16's records showed no written transfer notification was provided to the RR for the 08/15/2024 re-hospitalization .</p> <p>In an interview on 09/29/2024 at 6:56 PM Resident 16's RR stated they were transferred out of facility to an acute care hospital on 08/15/2024. Resident 16's RR stated they did not receive a written transfer notification for this discharge.</p> <p>In an interview on 10/02/2024 at 12:31 PM, Staff D (Social Service Director) stated the Social Service Department was not responsible for written transfer notifications, but they were responsible for notifying the LTCO, but they did not for Resident 16.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 10/02/2024 at 12:35 PM, Staff B (Director of Nursing) stated the nursing department was not responsible for providing written transfer notifications. In an interview on 10/02/2024 at 12:36 PM, Staff A (Executive Director) stated they would find out who was responsible for the written transfer notification and get back to this surveyor, no further information was provided.</p> <p>43642</p> <p>&lt;Resident 53&gt;</p> <p>Review of Resident 53's records showed a 09/24/2024 progress note indicating the resident was sent to the hospital for treatment and was picked up by transportation in stable condition.</p> <p>Review of Resident 53's records showed no documentation a written notice before transfer form was provided to the resident.</p> <p>In an interview on 10/02/2024 at 1:30 PM, Staff D stated they were unsure of what a written notice of transfer form was and indicated it was not something they provided to the residents. Staff D stated they did the notification to the LTCO when a resident is transferred or discharged from the facility. Staff D reviewed their log from September 2024 and stated Resident 53 was not included on the list of residents reported to the LTCO.</p> <p>REFERENCE: WAC 388-97-0120 (2)(a-d), -0140 (1)(a)(b)(c)(i-iii).</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>46479</p> <p>Based on interview and record review, the facility failed to provide the resident and/or the Resident's Representative (RR) a written notice of the facility's bed-hold policy, at the time of transfer or within 24 hours, for 3 (Residents 67, 16, &amp; 53) of 4 residents reviewed for hospitalization . This failure placed the residents and their representatives at risk of not being informed of their right to, and the cost of, holding the resident's bed while hospitalized that was necessary for decision making.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to page 6 of the facility's Admission Agreement, updated 05/2017, the facility would provide a bed-hold notice in accordance with applicable regulations and discuss bed-hold rates with the resident and their representative at the time of transfer to an acute hospital.</p> <p>&lt;Resident 67&gt;</p> <p>Review of Resident 67's 09/19/2024 Discharge Minimum Data Set (MDS - an assessment tool) showed the resident was transferred to an acute care hospital on 09/19/2024, with their return anticipated.</p> <p>Record review showed no documentation or indication the facility provided Resident 67 written information regarding the facility's bed-hold policy upon transfer to the hospital as required.</p> <p>In an interview on 10/02/2024 at 10:09 AM, Staff L (Admissions Assistant) stated it was important to offer bed-holds because the resident was at risk of losing their room to a new admit or the facility might not have a bed available upon the resident's return without signing the bed-hold agreement. Staff L stated they were responsible for providing bed-hold information to residents who were sent to the hospital. Staff L confirmed Resident 67 was not provided a bed-hold policy as required when transferred to the hospital.</p> <p>47836</p> <p>&lt;Resident 16&gt;</p> <p>According to the 08/15/2024 Modified Discharge Return Anticipated MDS, Resident 16 was severely cognitively impaired. The MDS showed Resident 16 was discharged to an acute care hospital on 08/15/2024.</p> <p>Review of Resident 16's records showed a nursing note stating they were transferred to an acute care hospital on 08/15/2024 at 5:30 PM. Resident 16's records showed no indication the facility provided Resident 16 information regarding the facility's bed hold policy upon transfer to the hospital as required.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 09/29/2024 at 6:56 PM Resident 16's RR stated they were transferred out of facility to an acute care hospital on 08/15/2024. Resident 16's RR stated they did not return to the same room and facility staff did not discuss their bed-hold policy with them or give them the option to return to the same room.</p> <p>In an interview on 10/02/2024 at 12:38 PM Staff K (Admissions Director) stated bed-hold notification was the responsibility of the Admissions Department, and their assistant was managing those.</p> <p>In an interview on 10/02/2024 at 1:00 PM Staff K &amp; Staff L stated they did not discuss their bed-hold policy with Resident 16 and/or the RR, but they should have. Staff K stated it was important to offer a bed-hold to accommodate resident's rights</p> <p>43642</p> <p>&lt;Resident 53&gt;</p> <p>Review of a 09/24/2024 progress note showed staff documented Resident 53 was being sent to the hospital for treatment and was picked up for transport in stable condition.</p> <p>Record review showed no documentation or indication the facility provided Resident 53 or their resident representative written information regarding a bed-hold prior to their transfer to the hospital as required.</p> <p>In an interview on 10/02/2024 at 1:30 PM, Staff D (Social Services Director) stated the admissions department was responsible for providing bed-hold information to residents if they were being sent to the hospital. Staff D reviewed Resident 53's records and was not able to locate a bed-hold form for Resident 53.</p> <p>REFERENCE: WAC 388-97-0120(4).</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>44296</p> <p>Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR) Level II comprehensive evaluations were obtained, and/or implemented, and incorporated into the Care Plan (CP) for 1 of 7 (Resident 23) residents reviewed for PASRR Level II. This failure placed residents at risk for not receiving necessary mental health care and services.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's July 2015 Mental Health Rehabilitation Services policy, residents diagnosed with a mental illness or developmental disability would be prescreened through the PASRR process and receive the treatment they were assessed to require from the evaluation. The policy showed the social services department was responsible for reviewing all residents receiving a Level II PASRR screening.</p> <p>&lt;Resident 23&gt;</p> <p>According to the 09/03/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 23 had medically complex diagnoses including a history of stroke, alcohol dependence, and a psychotic disorder. The MDS showed Resident 23 took antipsychotic medication.</p> <p>Record review showed Resident 23 had a 10/04/2024 physician's order for an antipsychotic medication, give 100 milligrams two times a day.</p> <p>Record review showed a 01/19/2023 PASRR Notification of Determination form that showed Resident 23 was assessed to have a significant change in their behavioral health. The form showed Resident 23 met the requirements for Level II services.</p> <p>Record review showed no Level II referral was completed for Resident 23 and no recommendations.</p> <p>In an in interview on 10/03/2024 at 9:34 AM Staff U (Divisional Director of Social Services) stated, after reviewing the record, they could not find a PASRR Level II for Resident 23. Staff U stated they would expect a referral and evaluation to be completed after the 01/29/2023 Notification of Determination.</p> <p>REFERENCE: WAC 388-97-1915 (4).</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203</b></p> <p>Based on interview and record review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASRR - a process to determine if a potential nursing home resident had mental health/intellectual disability needs which required further assessment/treatment) assessment was accurate to reflect the residents' mental health conditions for 3 of 7 (Residents 22, 57, &amp; 13) residents and 2 supplemental residents (Resident 185 &amp; 53) reviewed for PASRR. This failure placed residents at risk for inappropriate nursing home placement and/or not receiving timely and necessary services to meet their mental health needs.</p> <p>Findings included .</p> <p>&lt;Resident 22&gt;</p> <p>According to the 08/12/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 22 had diagnoses including depression, bipolar disorder, and Post Traumatic Stress Disorder (PTSD). The MDS showed Resident 22 took antidepressant medications. This MDS showed Resident 22 admitted on [DATE].</p> <p>According to the September 2024 Medication Administration Record (MAR), Resident 22 took two antidepressant medications (one first prescribed on 07/30/2022 and the second first prescribed on 05/10/2023), a medication to treat PTSD first prescribed on 05/24/2024, and an antianxiety medication first prescribed on 09/25/2024.</p> <p>Record review showed an 08/02/2022 Level I PASRR for Resident 22. This PASRR listed only a diagnosis of depression under the Serious Mental Illness [SMI] Indicators section. It did not include Resident 22's PTSD or bipolar diagnoses.</p> <p>A new Level I PASRR was completed by facility staff on 09/23/2024. This Level I PASRR had an admitted [DATE].</p> <p>In an interview on 10/04/2024 at 2:40 PM Staff U (Divisional Director of Social Services) stated it was important for PASRR forms to be accurate and updated with changes. Staff U reviewed Resident 22's chart and stated their PASRR should be updated when new SMI indicators were identified but was not.</p> <p>&lt;Resident 57&gt;</p> <p>According to the 09/03/2024 Significant Change MDS, Resident 57 had severely impaired memory, received hospice services, and had medically complex diagnoses including anxiety, bipolar disorder, and schizophrenia. The MDS showed Resident 57 received antipsychotic and antianxiety medications.</p> <p>Review of the physician's orders showed a 03/10/2024 order for an antipsychotic medication, a 07/25/2024 order for a second antipsychotic medication, and a 07/10/2024 order for a medication to treat anxiety.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review showed a 10/24/2023 Level I PASRR form. This PASRR showed Resident 57 had anxiety, bipolar, and schizophrenia diagnoses, and dementia. The Level I PASRR showed Resident 57 did not require a Level II Evaluation.</p> <p>In an interview on 10/04/2024 at 2:40 PM Staff U stated it was important for Level I PASRRs to be accurate. Staff U stated Level I PASRRs should be updated when necessary, including when a significant change was identified.</p> <p>46479</p> <p>&lt;Resident 13&gt;</p> <p>According to the 09/02/2024 Quarterly MDS, Resident 13 had diagnoses of anxiety, PTSD, bipolar disorder, and schizophrenia. The assessment showed Resident 13 was taking antipsychotic, antianxiety, and antidepressant medications. The MDS showed Resident 13's most recent admission to the facility was 09/13/2023.</p> <p>Review of Resident 13's 09/30/2024 physician orders showed the resident was receiving two different medications for anxiety, an antidepressant medication, one medication to treat bipolar disorder, and two different medications to treat their schizophrenia disorder.</p> <p>Review of Resident 13's 09/07/2023 Level I PASRR showed the evaluator marked no, indicating the resident did not have a SMI. The PASRR did not indicate Resident 13 had schizophrenia, mood, or anxiety disorders. The PASRR did not show whether Resident 13 had evidence of a SMI.</p> <p>In an interview on 10/02/2024 at 12:17 PM, Staff D (Social Services Director) reviewed Resident 13's PASRR and confirmed the form was incomplete. Staff D stated if Resident 13's Level I PASRR was completed, the resident would have a PASRR Level II assessment.</p> <p>43642</p> <p>&lt;Resident 185&gt;</p> <p>According to a 09/24/2024 Admission MDS, Resident 185 admitted to the facility on [DATE]. This MDS showed Resident 185 had multiple medically complex diagnoses including depression and required the use of an antidepressant medication during the assessment period.</p> <p>Review of Resident 185's September 2024 MAR showed the resident was receiving three different medications for depression.</p> <p>Review of a 09/18/2024 PASRR Level 1 showed Resident 185 had no SMI indicators. Staff did not identify the PASRR Level 1 was inaccurate on admission and did not include Resident 185's diagnosis of depression.</p> <p>In an interview on 10/02/2024 at 1:30 PM, Staff D stated an accurate PASRR Level 1 was important so a resident would get the services they required. Staff D stated their expectation was for a PASRR Level 1 to be accurate. Staff D reviewed Resident 185's PASRR Level 1 and stated it was inaccurate and needed to be revised.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>&lt;Resident 53&gt;</p> <p>According to a 09/02/2024 Admission MDS, Resident 53 admitted to the facility on [DATE]. This MDS showed Resident 53 had multiple medically complex diagnoses including depression and an anxiety disorder and required the use of antidepressant medications during the assessment period.</p> <p>Review of Resident 53's September 2024 MAR showed the resident was receiving an antidepressant medication for depression.</p> <p>Review of a 08/25/2024 PASRR Level 1 showed Resident 53 was identified with SMI indicators of a mood disorder, which included depression, and an anxiety disorder. Section four on the PASRR Level 1 was marked Resident 53 did not show indicators of SMI and no Level II evaluation was indicated. Staff did not correct section four of the 08/25/2024 PASRR Level 1 and refer Resident 53 for a PASRR Level II as required.</p> <p>In an interview on 10/04/2024 at 2:40 PM, Staff U reviewed Resident 53's records and stated staff should have, but did not correct the residents PASRR Level 1 and refer Resident 53 for a Level II evaluation.</p> <p>REFERENCE: WAC 388-97-1915(1)(2)(a-c).</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203</b></p> <p>Based on observation, interview, and record review the facility failed to develop and/or implement comprehensive Care Plan's (CP) for 6 of 20 sampled residents (Residents 53, 70, 32, 43, 45, &amp; 16) whose CPs were reviewed. The failure to develop comprehensive, individualized, or implement CPs with resident-specific goals and/or interventions, placed residents at risk for unmet care needs and a decreased quality of life.</p> <p>Findings included .</p> <p>&lt;Care Plan Development&gt;</p> <p>&lt;Resident 53&gt;</p> <p>According to a 09/02/2024 Admission Minimum Data Set (MDS - an assessment tool) Resident 53 was admitted to the facility on [DATE] with multiple medically complex diagnoses.</p> <p>Review of Resident 53's comprehensive CP showed an Establish the baseline Plan of Care problem was initiated by staff on admission. This CP, over 30 days after Resident 53's admission, did not have any measurable or individualized goals established by staff.</p> <p>&lt;Resident 70&gt;</p> <p>According to an 08/09/2024 Admission MDS, Resident 70 was admitted to the facility on [DATE] with multiple medically complex diagnoses. This MDS showed staff assessed Resident 70 had a functional limitation in range of motion to one side of the lower extremity, and normally used a wheelchair during the assessment period.</p> <p>Review of Resident 70's comprehensive CP, almost two months after the resident's admission to the facility, did not direct staff to the current ambulation status or what mobility device Resident 70 was assessed to require.</p> <p>In an interview on 10/04/2024 at 10:32 AM, Staff MM (Resident Care Manager - RCM) stated it was important to have a comprehensive CP, so staff were aware of the care and needs a resident requires. Staff MM stated CPs should be comprehensive, individualized, and have measurable goals.</p> <p>&lt;Resident 32&gt;</p> <p>Review of a 09/07/2024 Quarterly MDS showed Resident 32 admitted to the facility on [DATE] and had functional limitation in range of motion for upper and lower extremities, was dependent on staff for rolling left to right, was dependent on staff for Activities of Daily Living (ADLs), and had an unhealed pressure wound.</p> <p>Review of a Functional CP, revised on 05/22/2024, showed Resident 32's problem as resident has Establish the Baseline Plan of Care with functional abilities.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the revised 09/13/2024 Restorative CP for ADLs showed Resident 32's goal as resident will maintain current level of function with interventions for nursing staff to Refer to Baseline of care functional abilities.</p> <p>Review of the revised 11/08/2023 Physical Mobility CP showed Resident 32's task interventions as Refer to Baseline of care functional abilities.</p> <p>Review of Resident 32's records showed the most recent Baseline CP dated 07/07/2023 showed a handwritten 48 Hour Baseline CP form with checkboxes indicating Resident 32 needed two-person assistance with a mechanical lift for transfers and had a wheelchair.</p> <p>&lt;Resident 43&gt;</p> <p>According to a 07/03/2024 Admission MDS, Resident 43 admitted on [DATE] and had no memory impairment. The MDS showed Resident 43 was dependent on staff for toileting hygiene, lower body dressing, putting on/taking off footwear, and transfers. The MDS showed Resident 43 required maximal assistance from staff for showers/bathing, turning side to side in bed, going from a sitting position to a lying position, and going from lying in bed to sitting on side of bed. The assessment showed Resident 43 required setup for upper body dressing.</p> <p>Review of Resident 43's records showed a 07/06/2024 Impaired Physical Mobility CP and a revised 09/23/2024 ADL CP with refer to baseline CP as the only intervention listed.</p> <p>Review of Resident 43's records showed an 08/05/2024 physician order for a treatment to skin for Eczema (an inflammatory skin condition). Resident 43's records did not show a CP for the skin condition.</p> <p>&lt;Resident 45&gt;</p> <p>According to an 08/24/2024 Quarterly MDS, Resident 45 admitted on [DATE] and had no memory impairment. The MDS showed Resident 45 required supervision with some staff assistance for eating, oral hygiene, toileting hygiene, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS showed Resident 45 required maximal staff assistance with showers/bathing.</p> <p>Review of Resident 45's records showed a 06/03/2024 ADL CP with refer to baseline CP as the only intervention listed.</p> <p>&lt;Resident 16&gt;</p> <p>Review of Resident 16's records showed an 08/01/2024 diagnosis of paraplegia and chronic pain syndrome. Review of Resident 16's records showed no pain management CP.</p> <p>According to an 08/15/2024 Modified Discharge MDS, Resident 16 admitted on [DATE] and was severely cognitively impaired. The MDS showed Resident 16 was dependent on staff for toileting hygiene, upper/lower body dressing, putting on/taking off footwear, transfers, showers/bathing, turning side to side in bed, and going from a sitting position to a lying position.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 16's records showed an 08/09/2024 Impaired Physical Mobility CP and a revised 09/13/2024 ADL CP with refer to baseline CP as the only intervention listed.</p> <p>Review of Resident 16's records showed a 09/06/2024 referral for a Restorative Nursing Program (RNP) for both hand/arm and leg contractures. Review of Resident 16's records showed no RNP or contractures CP.</p> <p>In an interview on 10/03/2024 at 9:45 AM Staff BB (RCM) stated they were expected to develop comprehensive CPs within 14 days. Staff BB stated refer to baseline CP was not an acceptable CP and needed to list specific interventions for the residents as they progress with their cares.</p> <p>In an interview on 10/04/2024 at 8:59 AM, Staff B (Director of Nursing) stated Resident 16 did not have a pain CP but should because of their chronic pain diagnosis. Staff B stated it was important to develop a pain CP, so staff were providing individualized care to ensure their pain is managed appropriately. Staff B stated they expected staff to develop a comprehensive CP within 48-72 hours after admission. Staff B stated an intervention showing refer to baseline CP was not a comprehensive CP and staff should not be documenting that on the CP's. Staff B stated it is important to develop more individualized CPs to meet the specific resident needs with their treatment and cares.</p> <p>&lt;Care Plan Implementation&gt;</p> <p>&lt;Resident 16&gt;</p> <p>Review of an 08/01/2024 Baseline CP directed staff to keep Resident 16's heels elevated/floating.</p> <p>Review of a 09/13/2024 Actual Skin Impairments CP showed Resident 16 had pressure ulcers to both heels. The CP showed an intervention for Resident 16 was to follow facility policies/protocols for the prevention/treatment of skin breakdown.</p> <p>Observations on 10/02/2024 at 8:59 AM showed Resident 16 lying in bed without their heels elevated. A foam wedge cushion was lying on the floor by the table in the resident's room.</p> <p>In an interview on 10/02/2024 at 9:06 AM Staff BB stated Resident 16 should have both heels elevated at all times on the foam wedge cushion, but night shift did not have their heels elevated.</p> <p>In an observation and interview on 10/03/2024 at 5:21 AM, the foam wedge was lying on the floor and Resident 16's heels were lying directly on their bed. Staff AA (Registered Nurse - RN) stated Resident 16 should have both of their heels floating at all times, but they are not. Staff AA stated it was important to help in healing Resident 16's pressure ulcers to both of their heels.</p> <p>In an interview on 10/03/2024 at 5:28 AM Staff Z, (Certified Nursing Assistant - CNA) stated they did not know what Resident 16's CP directed them to do to relieve pressure from the resident's heels. Staff Z stated they were expected to implement care as directed by residents CP's. Staff Z stated they should have read through the CP to ensure they were providing care per Resident 16's CP.</p> <p>&lt;Resident #32&gt;</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Canterbury House		STREET ADDRESS, CITY, STATE, ZIP CODE  502 29th Street Southeast Auburn, WA 98002	
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a 09/07/2024 Quarterly MDS showed Resident 32 had functional limitation in range of motion for upper and lower extremities, was dependent on staff for rolling left to right, was dependent on staff for ADLs. The MDS showed the Resident 32 was understood, had clear speech, and had moderate memory impairment.</p> <p>Review of the Functional CP, revised on 05/22/2024, showed Resident 32 needed two people to assist with bed mobility, rolling from left to right, turning, and repositioning routinely.</p> <p>Review of a Pressure wound CP, revised on 06/04/2024, showed staff were to reposition Resident 32 every two hours.</p> <p>Review of a Pain CP, revised on 05/21/2024, showed Resident 32 had a potential for pain related to limited and decreased mobility, interventions were to turn and reposition resident every two hours and as needed.</p> <p>Review of a Respiratory CP, revised on 05/22/02024, showed Resident 32 was on oxygen therapy for respiratory failure with interventions to change resident's position every two hours to facilitate lung secretion movement and drainage.</p> <p>Review of September 2024 Treatment Administration Record (TAR) showed routine turning and positioning was ordered for Resident 32 on 01/09/2024. Resident 32's TAR showed staff initialed this task was completed every shift.</p> <p>Observation on 09/30/2024 at 9:17 AM showed Resident 32 sitting up in bed with the head of bed elevated. Resident 32 stated the staff did not come in to reposition them, but they should be.</p> <p>Observation on 10/01/2024 at 9:18 AM showed Resident 32 was sitting up with head of bed elevated.</p> <p>Observation on 10/02/2024 at 9:00 AM showed Resident 32 sitting up. Resident 32 was unable to reach the bed control remote to raise the head of bed up and do their painting activity.</p> <p>In an interview on 10/03/2024 at 10:00 AM Resident 32 stated the staff do not help the with turning, they used to, but they do not anymore.</p> <p>Observation on 10/03/2024 at 11:29 AM showed Resident 32 telling Staff J (RCM) they would like staff to turn them.</p> <p>In an interview on 10/03/2024 at 11:03 AM, Staff P (CNA) stated they turned Resident 32 every two hours. Staff P stated the resident was confused and did not know they were turned. Staff P stated they did not document if the resident refused to be repositioned.</p> <p>In an interview on 10/03/2024 at 11:13 AM Staff J stated Resident 32 needed two people to reposition the resident and expected the care staff to reposition the resident every two to three hours. Staff J stated staff should be turning the resident every two hours and before and after meals.</p> <p>In an interview on 10/04/2024 at 9:18 AM Staff H (RN) stated the staff try to turn Resident 32 but the resident refuses staff assistance.</p> <p>(continued on next page)</p>		

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F 0656  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	REFERENCE: WAC 388-97-1020(1), (2)(a-f).  43642  47836  50511

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43642</p> <p>Based on observation, interview, and record review the facility failed to ensure Care Plans (CPs) were updated and/or revised as needed to reflect person-centered care for 4 (Residents 70, 53, 185, &amp; 13) of 20 sample residents whose CPs were reviewed. The facility failed to ensure residents received and/or participated in care conferences that included the Interdisciplinary Team (IDT) for 2 (Residents 21 &amp; 43) residents reviewed. These failures left residents at risk for unmet care needs, inappropriate care, and other negative health outcomes.</p> <p>Findings included .</p> <p>&lt;Care Plan Revision&gt;</p> <p>&lt;Resident 70&gt;</p> <p>According to an 08/09/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 70 was admitted to the facility on [DATE] with multiple medically complex diagnoses.</p> <p>Review of Resident 70's comprehensive CP showed an Establish the baseline Plan of Care problem was initiated by staff on admission. This CP listed an intervention that Resident 70 was on isolation precautions for having a Peripherally Inserted Central Catheter (PICC - a long, thin, flexible tube that's inserted into a vein in the upper arm and threaded into a larger vein above the heart). Review of Resident 70's records showed this PICC line was discontinued on 08/20/2024.</p> <p>&lt;Resident 53&gt;</p> <p>According to a 09/02/2024 Admission MDS, Resident 53 had multiple medically complex diagnoses including heart failure and required the use of oxygen during the assessment period.</p> <p>Observations on 09/29/2024 at 10:05 AM showed Resident 53 lying in bed using oxygen and an unplugged humidifier container next to an oxygen concentrator machine.</p> <p>Review of Resident 53's 09/04/2024 oxygen therapy CP showed the resident had oxygen therapy r/t [related to]. Staff did not complete the reason the resident required the oxygen therapy. This CP listed an oxygen setting intervention for, humidified (SPECIFY). Staff did not specify if the oxygen was to be used with a humidifier.</p> <p>&lt;Resident 185&gt;</p> <p>According to a 09/24/2024 Admission MDS, Resident 185 admitted to the facility on [DATE] and had multiple medically complex diagnoses. This MDS showed staff assessed Resident 185 to require substantial assistance from staff to roll side to side in bed and was dependent on staff for toileting hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 185's 09/18/2024 Baseline CP showed an intervention for: TOILETING SCHEDULE: (SPECIFY) and COMMUNICATION: PRIMARY LANGUAGE: (SPECIFY). Staff did not indicate what the toileting schedule was or the primary language for Resident 185.</p> <p>In an interview on 10/04/2024 at 10:32 AM, Staff MM (Resident Care Manager - RCM) stated their expectation was for CPs to be updated and revised to reflect the resident's current conditions. Staff MM stated Resident 70, 53, and 185's CP's needed to be updated and revised.</p> <p>46479</p> <p>&lt;Resident 13&gt;</p> <p>According to the 09/02/2024 Quarterly MDS, Resident 13 had no memory loss. This MDS showed Resident 13 was taking antipsychotic, antianxiety, and antidepressant medications. The MDS showed Resident 13 experienced two falls during the assessment period.</p> <p>Review of a 06/12/2024 incident report showed Resident 13 experienced a fall when observed by facility staff putting themselves on the floor next to their bed. Review of a 07/31/2024 incident report showed Resident 13 had an unwitnessed fall when they were found lying next to their bed by staff.</p> <p>Review of Resident 13's 04/06/2023 High Risk for Falls CP showed interventions including to remind the resident about safety measures, follow the facility fall protocol, ensure the resident's call light was within reach, and review information on past falls and attempt to determine cause of falls . This CP showed no new interventions after Resident 13 fell in June 2024 and July 2024.</p> <p>&lt;Care Conferences&gt;</p> <p>&lt;Resident 21&gt;</p> <p>According to the 08/21/2024 Annual MDS, Resident 21 had no memory impairment, was understood, and could understand others in conversation. The MDS showed Resident 21 had diagnoses including heart failure, high blood pressure, the inability to control their blood sugars, anxiety, and depression.</p> <p>In an interview on 09/30/2024 at 9:34 AM, Resident 21 stated they were unfamiliar with care conferences and stated they did not have a care conference while at the facility.</p> <p>Review of a 03/14/2024 quarterly Care Conference evaluation form showed the resident, their significant other, and a social services staff person attended the care conference. The form showed the resident was invited to the care conference on 03/14/2024, the same day the care conference occurred. The nursing section of the form showed staff documented the resident was stable this quarter. This document showed no licensed nurses, direct care staff, dietary, therapy, or activities staff attended the care conference. The evaluation showed the care conference did not include the IDT.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a 06/03/2024 quarterly Care Conference evaluation form showed Resident 21 was invited to the care conference on 06/03/2024, the same day the care conference occurred. The nursing section of the form showed staff documented the resident was stable this quarter. This document showed the only staff member present was Staff D (Social Services Director). This document showed no licensed nurses, direct care staff, dietary, therapy, or activities staff attended the care conference. The evaluation showed the care conference did not include the IDT.</p> <p>In an interview on 10/02/2024 at 10:47 AM, Staff D stated care conferences usually included the social services assistant and the resident. Staff D stated RCMs would attend the care conference only if there were nursing concerns. Staff D stated it was important to include the IDT as part of care conferences because if residents had any issues or concerns, the resident's needs could be met at that time.</p> <p>In an interview on 10/04/2024 at 10:48 AM, Staff B (Director of Nursing) confirmed care conferences should consist of the IDT. Staff B stated residents should have prior notice of the care conference meetings.</p> <p>47836</p> <p>&lt;Resident 43&gt;</p> <p>According to a 07/03/2024 Admission MDS, Resident 43 admitted on [DATE] and had no memory impairment. The MDS showed Resident 43 had diagnoses of pressure ulcers, lower spinal cord injury, and chronic pain syndrome.</p> <p>In an interview on 09/30/2024 at 9:10 AM, Resident 43 stated they had a care conference when they first admitted but did not hear anything about scheduling another one. Resident 43 stated they would appreciate a care conference so they could know where they were at towards their goal of returning to their home.</p> <p>In an interview on 10/02/2024 at 12:33 PM, Staff D stated Resident 43 was overdue for their quarterly care conference. Staff D stated they usually had an assistant that arranged care conferences, but they did not have an assistant for about three weeks, so care conferences were not being done per regulation, and Resident 43 did not have one scheduled.</p> <p>In an interview on 10/04/2024 at 10:33 AM Staff A (Executive Director) stated they expected care conferences to be done upon admission within the first few days of being at the facility, quarterly, and as needed if residents/resident representatives request or the resident had a change of condition. Staff A stated they expected CP's to be updated and revised to reflect the resident's current conditions.</p> <p>REFERENCE: WAC 388-97-1020(2)(c)(d), (4)(c)(i-ii).</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>42203</p> <p>Based on observation, interview, and record review the facility failed to ensure physician's orders were clarified for 1 of 21 sample residents (Resident 29), or followed for 2 of 21 sample residents (Residents 4 &amp; 3). These failures placed residents at risk for unneeded care and unmet care needs.</p> <p>Findings included .</p> <p>43642</p> <p>&lt;Clarifying Orders&gt;</p> <p>&lt;Resident 29&gt;</p> <p>According to the 07/10/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 29 had medically complex diagnoses including cancer and high cholesterol.</p> <p>Review of the physician's orders showed a 08/15/2024 order for a fiber supplement, give one pill as needed. The order did not include a dosage.</p> <p>In an interview on 10/04/2024 at 2:13 PM Staff B (Director of Nursing) stated the order should include a dose and needed clarification</p> <p>&lt;Following Orders&gt;</p> <p>&lt;Resident 4&gt;</p> <p>According to the 09/04/2024 Quarterly MDS, Resident 4 had medically complex diagnoses including a chronic ulcer. The MDS showed Resident 4 received opioid medications.</p> <p>Record review showed a 12/06/2023 order for an opioid pain medication, give twice a day for chronic pain. The order showed staff should hold the medication if Resident 4's respiratory rate was lower than 14 breaths per minute.</p> <p>Observation of medication pass on 10/03/2024 at 8:22 AM showed Staff H (Registered Nurse) failed to measure Resident 4's respirations prior to administering the opioid pain medication.</p> <p>In an interview on 10/04/2024 at 2:13 PM Staff B stated it was important for orders to be followed, including adhering to the parameters for administration.</p> <p>&lt;Resident 3&gt;</p> <p>According to the 06/26/2024 Annual MDS, Resident 3 had diagnoses including heart failure, high blood pressure, and difficulty swallowing. The MDS showed Resident 3 took regular and as needed pain medications.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the July 2024 Medication Administration Record (MAR) showed a 09/01/2022 order for a medication to treat Resident 3's high blood pressure. The order directed nurses to hold the medication if Resident 3's heart rate dropped below 60 Beats Per Minute (BPM). The MAR showed on 07/28/2024 the medication was administered when Resident 3's heart rate was measured at 59 BPM.</p> <p>The September 2024 MAR showed Resident was given the blood pressure medication on 09/22/2024 for a heart rate of 51 BPM.</p> <p>The July 2024 MAR included a calorie-dense supplement, give 90 Cubic Centimeters (CC) twice a day. This MAR showed on 29 occasions Resident 3 was given 60 CC, on 17 occasions was given 120 CC, and one occasion 15 CC.</p> <p>The August 2024 MAR showed on 21 occasions Resident 3 was given 120 CC and on 33 occasions was given 60 CC.</p> <p>The September MAR showed on six occasions Resident 3 was given 120 CC of the calorie dense supplement, on three occasions was given 60 CC, and on one occasion was given 100 CC.</p> <p>In an interview on 10/04/2024 at 2:13 PM Staff B stated they expected staff to check Resident 3's respiration rate prior to giving the blood pressure medication. Staff B stated they expected nurses to follow orders and adhere to physician's ordered parameters.</p> <p>REFERENCE: WAC 388-97 -1620(2)(b)(i)(ii),(6)(b)(i).</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203</b></p> <p>Based on observation, interview, and record review the facility failed to ensure assistance with Activities of Daily Living (ADL - personal hygiene and other daily routines) was provided for 8 of 11 residents reviewed for ADL (Residents 70, 21, 20, 13, 22, 43, 16, &amp; 45). The failure to provide assistance with getting out of bed, nail care, and bathing placed residents at risk of poor hygiene, diminished sense of self-worth, skin impairment, and frustration.</p> <p>Findings included .</p> <p>43642</p> <p>&lt;Assistance With Getting Out of Bed&gt;</p> <p>&lt;Resident 70&gt;</p> <p>According to an 08/09/2024 Admission MDS, Resident 70 had no memory impairment, was assessed with a functional limitation in range of motion to one side of the lower extremity and had no rejection of care. This MDS showed staff assessed Resident 70 required substantial assistance to roll side to side in bed, was dependent on staff for upper and lower dressing, and transfers from bed to chair were not attempted due to medical condition or safety concerns.</p> <p>Observations on 09/29/2024 at 9:45 AM and 12:58 PM, 09/30/2024 at 8:26 AM showed Resident 70 lying in bed wearing a gown. In an interview on 09/30/2024 at 10:58 AM, Resident 70 stated they were frustrated staff did not assist them to get up out of bed daily.</p> <p>Observations on 10/01/2024 at 8:53 AM showed Resident 70 lying in bed wearing a gown. In an interview on 10/04/2024 at 9:17 AM, Resident 70 stated the last time staff assisted them to get dressed and out of bed was for their last appointment out of the facility on 09/24/2024, 10 days previously. Resident 70 stated the staff did not offer them to get up and indicated they would get out of bed if offered.</p> <p>Review of an 08/12/2024 functional ability Care Area Assessment (CAA) for Resident 70 showed staff documented the resident required assistance from staff to roll from side to side in bed and required dependent assistance to move from sitting to standing with chair/bed transfers. This CAA showed staff assessed Resident 70 to require assistance with upper and lower body dressing.</p> <p>Review of Resident 70's comprehensive Care Plan (CP) on 09/30/2024 showed no directions to staff regarding the resident's ambulation status or interventions to encourage or assist the resident to get up out of bed daily.</p> <p>In an interview on 10/04/2024 at 2:55 PM, Staff N (Certified Nursing Assistant) stated, physical therapy gets them [the residents] up, they [the residents] are already up when asked if any residents required assistance on Resident 70's unit. Staff N stated Resident 70 never asked them to get up out of bed.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 10/04/2024 at 10:32 AM, Staff MM (Resident Care Manager - RCM, Registered Nurse - RN) stated it was their expectation that staff assist residents who require help to get dressed and out of bed daily. Staff MM stated Resident 70 required staff help and should be assisted each morning.</p> <p>Observations on 10/04/2024 at 2:11 PM showed Resident 70 in the hallway sitting in their wheelchair smiling.</p> <p>&lt;Resident 21&gt;</p> <p>According to the 08/21/2024 Annual MDS, Resident 21 had no cognitive impairment. The assessment showed Resident 21 had clear speech, was understood, and could understand others in conversation. The assessment showed Resident 21 was totally dependent on staff assistance for transferring from their bed to wheelchair and had no rejection of care during the assessment period.</p> <p>Review of Resident 21's Kardex (directions to care staff) on 09/30/2024 showed the resident required the assistance of two staff members and a mechanical lift to be transferred from the bed to their wheelchair. The Kardex directed staff to assist the resident out of bed every Tuesday, Thursday, and Saturday evening.</p> <p>In an observation and interview on 09/30/2024 at 9:13 AM, Resident 21 was lying in bed. Resident 21 stated they have not been out of bed and the staff do not offer to get them up. Resident 21 stated it would be nice if [staff] would get me out of bed for an hour or so.</p> <p>An observation and interview on 10/01/2024 at 9:01 AM showed Resident 21 lying in bed. Resident 21 stated they had a brand-new wheelchair in their bathroom that they have never used. Observation at that time showed a wheelchair in the resident's bathroom. The chair appeared brand-new. There were no signs of wear and tear, and the product packet was resting on the seat of the wheelchair.</p> <p>In an interview on 10/03/2024 at 7:57 AM, Staff J (RCM) stated it was their expectation direct care staff offered to assist resident's out of bed every day.</p> <p>In an interview on 10/04/2024 at 10:51 AM, Staff B stated it was their expectation staff offered to assist residents out of bed each day if the resident was able/willing. Staff B stated staff should document if a resident refuses to get out of bed.</p> <p>44296</p> <p>&lt;Nail Care&gt;</p> <p>&lt;Resident 20&gt;</p> <p>According to the 9/20/2024 Quarterly MDS, Resident 20 had limited range of motion and depended on staff to complete all personal hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review showed the 07/18/2024 skin integrity CP included a goal for Resident 20's nails to be kept short, related to their hand contracture (permanent tightening of the tendons, causing the fingers to curl in) to maintain intact skin. The CP showed staff should keep Resident 20's hands from excessive moisture and keep their fingernails short.</p> <p>According to a 09/03/2024 physician's order, staff should do a weekly audit of Resident 20's skin for new impairment every Tuesday.</p> <p>Review of the September 2024 Treatment Administration Record (TAR) showed Staff documented that skin audits were completed on 09/03/2024, 09/10/2024, 09/17/2024, and 09/24/2024.</p> <p>Observation on 10/04/2024 at 11:14 AM, showed Resident 20's fingernails were long, extending half an inch above the end of the fingertip. The nail edges were rough and uneven. The fourth fingernail on Resident 20's left hand had a jagged sharp corner that corresponded with a cut on their left palm. Resident 20 had indentations in the palm of their right hand that corresponded with the second, third, and fourth fingernails on the right hand. The nails on both thumbs were long and chipped. Staff H (Licensed Practical Nurse - LPN) stated Resident 20's fingernails were too long and needed to be trimmed and filed.</p> <p>In an interview on at, Staff I (Occupational Therapist) stated Resident 20 should have gauze or a washcloth in their left hand. Staff I stated Resident 20's nails should be kept short to prevent skin injuries to the palm.</p> <p>46479</p> <p>&lt;Bathing&gt;Showers&gt;</p> <p>&lt;Resident 21&gt;</p> <p>Review of the 08/21/2024 Annual MDS showed Resident 21 had no cognitive impairment. This MDS showed it was very important to Resident 21 to choose between a shower or bed bath and the resident was dependent on staff for bathing assistance. This MDS showed Resident 21 did not reject care during the lookback period of the assessment.</p> <p>Review of Resident 21's 12/22/2023 Baseline Plan of Care CP showed Resident 21 preferred showers or bed baths and preferred bathing twice weekly. This CP showed the resident would receive bathing assistance on Tuesday and Friday evenings.</p> <p>In an interview on 09/30/2024 at 9:13 AM, Resident 21 stated they would like to go to the shower and that they have only been to the shower a couple of times. Resident 21 stated they mostly received bed baths and said their hair was never clean enough with a bed bath.</p> <p>Review of the June 2024 bathing task record showed Resident 21 received bathing assistance on two of eight opportunities for the month. Three of the bathing opportunities showed blank documentation and three opportunities show staff documented N/A [not applicable]. There were no progress notes or either documentation showing Resident 21 refused bathing assistance from staff.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the July 2024 bathing task record showed Resident 21 received bathing assistance on three of nine bathing opportunities for the month. Three of the bathing opportunities show blank documentation by staff and three opportunities show staff documented N/A. There were no progress notes or documentation showing Resident 21 refused bathing assistance from staff.</p> <p>Review of the August 2024 bathing task record showed Resident 21 received bathing assistance on three of nine bathing opportunities for the month. On six of the bathing opportunities, staff documented N/A. There were no progress notes or documentation showing Resident 21 refused bathing assistance from staff.</p> <p>&lt;Resident 13&gt;</p> <p>Review of the 09/02/2024 Quarterly MDS showed Resident 13 had no cognitive impairment. This MDS showed it was very important for Resident 13 to choose between a shower and bed bath and the resident required partial/moderate assistance from staff to shower/bathe themselves. This MDS showed Resident 13 rejected care one to three days during the assessment's lookback period.</p> <p>Review of Resident 13's 10/03/2023 Baseline Plan of Care CP showed the resident preferred showers twice weekly on Tuesday and Friday evenings.</p> <p>Observation on 09/30/2024 at 8:49 AM showed Resident 13 lying in bed asleep. Their hair was unkempt and greasy. Resident 13's room had an overwhelming smell of body odor and urine. Similar observations were made on 10/01/2024 at 10:25 AM.</p> <p>Review of Resident 13's July 2024 bathing task record showed the resident received one shower per their preferred schedule and three as needed showers for the month of July. This record showed on six occasions, Resident 13 was not offered a shower. On two occasions, staff documented N/A. There were no progress notes or documentation showing Resident 13 was offered and refused a shower.</p> <p>Review of Resident 13's August 2024 bathing task record showed the resident received zero showers per their stated schedule and received two as needed showers for the month of August. This record showed on six occasions, Resident 13 was not offered a shower. On two occasions, staff documented N/A. There were no progress notes or documentation showing Resident 13 was offered and refused a shower</p> <p>Review of Resident 13's September 2024 bathing task record showed Resident 13 received one scheduled bed bath and three as needed showers. The documentation shows on eight occasions, the resident was not offered a shower per their preferred schedule. The documentation shows Resident 13 refused one shower, on 09/18/2024.</p> <p>&lt;Resident 22&gt;</p> <p>According to the 01/12/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 22 had intact cognition and showed no rejection of care during the assessment's lookback period. The MDS showed Resident 22 was dependent on staff for ADL assistance and did not receive a bath or shower during the assessment's lookback period due to safety concerns. The MDS showed Resident 22 had frequent bowel incontinence.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 22's comprehensive Care Plan (CP) showed a 03/10/20024 ADL CP. This CP showed Resident 22 was scheduled to receive bathing assistance twice a week on Wednesday and Saturdays from two Certified Nursing Assistants (CNAs).</p> <p>In an interview on 09/29/2024 at 12:17 PM Resident 22 stated they were supposed to get bathing assistance Wednesdays and Saturdays. Resident 22 stated they normally received a shower Saturday but had difficulty getting bathing assistance on Wednesdays. Resident 22 stated they had to demand bathing assistance on occasion. on</p> <p>Record review showed in August 2024 Resident 22 received bathing assistance on three of five Saturdays (the 3rd, 24th, and 31st), and on two of four Wednesdays (the 14th and 21st). Resident 22 did not receive bathing assistance between 08/03/2024 and 08/14/2024, a wait of 11 days between baths. There were no documented refusals.</p> <p>Record review showed in September 2024 Resident 22 did not receive bathing assistance until 09/14/2024. Resident 22 went 13 days with no documented refusals. Resident 22 received bathing assistance on one Saturday (the 14th), and one Wednesday (the 25th) with refusals documented on 09/21/2024 and 09/25/2024 (Resident 22 accepted bathing assistance later that day.)</p> <p>In an interview on 10/04/2024 at 10:54 AM, Staff B (Director of Nursing) stated if residents refuse shower/bathing assistance, staff should be documenting the refusals. Staff B stated it was their expectation staff honored resident preferences for showering and bathing. Staff B stated shower aides were sometimes pulled to work the floor if staff called off from their scheduled shifts.</p> <p>47836</p> <p>&lt;Resident 43&gt;</p> <p>According to a 06/27/2024 Baseline CP, Resident 43 was to receive showers, per their preference, two times a week on Mondays and Thursdays. The CP showed Resident 43 required two staff assistance with transfers for showers and one-person maximal assistance with the shower.</p> <p>According to a 07/03/2024 Admission MDS, Resident 43 stated it was very important for them to be able to choose between a bed bath or shower. The MDS showed Resident 43 required maximal staff assistance with showers.</p> <p>Review of a facility bathing schedule showed Resident 43 would be offered showers every Monday and Thursday on evening shift.</p> <p>Review of Resident 43's July 2024 bathing records showed they were only offered and received a bed bath on 07/01/2024 and 07/11/2024 and a shower on 07/12/2024. Resident 43's August 2024 records showed they were only offered and received a bed bath on 08/05/2024, 08/15/2024, and 08/26/2024. Resident 43's September 2024 records showed they were only offered but refused bathing on 09/09/2024 and 09/19/2024.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 09/30/2024 at 9:15 AM Resident 43 stated they preferred showers, but staff told them they could not have showers. Resident 43 stated the few times staff had offered them a bed bath, they would only wipe their back after changing their brief and not provide a full body bed bath. Resident 43 stated when they developed maggots in their wound the contracted wound Physician Assistant told them they were very dirty and needed to be cleaned, but staff would not shower them or give them a full, thorough bed bath.</p> <p>In an interview on 10/03/2024 at 9:49 AM Staff BB (RCM, RN) reviewed Resident 43's records and stated the CP showed they preferred showers and were supposed to be offered showers every Monday and Thursday. Staff BB reviewed Resident 43's records and stated Resident 43 was not offered bathing seven of the nine assigned days for July 2024, six of the nine assigned days for August 2024, and seven of the nine assigned days for September 2024. Staff BB stated it was important to offer showers per Resident 43's preferences to ensure they were honoring the resident's rights. Staff BB stated Resident 43 should have been offered showers twice weekly, but they were not.</p> <p>&lt;Resident 16&gt;</p> <p>Review of Resident 16's CP showed an 08/01/2024 Baseline CP that instructed staff Resident 16 was dependent on staff for bathing. Resident 16's baseline CP did not direct staff on their bathing preferences or their assigned days/times. Resident 16's 08/09/2024 ADL CP showed refer to baseline CP as the only ADL intervention listed.</p> <p>According to a 08/07/2024 Admission MDS, Resident 16 admitted to the facility on [DATE] and was severely cognitively impaired. The assessment showed a Resident Representative participated for the facility to obtain Resident 16's goals/wishes. The MDS showed it was very important to Resident 16 to choose between a bath or a shower. The assessment showed Resident 16 was dependent on staff for bathing/showers. The MDS showed Resident 16 had diagnoses of Alzheimer's dementia, paraplegia, anxiety disorder, depression, pressure ulcers, adult failure to thrive, and chronic pain syndrome.</p> <p>Review of a facility bathing schedule showed Resident 16 would be offered showers every Monday and Thursday on evening shift.</p> <p>In an interview on 10/03/2024 at 9:45 AM Staff BB reviewed Resident 16's records and stated Resident 16 was not offered bathing two of nine assigned days for September 2024 per bathing schedule but should have been. Staff BB stated Resident 16's CP should reflect their bathing preference and the assigned bathing days/times per facility bathing schedule of every Monday and Thursday evening shift.</p> <p>&lt;Resident 45&gt;</p> <p>According to a 08/24/2024 Quarterly MDS, Resident 45 admitted to the facility on [DATE] with no memory impairment. The MDS showed it was very important to Resident 45 to choose between a bath or a shower. The assessment showed Resident 16 required maximal assistance from staff for bathing/showers. The MDS showed Resident 45 had diagnoses of yeast infection to skin and nails, morbid obesity, depression, and anxiety disorder.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 45's CP showed a 05/24/2024 baseline CP with bathing (specify). Resident 45's baseline CP showed bathing frequency, days of week and time of day were all left blank. Resident 45's revised 05/31/2024 baseline CP for bathing transfer showed res dependent on 2 staff for transfers and a revised 08/08/2024 baseline cp for bathing assistance showed res required maximal assist from two staff with their shower/bath. Resident 45's records showed a revised 09/23/2024 ADL CP, without bathing addressed and refer to baseline CP as the only ADL intervention listed.</p> <p>Review of a facility bathing schedule showed Resident 45 would be offered showers every Monday and Thursday on evening shift.</p> <p>Review of Resident 45's May 2024 records showed they were only offered and received a bed bath on Thursday 05/30/2024. Resident 45's June 2024 records showed they were not offered bathing on 06/03/2024, 06/24/2024, or 06/27/2024, per shower schedule. Resident 45's July 2024 records showed they were not offered bathing on 07/08/2024, 08/15/2024, 07/22/2024, or 07/25/2024, per bathing schedule. Resident 45's August 2024 records showed they were not offered bathing on 08/01/2024, 08/05/2024, 08/08/2024, 08/19/2024, or 08/29/2024, per bathing schedule. Resident 45's September 2024 records showed they were not offered bathing on 09/02/2024, 09/09/2024, 09/12/2024, or 09/16/2024, per bathing schedule. Resident 45's October 2024 records showed they were not offered bathing on 10/03/2024, per bathing schedule.</p> <p>In an interview on 10/03/2024 at 9:45 AM Staff BB reviewed Resident 45's records and stated Resident 45 was not offered bathing one of the two assigned days for May 2024, three of the eight assigned days for June 2024, four of the nine assigned days for July 2024, five of the nine assigned days for August 2024, and four of the nine assigned days for September 2024. Staff BB stated Resident 45's CP should reflect their bathing preference and the assigned bathing days/times per facility bathing schedule of every Monday and Thursday evening shift. Staff BB stated their expectation of staff was to offer bathing per resident preference and document if the resident refused or what type of bathing they accepted. Staff BB stated they expected staff to document on the assigned days and any additional days that bathing was needed or requested by the resident.</p> <p>Refer to F725 - Sufficient Nursing Staff</p> <p>REFERENCE: WAC 388-97-1060(2)(c).</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>50511</p> <p>Based on observation, interview, and record review the facility failed to ensure activity programs met the needs of each resident for 1 of 5 sample residents (Resident 32) reviewed for activities. Failure to provide meaningful activities left residents at risk for boredom, frustration, and a diminished quality of life.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's updated July 2015 Activities Program policy the facility would provide an ongoing program of activities designed to meet the interests as well as physical, mental, and psychosocial well-being of each resident. For residents confined to their room, the Activity Department would provide and assist with in-room activities in keeping with needs, abilities, and interests of residents.</p> <p>&lt;Resident 32&gt;</p> <p>According to a 05/15/2024 Quarterly Admission Minimum Data Set (MDS - an assessment tool) activities were very important for Resident 32. The MDS showed Resident 32 preferred to have books and newspapers, listen to music, and participate in their activities of choice. The assessment showed Resident 32 had moderate memory impairment and could communicate their needs, be understood by others, and had a diagnosis of depression.</p> <p>Record Review showed a physician's order dated 01/08/2024 for Resident 32 to participate in activities as tolerated.</p> <p>Review of a revised 05/21/2024 Activities Care Plan (CP) showed goals for Resident 32 to participate in one-on-one activities two-to-three times weekly including painting, arts and crafts, and coloring. The CP included interventions showing Resident 32 should receive assistance with activity functions, was dependent on staff for bed mobility, and had limited range of motion.</p> <p>Review of the activity participation records showed staff provided one-on-one activities to resident every day from 09/24/2024 through 10/04/2024.</p> <p>In an interview on 09/30/2024 at 9:07 AM Resident 32 stated they would like more activities; they enjoyed puzzles and music. Resident 32 stated staff did not bring puzzles to them, and they did not receive the daily activity sheet.</p> <p>In an interview on 10/01/2024 at 9:18 AM Resident 32 stated staff gave them a puzzle once, and the puzzle was no longer in their room. Observation at that time showed Resident 32 had their television on in their room, and no puzzles, books, or magazines were available.</p> <p>(continued on next page)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 10/03/2024 at 10:00 AM showed no daily activity sheet in the resident's room with no other activities available in the resident's room except a completed painting from 10/02/2024 on the cabinet behind Resident 32.</p> <p>Observation on 10/04/2024 at 9:13 AM showed the daily activity sheet was not provided to the resident.</p> <p>Observation on 10/04/2024 at 10:51 AM showed Staff Y (Certified Nursing Assistant) walk past Resident 32's room with a rolling cart of activities including puzzles, coloring, art supplies, and other items. Staff Y did not stop at Resident 32's room to offer any activities or to provide a calendar.</p> <p>In an interview on 10/04/2024 at 10:53 AM, Staff Y stated they just started helping with the activities department. Staff Y stated they handed out activity calendars at 9:00 AM and stated they did provide Resident 32 with an activity calendar. Staff Y stated when a resident was interested, they provided activities to the resident. Staff Y stated Resident 32 was not on the schedule to receive activities that day and that was why they passed Resident 32's room. Staff Y stated the prior day (10/03/2024) they provided an activity sheet to Resident 32 and provided one-on-one time.</p> <p>In an interview on 10/04/2024 at 10:56 AM Resident 32 stated they did not receive an activity sheet that day. No activity sheet was observed in Resident 32's room.</p> <p>In an interview on 10/02/2024 at 8:50 AM Staff X (Activities Director) stated Resident 32 should have one-on-one activities. Staff X stated Resident 32 liked painting and should be provided with activities. For residents that were bed bound, activity staff should deliver the activities schedule to the resident daily rather than posting it on the resident's door. Staff X stated activities staff should document the activities they provided for the resident. Staff X stated care staff were expected to turn on the television and see what activities they could set up for a resident.</p> <p>In an interview on 10/04/2024 at 2:06 PM, Staff X stated they would talk with their activities team about providing activities with Resident 32. Staff X stated activities should be provided two to three times weekly for the resident and staff should check the daily activities and offer activities at that time.</p> <p>REFERENCE: WAC 388-97-0940 (1).</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47836</b></p> <p>Based on observation, interview, and record review the facility failed to consistently assess and monitor change in condition and implement provider orders timely for 1 of 1 resident (Resident 16) reviewed for significant injury of unknown origin. Resident 16 experienced harm when there was a delay in assessment and treatment by a medical professional and the resident required surgical intervention for a large, expanding hematoma to their right calf, and a blood transfusion for a critically low blood count. These failures placed all residents at risk for delay in treatment, worsening of condition, unmet care needs, and decreased quality of life.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to a facility policy titled, Skin Integrity, revised October 2022, nursing staff would complete a full body skin assessment weekly. The policy showed when a skin impairment was identified after admission, the facility would place the resident on alert charting for the skin impairment. The policy showed staff would document the notification of the skin impairment to the physician and the resident representative in the resident's records. The policy showed the facility would implement new interventions and document on the resident's care plan. The policy showed the staff would notify the Director of Nursing (DON) of skin impairments that indicated a potential significant change in condition such as a hematoma. The policy showed the DON would document their assessment of the skin impairment in the resident's records in a nursing note. The policy showed the significant bruising would be evaluated and documented weekly by nursing staff in the resident's records.</p> <p>Review of the facility policy titled, Abuse Protection, revised October 2022, showed the facility would respond immediately to suspicion/allegations of abuse/neglect. The policy showed the facility would examine the alleged victim for signs of injury which included a physical examination and/or a psychological examination. The policy showed the facility would provide medical treatment as needed.</p> <p>&lt;Resident 16&gt;</p> <p>Review of Resident 16's records showed an 08/01/2024 skin assessment upon admission that only showed no new skin impairments were identified but did not have an assessment of the three pressure ulcers Resident 16 admitted with. There were no other weekly skin assessments in Resident 16's records.</p> <p>According to the 08/07/2024 Admission MDS, Resident 16 admitted to the facility on [DATE] and was severely cognitively impaired. Resident 16 had diagnoses of three active pressure ulcers, paraplegia, non-Alzheimer's dementia, and chronic pain syndrome. The assessment showed Resident 16 was taking blood thinner medications during the assessment period. The MDS showed no hematomas or other non-pressure skin concerns were identified at time of the assessment.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 16's records showed an order was placed by the facility Physician Assistant (PA) on 08/13/2024 to obtain an ultrasound STAT (immediately) of the right leg. Resident 16's records showed an 08/15/2024 progress note from the contracted wound PA that instructed staff to send Resident 16 to the hospital for the right calf hematoma. Resident 16's records showed no nursing skin assessments of the hematoma, no pain assessments were completed, no ultrasound was obtained, and no monitoring of the right calf hematoma.</p> <p>According to the 08/15/2024 Modified Discharge Return Anticipated MDS, Resident 16 was discharged to an acute care hospital on 08/15/2024 and had a diagnosis of unspecified soft tissue disorder related to use/pressure of their right lower leg.</p> <p>Review of the 08/23/2024 hospital summary report showed Resident 16's primary diagnosis was an expanding right calf hematoma that required surgical evacuation and a critically low blood count which required a blood transfusion.</p> <p>In an interview on 09/29/2024 at 6:56 PM, the Resident Representative (RR) for Resident 16 stated they found and reported to nursing staff, a large hematoma on Resident 16's right calf on 08/10/2024. Resident 16's RR stated the nursing staff told them the hematoma would not be assessed until the contracted wound team came in on 08/15/2024. The RR for Resident 16 stated they were concerned about waiting because the hematoma was getting larger, the right lower leg was swollen, red and warm to the touch, and the dressing had been saturated with blood, so they called and reported to Staff B (Director of Nursing) on 08/13/2024.</p> <p>In an interview on 10/02/2024 at 1:47 PM Staff B provided a paper copy of a communication form, dated 08/10/2024, to the Medical Director (MD) that showed nursing informing the MD on 08/10/2024 of the hematoma to Resident 16's right calf. Staff B stated the RR reported the hematoma to them on 08/13/2024 with the suggestion the hematoma may have happened during a transfer for a shower on 08/09/2024. The MD communication form showed orders for an ultrasound written on 08/12/2024 from the facility PA. Staff B stated they did not send the STAT ultrasound to the contracted company until 08/14/2024 and the ultrasound did not get done because Resident 16 discharged to the hospital on 08/15/2024. Staff B stated they did not document an assessment of the hematoma, complete a pain assessment, or complete a skin check.</p> <p>In an interview on 10/03/2024 at 10:38 AM Staff B provided a copy of an undated witness interview with the bath aide regarding what the bath aide observed during the bed bath they provided on 08/09/2024. The bath aide witness statement showed Resident 16 had no swelling to right foot/leg on that day (08/09/2024), no skin issues, and no bruising.</p> <p>In an interview on 10/04/2024 at 10:33 AM Staff A stated they should have reported Resident 16's significant injury of unknown origin to the state agency within two hours, ordered the ultrasound the same day the facility PA ordered it, and started the investigation immediately to rule out abuse and neglect, but they did not. Staff A stated they expected a STAT order to be done the same day it was placed.</p> <p>Refer to F609 - Timeframe: Abuse reported to Administration/State Agency, Timeframe: Investigate Abuse.</p> <p>Refer to F610 - Investigate Abuse.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684  Level of Harm - Actual harm  Residents Affected - Few	REFERENCE: WAC 388-97-1060(1).  44296

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505344	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/04/2024
NAME OF PROVIDER OR SUPPLIER  Canterbury House		STREET ADDRESS, CITY, STATE, ZIP CODE  502 29th Street Southeast Auburn, WA 98002	
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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43642</p> <p>Based on observation, interview, and record review the facility failed to ensure 3 of 7 residents (Resident 70, 16, &amp; 43) reviewed for Range of Motion (ROM) and 1 supplemental resident (Residents 46) received a Restorative Nursing Program (RNP) as ordered. This failure placed residents at risk of further decline in ROM, loss of function, and/or permanent immobility.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's March 2019 Restorative Program policy, residents would be evaluated for restorative needs on admission, quarterly, and with significant changes. The policy showed restorative nursing assistants and other staff would provide RNPs to residents and document on a restorative flow sheet.</p> <p>&lt;Resident 70&gt;</p> <p>According to an 08/09/2024 Admission Minimum Data Set (MDS - an assessment tool) Resident 70 had multiple medically complex diagnoses including muscle weakness and difficulty in walking. This MDS showed Resident 70 had a recent surgical procedure involving tendons, ligaments, or muscles, had a functional limitation in ROM to one side of their lower extremity, and had no rejection of care.</p> <p>In an interview on 09/30/2024 at 11:03 AM, Resident 70 stated they were frustrated they were no longer getting physical therapy, and they expressed a desire to work on mobility to reach their discharge goals. Resident 70 stated they were only receiving their RNP once weekly.</p> <p>According to an undated Restorative Program referral form, Resident 70 was referred for a restorative program to maintain strength and ROM three times a week. This referral form indicated instructions and training were provided by the therapy department on 09/06/2024. Nursing staff signed the form as noted on 09/18/2024, 12 days after the referral was made.</p> <p>Review of a revised 09/18/2024 impaired mobility Care Plan (CP) showed Resident 70 had interventions that directed staff to provide an active ROM program three times a week with a goal to maintain present muscle strength and endurance.</p> <p>Review of September 2024 restorative documentation showed staff only provided the restorative program to Resident 70 on two of six occurrences once the program was implemented by nursing staff.</p> <p>In an interview on 10/04/2024 at 10:32 AM, Staff MM (Resident Care Manager) stated restorative programs were important to follow up with mobility, assist with strengthening, and to help prevent contractures. Staff MM stated once a referral was made for a restorative program, they expected the program to be established and to be completed as directed.</p> <p>47836</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>&lt;Resident 16&gt;</p> <p>According to an 08/07/2024 Admission MDS, Resident 16 admitted on [DATE] and was severely cognitively impaired. The MDS showed Resident 16 had diagnoses of Alzheimer's dementia, paraplegia, anxiety disorder, depression, pressure ulcers, adult failure to thrive, and chronic pain syndrome.</p> <p>Review of Resident 16's records showed a RNP referral was placed on 09/06/2024. The referral was for Resident 16 to have both hands splinted for 12 hours a day and for the Restorative Nursing Aide (RNA) to provide stretching to Resident 16's hands/arms and both legs for their contractures five times a week.</p> <p>In an interview on 09/29/2024 at 7:13 PM Resident 16's Representative (RR) stated both of Resident 16's hands were severely contracted. Resident 16's RR stated their right thumb nail had started growing and curled under because of their contracture.</p> <p>Observations on 09/29/2024 at 8:51 AM, 09/29/2024 at 11:23 AM, 09/29/2024 at 2:12 PM, 09/30/2024 at 8:13 AM, 09/30/2024 at 9:59 AM, 09/30/2024 at 1:33 PM, 10/01/2024 at 8:36 AM, 10/01/2024 at 12:36 PM, 10/01/2024 at 1:59 PM, 10/02/2024 at 9:22 AM, 10/02/2024 at 9:53 AM, 10/02/2024 at 12:07 PM, on 10/03/2024 from 5:11 AM to 7:42 AM, 10/03/2024 at 9:22 AM, and 10/03/2024 at 11:01 AM showed Resident 16's splints on the table in their room.</p> <p>In an interview on 10/02/2024 at 9:53 AM, Resident 16's RR stated the hand splints on Resident 16's table came from the hospital with the resident. Resident 16's RR stated staff did not put the hand splints on Resident 16 since they were at the facility.</p> <p>In an interview on 10/02/2024 at 12:03 PM, Staff BB (Resident Care Manager) stated they did not know if Resident 16 was supposed to have the hand splints on.</p> <p>In an interview on 10/04/2024 at 8:02 AM, Staff BB stated they checked on the hand splints and found a 09/06/2024 referral in Resident 16's records for a RNP that included the hand splints and stretching exercises. Staff BB stated the referral for Resident 16 was not initiated but was supposed to be initiated on 09/06/2024. Staff BB stated the RNP was important to prevent further deformity of Resident 16's hands/arms and legs.</p> <p>&lt;Resident 43&gt;</p> <p>According to a 07/03/2024 Admission MDS, Resident 43 admitted on [DATE] and had no memory impairment. The MDS showed Resident 43 had diagnoses of chronic pain syndrome and damaged nerves below the spinal cord.</p> <p>Review of Resident 43's records showed a RNP referral placed on 07/06/2024. The referral was for Resident 43 to have elastic band exercises to both arms, three times a week.</p> <p>Review of an 08/06/2024 Impaired Physical Mobility CP, Resident 43 would be offered a RNP three times a week. The CP showed Resident 43 had decreased range of motion to both arms.</p> <p>In an interview on 09/30/2024 at 9:32 AM, Resident 43 stated they had decreased range of motion to their upper extremities. Resident 43 stated the staff were not offering or providing a RNP.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 10/04/2024 at 8:59 AM Staff B (Director of Nursing) stated they expected RNPs to be carried out as ordered. Staff B stated it was important to complete RNPs to maintain a resident's level of care.</p> <p>In an interview on 10/04/2024 at 11:59 AM Staff HH (RNA) stated they were expected to offer RNPs per referral. Staff HH stated they were not able to complete the RNPs because of their workload. Staff HH stated they were expected to document each time they offered and when a resident refused. Staff HH stated they did not offer Resident 43 their RNP as ordered but should have.</p> <p>In an interview on 10/04/2024 at 8:59 AM Staff B stated they expected RNPs to be carried out as ordered. Staff B stated it was important to complete RNPs to maintain a resident's level of care.</p> <p>In an interview on 10/04/2024 at 11:59 AM Staff HH stated they were expected to offer RNPs per referral. Staff HH stated they were not able to complete RNPs because of their workload. Staff HH stated they were expected to document each time they offered and when a resident refused. Staff HH stated they did not offer Resident 43 their RNP as ordered but should have.</p> <p>42203</p> <p>&lt;Resident 46&gt;</p> <p>According to the 09/19/2024 Quarterly MDS Resident 46 had diagnoses including paraplegia. This MDS showed Resident 46 received a RNP.</p> <p>According to the 07/16/2024 Impaired Mobility . CP Resident 46 had a goal to maintain muscle strength in their legs. The CP showed Resident 46 was scheduled to receive a RNP three times a week incorporating various stretches on their legs and feet.</p> <p>Review of the September 2024 RNP documentation showed no RNP program was provided on any day that month. On 09/03/2024 staff documented NA (Not Applicable). There were no documented refusals.</p> <p>In an interview on 10/04/2024 at 10:57 AM Staff B stated it was important to provide a RNP when required to prevent worsening ROM. Staff B stated RNP documentation should be accurate, and refusals should be documented.</p> <p>REFERENCE: WAC 388-97-1060 (3)(d).</p> <p>44296</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203</b></p> <p>Based on observation, interview and record review the facility failed to ensure residents were free of accident hazards for 4 (Residents 41, 57, 43, &amp; 16) supplemental residents reviewed. The failure to ensure residents were free from potential restraints (Resident 41), ensure staff safely used and monitored air mattresses (Residents 57, 16, &amp; 43), ensure sharps (syringe needles, razors etc.), and chemicals were stored safely, placed residents at risk for potential restraints, injury, exposure to soiled medical equipment, and unsafe chemicals.</p> <p>Findings included .</p> <p>&lt;Resident Mattress&gt;</p> <p>&lt;Resident 41&gt;</p> <p>According to the 06/27/2024 Annual Minimum Data Set (MDS - an assessment tool) Resident 41 had moderate memory impairment and needed substantial assistance from staff to roll from side to side in bed.</p> <p>Observation on 09/30/2024 at 2:21 PM showed a folded blanket placed under the right side of Resident 41's mattress between the mattress and the bed frame. The blanket raised the right side of the mattress one-to-two inches.</p> <p>Observation on 10/03/2024 at 12:19 PM showed a folded blanket between Resident 41's mattress and their bed frame. In an interview at that time, Staff M (Licensed Practical Nurse) stated staff should not place a blanket between the mattress and the bed frame.</p> <p>In an interview on 10/04/2024 at 11:02 AM Staff B (Director of Nursing) stated they were unaware of the blanket placement concern. Staff B stated it was not facility practice to put blankets between the mattress and bed frame because it could be a restraint.</p> <p>44296</p> <p>&lt;Air Mattresses&gt;</p> <p>&lt;Resident 57&gt;</p> <p>Review of the 09/03/2024 Significant Change MDS showed Resident 57 started hospice care for a terminal illness, was at risk of falls, had two non-injury falls since the prior assessment, and was cognitively impaired. The MDS showed Resident 57 weighed 108 pounds. The MDS showed Resident 57 was assessed to require complete staff assistance with all bed mobility and personal care.</p> <p>Review of the 09/04/2024 Care Plan (CP) showed Resident 57 had actual falls and required a perimeter mattress (mattress with raised edges). The CP did not show any information about the use of an air mattress.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the 09/05/2024 device assessment form showed Resident 57 had confusion, dementia, history of falls, and poor safety awareness. The assessment showed the interdisciplinary team recommended the perimeter mattress. The assessment did not show any information about an air mattress. Review of Resident 57's records showed no assessments were completed for an air mattress.</p> <p>In an observation and interview on 09/29/2024 at 1:24 PM, Resident 57 was lying in bed on an inflated air mattress with a pump hanging on the foot of the bed. The pump showed various setting options and had a red flashing light indicator of low air pressure. Observation showed the pump was set to 150 pounds and there was an option to set the pump at 100 pounds. Resident 57 stated they had a fall and now had a new bed.</p> <p>Observations on 09/30/2024 at 9:07 AM, 10/01/2024 at 8:23 AM, 10/02/2024 at 8:23 AM, 10/03/2024 at 5:27 AM, 10/04/2024 at 7:54 AM, and 10/04/2024 at 8:04 AM, showed Resident 57 in bed. The pump on the end of the bed showed a setting of 150 pounds and the red light was flashing for low air pressure.</p> <p>Review of Resident 57's 10/2024 physician orders showed no order for an air mattress, no settings, or directions to staff to monitor for safety or function of the air mattress.</p> <p>&lt;Resident 43&gt;</p> <p>Observation on 09/30/2024 at 9:25 AM showed Resident 43 lying on an air mattress.</p> <p>Similar findings for Resident 43's records showed no air mattress settings in the physician orders, no nurse monitoring for safety, settings, or pump functioning every shift, and no consent received with risks and benefits reviewed.</p> <p>&lt;Resident 16&gt;</p> <p>Observation on 10/01/2024 at 9:13 AM showed Resident 16 lying on an air mattress.</p> <p>Similar findings for Resident 16's records showed no air mattress settings in the physician orders and no nurse monitoring for safety, settings or pump functioning every shift.</p> <p>In an interview on 10/04/2024 at 11:34 AM, Staff B stated when a resident received a new device, including an air mattress, a device assessment was completed, consent with risks and benefits were reviewed with the resident or their decision maker, and an order was obtained from the physician. The nurse staff would monitor the device each shift for proper settings and functioning of the mattress and pump, and document in the resident's record. Staff B stated an air mattress should have pump settings according to the resident's weight and settings should be written in the physician's order. Staff B stated the nurse staff should monitor on the pump each shift and if there was an issue with the pump, the staff should notify the maintenance staff. Review of findings in Resident 57, 16 and 43's records with Staff B, who confirmed the system for implementing and monitoring resident's use of air mattresses was not intact.</p> <p>43642</p> <p>&lt;Unsecured Sharps&gt;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observations on 10/01/2024 at 2:01 PM showed items in a clear bag with a biohazard label sitting on an isolation bin in the hallway outside of room [ROOM NUMBER]. This bag was visible to others walking by in the hallway. On 10/01/2024 at 2:07 PM a staff member entered room [ROOM NUMBER], passing the bag on the cart, provided assistance to a resident, exited the room at 2:20 PM, and walked away from the area. Observations on 10/01/2024 at 2:26 PM showed two nurses walking in the hallway passing the room with the bag visibly sitting on the isolation cart.</p> <p>In an observation and interview on 10/01/2024 at 2:30 PM, Staff MM (Resident Care Manager) picked up the bag and identified the following items inside: 15 blood collection needles, five blood collection sets, and one push button needle collection set. Staff MM stated the items should not be out in the hallway unsecured and indicated the bag of sharps was probably left there by the lab draw company. Staff MM stated there was a risk for safety if residents passed by and picked up the bag.</p> <p>47836</p> <p>&lt;West Hall Shower Room/Unsecured Chemicals&gt;</p> <p>Observation on 10/03/2024 at 5:17 AM showed the shower room door in the [NAME] hallway was unlocked. There were bottles of shampoo, body wash, moisturizer, shaving cream, and a razor on the counters.</p> <p>In an interview on 10/03/2024 at 5:28 AM, Staff Q (Registered Nurse) confirmed the shower room was unlocked and stated the keypad was not working. Staff Q stated a razor and chemicals should not be left on the counters in an unlocked shower room and stated the door should be locked but it was not.</p> <p>50511</p> <p>Observation on 09/29/2024 at 9:23 AM, showed the [NAME] hall shower room door was unlocked. One spray can of [NAME] Lithium Grease Lubricant and Anti-Corrosion Agent was found on the bookcase stored in the shower room. The spray can had a danger warning label that read harmful or fatal if swallowed.</p> <p>Observation on 10/02/2024 at 10:55 AM showed the spray can of [NAME] Lithium Grease Lubricant and Anti-Corrosion Agent was still in shower room on the bookshelf.</p> <p>In an interview on 10/02/2024 at 11:58 AM Staff M stated the spray can should not be in the shower room as it could be hazardous to residents.</p> <p>In an interview on 10/02/2024 at 12:01 PM Staff N (Certified Nursing Assistant) stated they did not know why the spray can was in the shower room and that it should not be.</p> <p>In an interview on 10/04/2024 at 9:33 AM, Staff B stated chemicals should be locked up and out of reach of residents. Staff B stated when staff see medications or chemicals that are not locked up, they expect staff to make sure the items were kept away and out of reach of residents.</p> <p>REFERENCE: WAC 388-97-1060(3)(g).</p> <p>45941</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50511</p> <p>Based on observation, interview, and record review the facility failed to ensure 5 of 5 sample residents (Residents 32, 45, 53, 185, &amp; 22) reviewed for oxygen administration were provided care consistent with professional standards of practice. Failure to provide oxygen treatments and maintain oxygen equipment left residents at risk for respiratory discomfort, oxygen-related accidents, and a decreased quality of life.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's December 2017, Oxygen Administration Policy, oxygen would be provided in accordance with physician's orders, state and federal regulations, and standards of practice. Safety precautions and care of oxygen delivery equipment were performed according to state and federal regulation and manufacturer guidance, equipment that was soiled would be replaced. Oxygen liter flow would be set by a licensed nurse in accordance with physician's orders including liter flow and parameters for duration and frequencies.</p> <p>&lt;Providing Oxygen as Ordered&gt;</p> <p>&lt;Resident 32&gt;</p> <p>According to the 09/07/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 32 had respiratory failure, heart failure, low oxygen saturation (measure of oxygen levels in the blood), and required oxygen therapy.</p> <p>Review of the revised 06/03/2024 Respiratory Care Plan (CP) showed Resident 32 required aerosol contact precautions (precautions to prevent the spread of COVID-19 using personal protective equipment and hand hygiene) related to congestion, and respiratory failure. The CP included interventions to administer oxygen at two Liters Per Minute (LPM) and to maintain oxygen saturation above 92%.</p> <p>Review of the physician orders showed a 01/08/2024 order to administer oxygen at two LPM via tubing that delivered oxygen through the nostrils as needed.</p> <p>Review of a 09/23/2024 progress note signed by Staff R (Registered Nurse - RN) showed Resident 32 was drowsy, and their oxygen level was low. Staff R increased the oxygen administered to four LPM, and documented they would adjust when oxygen levels were stable. Staff R documented they were waiting for further orders from provider and would continue to monitor.</p> <p>Review of progress notes from 09/23/2024 through 10/01/2024 did not show further documentation regarding monitoring Resident 32's oxygen saturation levels, did not show further documentation by the nurse practitioner regarding adjusting oxygen levels, and did not show any change in the oxygen orders.</p> <p>Observation on 09/30/2024 at 12:37 PM showed Resident 32's oxygen set at four LPM.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 10/01/2024 at 9:18 AM showed Resident 32's oxygen at 4.25 LPM. The oxygen filter located on the back of oxygen concentrator was observed to be dusty.</p> <p>In an interview on 10/01/2024 at 2:01 PM, Staff J (Resident Care Manager) verified the physician orders for Resident 32 and stated the oxygen should be at two LPM. Staff J verified Resident 32's oxygen was set to four LPM. Staff J stated this was not correct, and the oxygen should be set to two LPM. Staff J stated if the nurse increased the oxygen to four LPM, there should be communication with the doctor to discuss the increase. Staff J verified the oxygen filter on the back of the concentrator was covered with dust and stated they were not aware of how often the filter on the back of the concentrator needed to be cleaned.</p> <p>Observation on 10/02/2024 at 9:06 AM showed Resident 32's oxygen tubing was on the floor next to their bed.</p> <p>Observation on 10/04/2024 at 9:13 AM showed Resident 32's oxygen tubing was placed incorrectly on their head rather than under their nose.</p> <p>In an interview on 10/04/2024 at 9:18 AM Staff H (RN) stated the resident would not keep their oxygen tubing in place.</p> <p>In an interview on 10/04/2024 at 9:40 AM Staff B (Director of Nursing) stated nurses should check oxygen orders and concentrator levels continuously. Staff B stated if nurses saw a resident's oxygen saturation dropping, they could increase the amount of oxygen provided for urgent issues, but the nurse would have to obtain physician's orders and document their actions.</p> <p>47836</p> <p>&lt;Resident 45&gt;</p> <p>Review of Resident 45's records showed a 05/24/2024 physician's order for oxygen to be administered at two LPM.</p> <p>According to an 08/24/2024 Quarterly MDS, Resident 45 admitted to the facility on [DATE] with no memory impairment. The assessment showed Resident 45 received oxygen therapy during the assessment period. The MDS showed Resident 45 had diagnoses of anxiety, depression, Chronic Obstructive Pulmonary Disease (COPD), and respiratory failure.</p> <p>Observations on 09/30/2024 at 10:12 AM, on 10/01/2024 at 10:32 AM, and on 10/04/2024 at 8:17 AM showed Resident 45's oxygen was administered at 3.5 LPM.</p> <p>In an interview on 10/04/2024 at 8:18 AM Staff E (Licensed Practical Nurse) stated Resident 45 was administered 3.5 LPM. Staff E stated the physician's order was for oxygen at two LPM so it should not be set at 3.5 LPM. Staff E stated it was important to administer the correct dose of oxygen per physician's order because Resident 45 had COPD and administering more than the ordered dose risked the resident retaining carbon dioxide which would not be beneficial and could cause them to have respiratory distress.</p> <p>&lt;Oxygen Equipment Maintenance&gt;</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>&lt;Resident 45&gt;</p> <p>Observations on 09/30/2024 at 10:12 AM, 10/01/2024 at 10:32 AM, and 10/04/2024 at 8:17 AM showed Resident 45's oxygen concentrator had a thick layer of dust on top of the machine and the oxygen filter was full of dust.</p> <p>In an interview and observation on 10/01/2024 at 11:15 AM, Staff BB (Resident Care Manager) confirmed Resident 45's oxygen concentrator had a layer of dust on top of the machine and an unclean filter that was full of debris. Staff BB stated their expectation was for staff to clean oxygen concentrators and filters weekly and as needed. Staff BB stated Resident 45's oxygen concentrator and filter needed to be cleaned.</p> <p>In an interview on 10/04/2024 at 8:59 AM Staff B stated they expected staff to follow physician orders when administering oxygen. Staff B stated they expected oxygen concentrators and filters to be cleaned weekly. Staff B stated it was important to administer oxygen as ordered and maintain oxygen equipment for residents' respiratory health and safety.</p> <p>&lt;Resident 32&gt;</p> <p>Observation on 10/01/2024 at 9:18 AM showed Resident 32's oxygen at 4.25 LPM. The oxygen filter located on the back of oxygen concentrator was observed to be dusty.</p> <p>In an interview on 10/01/2024 at 2:01 PM, Staff J verified that the oxygen filter on back of concentrator was covered with dust and stated they were not aware of how often the filter on the back of the concentrator needed to be cleaned.</p> <p>43642</p> <p>&lt;Resident 53&gt;</p> <p>According to a 09/02/2024 Admission MDS, Resident 53 had multiple medically complex diagnoses including heart failure and required the use of oxygen during the assessment period. This MDS showed staff assessed Resident 53 with no memory impairment.</p> <p>Observations on 09/29/2024 at 10:05 AM showed an oxygen concentrator machine with a filter area on the side visible from Resident 53's doorway. The filter inlet had a thick layer of grayish debris and fuzz, preventing visualization of the machine's actual filter. Resident 53 was in bed wearing their oxygen tubing that was undated. In an interview at this time, Resident 53 stated they did not recall staff changing and/or cleaning their oxygen tubing.</p> <p>In an interview on 10/01/2024 at 11:15 AM, Staff BB stated their expectation was for staff to clean oxygen concentrators and filters weekly and as needed.</p> <p>&lt;Resident 185&gt;</p> <p>According to a 09/24/2024 Admission MDS, Resident 185 had multiple medically complex diagnoses including lung disease and required the use of oxygen during the assessment period. This MDS showed staff assessed Resident 53 with no memory impairment.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observations on 09/30/2024 at 9:45 AM showed Resident 185 lying in bed wearing oxygen with tubing that was undated. In an interview at this time, Resident 185 stated they did not recall staff changing and/or cleaning their oxygen tubing.</p> <p>In an interview on 10/04/2024 at 2:13 PM, Staff B stated oxygen concentrator filters should be cleaned weekly and oxygen tubing should be dated by staff.</p> <p>&lt;Resident 22&gt;</p> <p>According to the 08/12/2024 Quarterly MDS Resident 22 had diagnoses including respiratory failure with low oxygen saturation and a cough. The MDS showed Resident 22 used supplemental oxygen.</p> <p>Record review showed an 11/07/2023 order for Resident 22 to receive oxygen via tubing to the nose at four LPM every shift to treat their respiratory failure.</p> <p>Observation on 09/29/2024 at 9:24 AM showed Resident 22 in bed using supplemental oxygen via tubing to their nose. There was no date on the tubing to indicate when it was started or to indicate when it needed to be replaced.</p> <p>In an interview on 10/04/2024 at 2:13 PM, Staff B stated oxygen tubing should be dated by staff.</p> <p>REFERENCE: WAC 388-97-1060 (3)(j)(vi).</p> <p>42203</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47836</b></p> <p>Based on observation, interview, and record review the facility failed to ensure pain management was provided to residents consistent with professional standards of practice including the failure to offer nonpharmacological interventions, identify parameters for administration of as needed (PRN) pain medications, and administer pain medications timely for 1 of 2 residents (Resident 16) reviewed for pain management. These failures placed residents at risk for experiencing untreated pain and a decreased quality of life.</p> <p>Findings included .</p> <p>&lt;Resident 16&gt;</p> <p>According to a 09/03/2024 Significant Change Minimum Data Set (MDS - an assessment tool), Resident 16 admitted [DATE] and was severely cognitively impaired. The assessment showed Resident 16 received pain medications routinely and PRN. The MDS showed Resident 16 did not receive non-medication interventions for pain. The MDS showed a pain assessment interview should not be conducted with Resident 16/Resident Representative (RR) at the time of the assessment. The MDS showed Resident 16 had diagnoses of chronic pain syndrome and pressure wounds to their sacrum.</p> <p>Record review of Resident 16's records showed no nonpharmacological interventions for pain management. Resident 16's records showed a 09/18/2024 physician order for an PRN pain medication. Resident 16's records showed no care plan for chronic pain.</p> <p>In an interview on 09/29/2024 at 7:07 PM, Resident 16's RR stated they had to request PRN pain medication for Resident 16 when they were showing signs of pain, or the staff would not give it to them. Resident 16's RR stated the staff would tell them Resident 16 did not reported any pain. Resident 16's RR stated they told staff multiple times Resident 16 was unable to report their pain and staff needed to assess Resident 16 based on physical signs of pain such as breathing hard, restlessness, or excessive sweating.</p> <p>In an observation on 10/02/2024 at 9:51 AM, Resident 16 appeared sweaty and had heavy/labored respirations. Resident 16's RR requested their PRN pain medication from Staff E (Licensed Practical Nurse) at this time.</p> <p>Observation on 10/02/2024 at 10:01 AM showed Staff E enter Resident 16's room and provide wound care. Staff E did not administer Resident 16's pain medication at this time. Staff E completed Resident 16's wound care at 10:18 AM.</p> <p>Observation on 10/02/2024 at 10:30 AM showed Staff E return to Resident 16's room with their pain medication and stated it took them 40 minutes to bring the pain medication for Resident 16 because they had to change their bandage. Staff E stated they should have administered the pain medication when the RR requested and before they provided the wound care.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 10/03/2024 at 9:34 AM Staff BB (Resident Care Manager) stated Resident 16 should have an order for nonpharmacological pain interventions, but they did not. Staff BB stated nonpharmacological pain interventions were important to not administer unnecessary pain medication that could be treated without medications.</p> <p>In an interview on 10/04/2024 at 8:59 AM Staff B (Director of Nursing) stated Resident 16 had a diagnosis of chronic pain so they would expect staff to initiate a pain care plan to make sure they were addressing the specific needs for Resident 16's pain management but they did not. Staff B stated they expected staff to administer pain medication when a resident requests or was showing signs of pain as soon as possible but not later than 15 minutes. Staff E stated it was important to administer pain medications timely so the resident would not suffer in pain.</p> <p>REFERENCE: WAC 388-97-1060(1).</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>46479</p> <p>Based on observation, interview, and record review the facility failed to have sufficient nursing staff to provide timely assistance to residents, supervise care of residents, meet Activities of Daily Living (ADL) needs including showering/bathing, assisting residents out of bed, and call light response time as evidenced by information provided by 13 (Resident 21, 234, 38, 45, 72, 185, 18, 54, 62, 21, 35, 71, &amp; 61) residents interviewed. These failures placed residents at risk for unmet care needs, accidents, and a decreased quality of life.</p> <p>Findings included .</p> <p>&lt;Staff and Call Light Observations&gt;</p> <p>Observation on 10/03/2024 at 5:03 AM showed Staff LL (Certified Nursing Assistant) asleep at the East Hall nurse's station. Three call lights were going off and no other staff members were observed in the hallways. In an interview at that time, Staff LL acknowledged they were asleep and stated they were responsible for answering call lights on the East unit. Staff LL stated they did not feel like there were enough staff at night as they were unable to take all of their breaks.</p> <p>In an interview on 10/03/2024 at 5:11 AM, Staff AA (Registered Nurse) stated they were the night shift supervisor for East and Southeast wings and were expected to supervise the night shift staff assigned to these wings. Staff AA stated staff should not be sleeping at the nursing station.</p> <p>In an interview on 10/04/2024 at 2:41 PM, Staff A (Executive Director) confirmed staff should not sleep while on shift.</p> <p>&lt;Call Light Response Time&gt;</p> <p>Resident 21</p> <p>In an interview on 09/30/2024 at 9:10 AM, Resident 21 stated they felt the care they received was less since they had moved to the long term care side of the building. Resident 21 stated they waited for three hours on night shift to be changed. Resident 21 stated the aid told me they were getting supplies and be back. Resident 21 stated the aid did not return for three hours and told the resident, they were tired, so they took a nap before assisting the resident to be changed.</p> <p>&lt;Resident 234&gt;</p> <p>In an interview on 09/29/2024 at 11:51 AM, Resident 234 stated sometimes their call light went unanswered for hours. Resident 234 stated they have had to go in their brief before because their call light was not answered timely.</p> <p>&lt;Resident 38&gt;</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 10/01/2024 at 8:15 AM, Resident 38 stated they have waited 30-40 minutes for their call light to be answered.</p> <p>47836</p> <p>&lt;Resident 45&gt;</p> <p>In an interview on 09/29/2024 at 11:43 AM Resident 45 stated the average call light response time varied but they had to wait three hours for their call light to be answered by staff. Resident 45 stated their main concern was the wait time to be changed after an incontinent episode in their brief. Resident 45 stated they had severe edema to both legs but had not accepted an increase in their water pill dose because they had to wait in a soiled brief for three hours.</p> <p>&lt;Resident 72&gt;</p> <p>Observation on 10/01/2024 at 2:20 PM showed Resident 72's call light turned on. At 3:00 PM, 40 minutes later, a staff member answered Resident 72's call light.</p> <p>43642</p> <p>&lt;Resident 185&gt;</p> <p>According to a 09/24/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 185 had clear speech, was understood, and able to understand others. This MDS showed staff assessed Resident 185 with no memory impairment.</p> <p>In an interview on 09/30/24 at 9:45 AM, Resident 185 stated they felt the facility did not have enough staff, especially at shift change, on the night shift. Resident 185 stated they would have to wait anywhere from 15 minutes to one hour to get assistance from staff with their toileting needs.</p> <p>50511</p> <p>&lt;Resident 18&gt;</p> <p>In an interview on 09/29/2024 at 10:10 AM Resident 18 stated the facility had long wait times, after pushing the call light resident stated they had waited up to 3 hours. Resident 18 stated sometimes the staff don't see or hear call lights in the hallways.</p> <p>&lt;Resident 54&gt;</p> <p>In an interview on 09/29/2024 at 12:44 PM Resident 54 stated there was an incident where another resident entered their room during the middle of the night. Resident 54 stated they pushed their call light for staff to assist the other resident back to their own room, a staff member did not come. Resident stated they had to scream for help and still a staff member did not come.</p> <p>&lt;Resident 62&gt;</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 09/29/2024 at 10:02 AM Resident 62 stated sometimes a call light will stay on too long and may not be answered for 3 hours. Resident 62 stated the wait for a staff member seems to be longer during the middle of the night.</p> <p>&lt;Resident Grievances&gt;</p> <p>&lt;Resident 21&gt;</p> <p>Review of a 06/04/2024 grievance form showed Resident 21 filed a grievance related to long call light wait times on night shift. This grievance showed the staff were educated on call light response times.</p> <p>&lt;Resident 35&gt;</p> <p>Review of a 09/13/2024 grievance form showed Resident 35 and their significant other filed a grievance for having to wait greater than 30 minutes for the call light to be answered. This grievance form showed education was provided to staff.</p> <p>&lt;Resident 71&gt;</p> <p>Review of a 09/13/2024 grievance form showed Resident 71 filed a grievance for call light response taking 30-40 minutes, stating the staff do not respond often. This grievance showed staff were educated on call light response times.</p> <p>&lt;Resident 61&gt;</p> <p>Review of a 09/16/2024 grievance form showed Resident 61 filed a grievance for call light response times taking 20 minutes during the day and more that 30 minutes at night. This grievance showed staff were educated on call light response times.</p> <p>In an interview on 10/04/2024 at 8:59 AM Staff B (Director of Nursing) stated call lights should be answered within 15 minutes and no longer than 30 minutes if they were busy. Staff B stated staff should not ever be sleeping at the nursing station or while on duty. Staff B stated they expected the night shift supervisor to ensure staff were doing their work when on the floor and taking their breaks in the break room.</p> <p>Refer to F677 - ADL Care Provided for Dependent Residents</p> <p>REFERENCE: WAC 388-97-1080(9).</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43642</p> <p>Based on interview and record review, the facility failed to ensure licensed pharmacist's monthly Medication Regimen Reviews (MRRs) were added to resident records and that recommendations were reviewed and followed up timely for 3 of 5 residents (Residents 3, 13, &amp; 23) whose medication regimens were reviewed and 2 supplementary residents (Residents 46 &amp; 16). This failure placed residents at risk for delays in necessary medication changes, at risk for adverse side effects, and negative outcomes.</p> <p>Findings included .</p> <p>&lt;Resident 3&gt;</p> <p>According to a 06/29/2024 Annual Minimum Data Set (MDS - an assessment tool) Resident 3 had multiple medically complex diagnoses including dementia, depression, a bipolar disorder (a mental illness characterized by extreme mood swings) and a psychotic disorder (severe mental disorders that cause abnormal thinking and perceptions) and required the use of antidepressant and antipsychotic medications during the assessment period.</p> <p>Review of Resident 3's records showed no documentation that pharmacy MRRs were completed monthly and/or if there were any recommendations made for the resident since March 2024.</p> <p>On 10/02/2024 Staff B (Director of Nursing) provided paper copies of the pharmacy MRRs not in Resident 3's records for March 2024, May 2024, June 2024, July 2024, August 2024, and September 2024.</p> <p>Review of a printed 03/26/2024 MRR showed a recommendation to Resident 3's physician to review the resident's psychotropic medications and to indicate a clinical rationale if the resident was not a candidate for dose reductions at that time. There was no clinical rationale documented on the form or acknowledgment the physician reviewed the March 2024 recommendation for Resident 3.</p> <p>Review of a printed 05/28/2024 MRR showed a second recommendation to Resident 3's physician to review the resident's psychotropic medications for possible reduction. This form had a title of, <b>**Duplicate Note**</b>Original from 03/20/2024 <b>**No response scanned into [electronic records] **</b> There was no clinical rationale documented on the form or acknowledgment the physician reviewed the May 2024 recommendation for Resident 3.</p> <p>Review of a 06/10/2024 MRR showed a recommendation to Resident 3's physician to consider a trial dose reduction of an acid-reducing medication from twice daily to once daily or to provide clinical rationale for continued need as Resident 3 was not having any documented active stomach acid symptoms. There was no clinical rationale documented on the form or acknowledgment the physician reviewed the June 2024 recommendation for Resident 3.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a 07/12/2024 MRR showed a third recommendation to Resident 3's physician to review the resident's psychotropic medications for possible reduction. This form had a title of, <b>**Duplicate Note**Original from 03/20/2024**</b> No response scanned into [electronic records] <b>**</b> There was also a second request under a pending section included in the July 2024 MRR's indicating the recommendation for a trial dose reduction of the acid-reducing medication for Resident 3 still needed to be addressed by the facility. There was no clinical rationale documented on the form or acknowledgments the physician reviewed the July 2024 recommendations for Resident 3.</p> <p>Review of an 08/13/2024 MRR showed a third request to the physician to consider a trial dose reduction of the acid-reducing medication for Resident 3. There was no clinical rationale documented on the form or acknowledgments the physician reviewed the August 2024 recommendations for Resident 3.</p> <p>Review of a pending section from a printed 09/11/2024 MRR showed, This is a repeat recommendation from June. If this was already addressed, please disregard recommendation. This form listed a fourth request to consider a trial dose reduction of the acid-reducing medication for Resident 3. There was no clinical rationale documented on the form or acknowledgments the physician reviewed the September 2024 recommendations for Resident 3.</p> <p>According to the September 2024 Medication Administration Records, Resident 3's psychotropic medications were unchanged since January 2024 and the acid reducing medication remained unchanged since 2022.</p> <p>In an interview on 10/04/2024 at 2:13 PM, Staff B (Director of Nursing) stated their expectation was for pharmacy MRRs to be followed up as soon as possible and to be addressed before the end of the month of when the recommendation was received. Staff B stated the pharmacy recommendations should be readily available in the resident records. Staff B stated they would have expected Resident 3's pharmacy recommendations to be followed up timely.</p> <p>46479</p> <p>&lt;Resident 13&gt;</p> <p>According to the 09/02/2024 Quarterly MDS, Resident 13 had diagnoses including psychiatric and mood disorders, and a thyroid disorder. This MDS showed Resident 13 was taking antipsychotic medications.</p> <p>Review of Resident 13's 09/30/2024 physician order summary showed two 09/13/2023 orders for two different medications to treat side effects caused by their antipsychotic medications. The order summary showed Resident 13 had a 09/18/2024 order for a medication to treat their thyroid disorder.</p> <p>Review of a 09/11/2024 MRR showed the facility's pharmacist reviewed the two different medications Resident 13 took to treat side effects caused by antipsychotic medications. The MRR showed the pharmacist provided information that long term use of the medications in elderly patients could increase the resident's risk for dementia. The pharmacist recommended if both medications were to remain ordered by the physician, a risk versus benefit should be provided to Resident 13 along with justification for continued use of the medications.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 13's August 2024 and September 2024 Medication Administration Records (MARs) showed staff monitored the resident every shift for adverse side effects of the antipsychotic medication. The MAR showed Resident 13 experienced no side effects in August or September 2024.</p> <p>Review of an 08/13/2024 MRR showed the facility's pharmacist noted Resident 13 had high thyroid levels and recommended the facility consider an increase in the resident's thyroid medication and rechecking their thyroid levels. A 09/11/2024 MRR showed a repeated recommendation of the 08/13/2024 recommendation.</p> <p>Review of Resident 13's record showed no progress notes, orders, or risks versus benefits indicating the MRR was acknowledged or followed up on by the facility staff regarding the medications used to treat the side effects caused by antipsychotic medications. Review of Resident 13's record showed the facility did not implement the recommendation to increase the resident's thyroid medication until 09/18/2024, over five weeks after the original 08/13/2024 MRR.</p> <p>In an interview on 10/04/2024 at 11:18 AM, Staff B (Director of Nursing) stated the facility's process for MRRs was that Staff B obtained the MRR, placed it in the provider's box. Once the MRR was reviewed and signed by the provider, facility staff were to process the orders as soon as possible and at least within 48 hours.</p> <p>44296</p> <p>&lt;Resident 23&gt;</p> <p>Record review showed a September 2024 MRR created between 9/10/2024 and 9/11/2024 that recommended discontinuing an iron supplement. On 10/02/2024 the physician annotated their agreement with the recommendation.</p> <p>In an interview on 10/04/2024 at 2:13 PM Staff B stated they expected MRRs to be reviewed by the end of the month they were completed by the pharmacist.</p> <p>47836</p> <p>&lt;Resident 16&gt;</p> <p>According to a 09/03/2024 Significant Change MDS, Resident 16 admitted [DATE] and was severely cognitively impaired. Resident 16 had diagnoses of high blood pressure and chronic pain syndrome.</p> <p>Record review of Resident 16's records showed no MRRs by the pharmacy. Resident 16's records showed an 08/28/2024 physician order for a blood pressure medication to be administered three times a day at 7:00 AM, 3:00 PM, and 11:00 PM.</p> <p>On 10/02/2024 Staff B (Director of nursing) provided paper copies of pharmacy medication regimen reviews that were not in Resident 16's records. The 08/14/2024 pharmacy review recommended that Resident 16's blood pressure medication be administered every three to four hours apart and no later than 6:00 PM.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 10/04/2024 at 8:59 AM Staff B stated Resident 16's pharmacy recommendation was not initiated. Staff B stated the blood pressure medication recommendations were not addressed by the provider or initiated for Resident 16, and were not scanned into their records but should be.</p> <p>42203</p> <p>&lt;Resident 46&gt;</p> <p>According to the 09/19/2024 Quarterly MDS Resident 46 admitted to the facility on [DATE] and had diagnoses including Diabetes Mellitus (a condition making managing blood sugar more difficult). The MDS showed Resident 46 took insulin.</p> <p>Review of the September 2024 MAR showed Resident 46 had a 06/13/2024 order for insulin to be administered on a sliding scale (adjusting the dose depending on the resident's blood sugar level).</p> <p>Record review showed a 09/10/2024 MRR recommending consideration of the risks and benefits of using sliding scale insulin without a longer acting insulin. This MRR was acknowledged by the physician on 10/02/2024.</p> <p>In an interview on 10/04/2024 at 2:13 PM Staff B stated they expected MRRs to be reviewed by the end of the month they were completed by the pharmacist.</p> <p>REFERENCE: WAC 388-97-1300 (4)(c).</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>43642</p> <p>Based on interview and record review, the facility failed to ensure 2 (Residents 3 &amp; 23) of 5 residents reviewed for unnecessary medications, were free from unnecessary psychotropic (medication that affected behavior, mood, thoughts, or perception) medications. This failure left residents at risk for unnecessary medications, adverse side effects, and other negative health outcomes.</p> <p>Findings included .</p> <p>&lt;Resident 3&gt;</p> <p>According to a 06/29/2024 Annual Minimum Data Set (MDS - an assessment tool), Resident 3 had multiple medically complex diagnoses including dementia, depression, a bipolar disorder (a mental illness characterized by extreme mood swings) and a psychotic disorder (severe mental disorders that cause abnormal thinking and perceptions) and required the use of antidepressant and antipsychotic medications during the assessment period. This MDS showed staff documented the last Gradual Dose Reduction (GDR) was 05/16/2023, over a year ago, and a GDR was not documented by a physician as clinically contraindicated.</p> <p>Review of Resident 3's September 2024 Medication Administration Records (MAR) showed the resident received the same dose of an antidepressant since 08/01/2018 and the same dose of an antipsychotic since 01/12/2024.</p> <p>Review of the 03/13/2024, 04/17/2024, and 05/08/2024 Psychotropic Drug and Behavior Monthly reviews completed by staff showed the team recommendations were to continue to monitor recent change in the antipsychotic medication, then consider to discontinue it if no significant behaviors.</p> <p>Review of the 06/19/2024 Psychotropic Drug and Behavior Monthly review showed Resident 3's mood and behaviors were managed by their medications. The review showed sometimes Resident 3 was particular about how their room was cleaned but the resident was easily redirected. The review's Target Behavior (TB - the behaviors a medication was prescribed to treat) Summary/Trend since last review section on the form showed staff documented none for Resident 3. This review was not signed as completed by staff until 07/08/2024, almost three weeks later.</p> <p>Review of the 07/12/2024 Psychotropic Drug and Behavior Monthly review showed Resident 3's mood and behaviors were managed by their medications. The review showed sometimes Resident 3 was particular about how their room was cleaned but the resident was easily redirected. The TB Summary/Trend since last review section showed staff documented, none for Resident 3.</p> <p>Review of the 08/14/2024 Psychotropic Drug and Behavior Monthly review showed Resident 3's mood and behaviors were managed by their medications. The review showed sometimes Resident 3 was particular about how their room was cleaned but the resident was easily redirected. The TB Summary/Trend since last review section showed staff documented, none for Resident 3. This review was not signed as completed by staff until 09/03/2024, over one month later.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the 09/11/2024 Psychotropic Drug and Behavior Monthly review showed Resident 3's mood and behaviors were managed by their medications. The review showed sometimes Resident 3 was particular about how their room was cleaned but the resident was easily redirected. The TB Summary/Trend since last review section showed staff documented, none for Resident 3.</p> <p>Review of Resident 3's June 2024, July 2024, August 2024, and September 2024 MARs showed only two days, over the past four months, when staff documented Resident 3 had TBs. There was no documentation that staff monitored the resident's behaviors related of the antidepressant.</p> <p>Review of pharmacy medication regimen reviews showed the pharmacist recommended Resident 3's physician review the resident's psychotropic medications and indicate a clinical rationale if the physician assessed Resident 3 was not a candidate for dose reductions in March 2024, May 2024, and July 2024. There was no clinical rationale documented on the recommendation forms or acknowledgment the physician reviewed the pharmacy reviews for Resident 3.</p> <p>In an interview on 10/04/2024 at 2:13 PM, Staff B (Director of Nursing) stated GDRs were important to meet regulatory requirements. Staff B stated it was important to determine nonpharmacological interventions to treat resident behaviors and medications were a last resort. Staff B stated the facility process was to meet monthly with the pharmacist and interdisciplinary team (a team composed of various facility departments) to review residents' psychotropic medications to determine appropriate GDRs. Staff B stated it was their expectation GDRs be attempted when appropriate.</p> <p>44296</p> <p>&lt;Resident 23&gt;</p> <p>According to the 09/03/2024 Quarterly MDS, Resident 23 had diagnoses including stroke with communication deficits, dementia, history of alcohol dependence, psychotic disorder, and a disorder related to personality and behaviors. The MDS showed Resident 23 had no behaviors related to acute delirium, no physical or verbal behaviors directed to self or others, no behaviors that affected Resident 23's care, no rejection of care, no wandering, and no changes in behavior compared to the prior assessment. The MDS showed Resident 23 was administered routine antipsychotic medication, did not have a GDR of antipsychotic medications, and did not have physician documentation of a GDR being clinically contraindicated. The MDS showed Resident 23 did not have a drug regimen review completed by the pharmacist to review clinically significant medication issues.</p> <p>Review of the 08/27/2024 Care Plan (CP) for behaviors showed Resident 23 had a history of behavior problems including aggressive, threatening, irritability, refusing medications and medical care, allegations of physical abuse, and verbal altercations with other residents. The CP showed interventions to Resident 23's behaviors included: determine root cause of behavior, anticipate and meet Resident 23's unmet needs, provide space to Resident 23 when escalating and protect other residents, encourage calmness and provide rewards to decrease anxiety, monitor and document behaviors, look for trends such as time of day, persons involved, location and situation, activity engagement to distract behaviors, and provide simple conversation and yes/no questions.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the 09/2024 behavior monitoring documented on the MAR showed Resident 23 had no documented behaviors observed on any day, evening, or night shifts from 09/01/2024 through 09/30/2024, except on 09/27/2024. The MAR showed on 09/27/2024 Resident 23 had worry and angry outbursts without any associated triggers, interventions provided, or outcomes documented.</p> <p>Review of the 09/2024 MAR showed Resident 23 was administered an antipsychotic medication three times per day from 09/01/2024 through 09/30/2024. The MAR showed two changes in the antipsychotic medication with increases in dosage and change from immediate release tablets to 24 hour extended release tablets on 09/24/2024 and 09/30/2024, six days apart.</p> <p>Review of the 09/18/2024 psych evaluation note from the behavioral health specialist showed a routine follow up visit was conducted for medication evaluation, behaviors were assessed as uncooperative, attitude is disinterested and shows impulsivity. The note showed a recommendation to increase the antipsychotic medication to 75 milligrams (mg) by mouth twice daily.</p> <p>Review of a 09/23/2024 nursing progress note showed Resident 23 tested positive for COVID-19 (a respiratory infection) and was started on antiviral medication. The progress note showed Resident 23 was not feeling well, not able to get out of bed, had decreased appetite, and refused a shower.</p> <p>Review of a 09/24/2024 nursing progress note showed Resident 23 had behaviors triggered by being placed on isolation, was yelling, and refused to keep their room door closed.</p> <p>Review of a 09/24/2024 nursing progress note showed the behavioral health practitioner increased the antipsychotic medication. The new antipsychotic medication dose entered to the 09/24/2024 physician orders was 75 mg 24- hour extended release tablet by mouth twice daily, noted difference from the 09/18/2024 behavior health specialists' recommendation that did not specify 24-hour extended release tablets.</p> <p>Review of the 09/25/2024 through 10/01/2024 nursing progress notes showed Resident 23 had one behavior episode of yelling and agitation triggered by wanting a spoon. The progress note showed a spoon was provided and there was no further documentation of behaviors after 09/29/2024.</p> <p>Review of a 09/30/2024 practitioner order showed Resident 23's antipsychotic medication was increased to 100 mg 24-hour extended release tablet by mouth twice daily. This was only six days after the last increase of the antipsychotic medication. There was no documentation found that staff notified the practitioner of the prior increased dose on 09/24/2024.</p> <p>Review of the 09/30/2024 through 10/04/2024 practitioner progress notes showed no progress notes were entered into Resident 23's record by the prescribing practitioner. There was no documentation of the rationale of increasing the antipsychotic medication on 09/30/2024, after the antipsychotic medication was increased six days earlier.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 10/04/2024 at 12:02 PM with Staff B and Staff PP (Divisional Director of Clinical Operations), Staff PP stated nursing staff were expected to document resident behaviors, identify triggers, provide non-pharmacological interventions, and document outcomes on the behavior monitor for Resident 23. Staff PP stated behavior monitoring and non-pharmacological interventions should be used before increasing any antipsychotic medications. Staff B stated an interdisciplinary team review is used to review antipsychotic medication dosages and recommendations. Staff B stated new orders were reviewed by the resident care managers daily and discussed in morning status meetings with follow up as required.</p> <p>Review of the 04/22/2024 Medication Regimen Review (MRR - a review of medications completed by the pharmacist) showed Resident 23 was prescribed an antipsychotic medication 37.5 mg three times daily. The MRR showed there was no attempt at reduction of dosage since 02/2023, when Resident 23 was changed from one antipsychotic med to another antipsychotic medication, over one year prior to the MRR. The MRR showed guidelines require that psychotropic medications undergo a GDR attempt in two separate quarters [with at least one month between the attempts] during the first year of initiation or admission, then annually thereafter, unless clinically contraindicated. The practitioner signed the document, declined the recommendation of a GDR, and wrote on the MRR, Patient has failed past GDR attempts. Benefit of correct therapy outweighs risks. Currently researching possibility of transitioning to another [antipsychotic].</p> <p>Review of the 04/25/2024 MRR showed Resident 23 was prescribed an antipsychotic 37.5 mg at 8:00 AM, 50 mg at 12:00 PM, and 37.5 mg at 8:00 PM. The MRR showed the guidelines for psychotropic medication requirement for GDR. The MRR showed in bold underlined instructions for the practitioner to indicate with a clinical rationale if the resident was a candidate for a GDR at this time. The practitioner did not complete the choice selection for a GDR or a clinical rationale, and wrote Benefits outweigh the risks of continuing therapy.</p> <p>In an interview on 10/04/2024 at 12:02 PM, Staff B stated there should be documentation in Resident 23's records for a failed GDR if it was attempted. Staff B was asked to provide all documentation of attempted GDRs on Resident 23's AP medication, none was provided.</p> <p>Refer to F760 Residents are free from Significant Med Errors.</p> <p>REFERENCE: WAC 388-97-1060(3)(k)(i).</p> <p>46479</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>43642</p> <p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observation, interview, and record review the facility failed to ensure a medication error rate of less than 5 Percent (%). Failure to properly administer 7 of 26 medications for 2 of 5 residents (Resident 72 &amp; 4) observed during medication pass resulted in a medication error rate of 26.92 %. This failure placed residents at risk for not receiving the correct dose or receiving less than the intended therapeutic effects of physician ordered medication.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>Review of the 01/2024 facility, Medication Administration Guidelines policy showed medications should be administered in accordance with written orders of the prescriber. Medications should be verified three times before administering; when pulling a medication package from the medication cart, when the dose is prepared, and before the dose is administered. The policy showed long-acting, extended released, or enteric coated dosage forms should not be crushed.</p> <p>&lt;Resident 72&gt;</p> <p>Observations of medication pass on 10/01/2024 at 9:45 AM, showed Staff FF (Licensed Practical Nurse) prepare medications for Resident 72. Staff FF put one 25 milligram (mg) tablet of an extended-release beta-blocker (a medication that causes the heart to beat slower) Blood Pressure (BP) medication, in a cup and then put the medication card back into the cart. While Staff FF continued to add other medications, they grabbed the same beta-blocker BP medication card out of the cart and stated, here is the [calcium channel blocker - a different BP medication that causes the heart and arteries to relax]. Staff FF did not realize they were holding the same beta-blocker BP medication card from earlier, rather than the calcium channel BP medication. Staff FF then added a second 25 mg tablet of the extended-release beta-blocker into a cup. Once Staff FF completed preparing the medications for administration, they crushed all of Resident 72's medications, including the following: an enteric coated iron tablet; an extended-release beta-blocker BP medication; and a delayed release anticonvulsant medication (a medication used to treat mental illness characterized by extreme mood swings). Staff FF then picked up some applesauce to mix in with the medications, while they were still separated, and stated they were ready to go administer the medications to Resident 72 after mixed. In an interview at this time, Staff FF was asked to stop and pull out the medication card for the calcium channel BP medication from the medication cart. Staff FF opened the drawer and was unable to locate a calcium channel BP medication for Resident 72. Staff FF confirmed they had accidentally doubled the dose of Resident 72's beta-blocker BP medication and omitted the resident's calcium channel BP dose.</p> <p>Review of Resident 72's September 2024 Medication Administration Record (MAR) revealed directions to staff to administer only 25 mg of the beta-blocker BP medication, rather than the 50 mg Staff FF almost administered. This MAR showed directions to staff to also administer 10 mg of a calcium channel BP medication, which Staff FF omitted.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 10/01/2024 at 10:31 AM, Staff FF was asked if they had a list of what medications could be crushed available to them, Staff FF stated they were not aware of any lists. In an interview on 10/01/2024 at 2:01 PM, Staff FF indicated they reviewed the medications and stated they should not have crushed the iron tablet or any extended or delayed released medications.</p> <p>On 10/02/2024 at 9:08 AM, Staff B (Director of Nursing) provided a copy of the facility's pharmacy list of medications that should not be crushed or altered. Review of the list showed the enteric coated iron tablet, the extended-release beta-blocker BP medication, and the delayed release anticonvulsant medication were on the list.</p> <p>&lt;Resident 4&gt;</p> <p>Observation of medication pass on 10/03/2024 at 8:22 AM showed Staff H (Registered Nurse) prepare and administer multiple medications by mouth to Resident 4. During administration, Staff H handed the medication cup to Resident 4 and then looked away towards a television in the room. Resident 4 brought the cup of medications to their mouth to take the pills, and one white tablet fell and landed on the floor when Staff H was not looking. Resident 4 had the other pills on their tongue and was trying to tell and show the nurse the first pill fell out, when a second pill fell and landed on their shirt. Staff H assisted Resident 4 to retrieve the pill on their shirt and stated, there you go. In an interview at this time, Staff H stated Resident 4 got all their medications. Observations at this time, showed the white pill that fell on the floor near the bed. Staff H moved the bed and located the dropped pill. Staff H confirmed the omitted medication was a vitamin D tablet.</p> <p>Review of Resident 4's September 2024 MAR revealed directions to staff to administer 1000 units of vitamin D and 1000 micrograms of vitamin B every morning. Both of these medications were omitted when Staff H administered Resident 4's medications.</p> <p>In an interview on 10/03/2024 at 11:05 AM, Staff H stated they must have clicked both medications on the computer since the names and doses looked similar. Staff H stated it was important to observe a resident during medication administration in order to ensure all medications were administered and did not fall out.</p> <p>In an interview on 10/04/2024 at 2:13 PM, Staff B stated it was their expectation staff administer medications as ordered, observe as medications were administered, and not crush uncrushable medications.</p> <p>Refer to F760 Residents Are Free Of Significant Medication Errors.</p> <p>REFERENCE: WAC 388-97-1060 (3)(k)(ii).</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>44296</p> <p>Based on interview and record review, the facility failed to ensure 2 of 20 sample residents (Residents 23 &amp; 72) were free from significant medication errors. These failures placed residents at risk for incorrect dosage, adverse side effects, and other negative health outcomes.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>Review of the 01/2024 facility, Medication Administration Guidelines policy showed medications should be administered in accordance with written orders of the prescriber. Medications should be verified three times before administering; when pulling medication package from medication cart, when dose is prepared, and before dose is administered.</p> <p>&lt;Resident 23&gt;</p> <p>According to the 09/03/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 23 had diagnoses including stroke with communication deficits, dementia, a history of alcohol dependence, psychotic disorder, and a disorder related to personality and behaviors. The MDS showed Resident 23 was administered routine antipsychotic medication.</p> <p>Review of the September 2024 Medication Administration Record (MAR) showed Resident 23 received an antipsychotic medication, 37.5 Milligram (mg) immediate release at 8:00 AM and 8:00 PM from 09/01/2024 through 09/30/2024 AM. Resident 23 received the antipsychotic medication, 50 mg immediate release at 2:00 PM from 09/01/2024 through 09/24/2024.</p> <p>The September 2024 MAR showed on 09/24/2024 the antipsychotic medication dose was increased to 75 mg twice daily. The antipsychotic medication was changed from an immediate release tablet to a 24-hour extended release tablet twice daily at 8:00 AM and 8:00 PM. The antipsychotic 37.5 mg immediate release tablet twice daily was not discontinued. The MAR showed both the 37.5 mg immediate release tablet and the 75 mg 24-hour extended release tablet were given twice daily at 8:00 AM and 8:00 PM.</p> <p>The September 2024 MAR showed on 09/30/2024 the antipsychotic medication 24-hour extended release dose was increased a second time from 75 mg twice daily to 100 mg twice daily. The MAR showed Resident 23 was administered both the 100 mg 24-hour extended release tablet and the 37.5 mg immediate release tablet twice daily.</p> <p>The October 2024 MAR showed Resident 23 was administered 50 mg 24-hour extended release tablets, two tablets (100 mg), twice daily at 8:00 AM and 8:00 PM. This MAR showed the 37.5 mg immediate release tablet twice daily was discontinued on 10/01/2024.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an observation and interview on 10/04/2024 at 1:36 PM, Staff R (Registered Nurse) was at the medication cart and showed the medication cards for Resident 23. There was a card for the antipsychotic medication 50 mg immediate release tablets with instructions to administer once daily. Staff R stated that dose was discontinued and removed the card from the cart. Staff R verified the discontinue date of the 50 mg was on 09/24/2024. Staff R showed another card for the antipsychotic medication 50 mg 24-hour extended release tablets with two tablets (100 mg) in each bubble (individual dose). The instructions directed nurses to give two 24-hour extended release tablets (100 mg) twice daily. Staff R stated the 100 mg 24-hour extended release tablets was the new order. Staff R looked at the antipsychotic medication order on their computer and compared to the antipsychotic card of medication. Staff R stated the physician order matched the card of medication and Resident 32 received 100 mg of the 24-hour extended release tablets twice a day. Staff R was asked if a 24-hour extended release tablet should be given twice a day, or if the instructions should be clarified with the practitioner. Staff R stated the nurse should have clarified the order with the practitioner and that a 24-hour tablet should not be given twice a day.</p> <p>In a phone interview on 10/04/2024 at 2:02 PM, the facility pharmacist stated a 24-hour extended release tablet should only be administered once a day. The pharmacist stated a person could take either the immediate release tablet multiple times per day or the 24-hour extended release medication once a day but should not take them together, that dosage would be excessive. The pharmacist looked at Resident 23's prescriptions in the pharmacy ordering system and confirmed the antipsychotic 24-hour extended release was ordered by the practitioner to be given twice a day. The pharmacist stated the order should have been clarified with the practitioner by the nurse or the pharmacist.</p> <p>43642</p> <p>&lt;Resident 72&gt;</p> <p>According to an 08/20/2024 Admission MDS, Resident 72 had multiple medically complex diagnoses including high Blood Pressure (BP), end stage kidney failure, a thyroid disorder, and a seizure disorder. This MDS showed staff assessed Resident 72 with a history of falls on admission.</p> <p>Review of Resident 72's September 2024 MAR showed the resident was taking both a beta-blocker (a medication that causes the heart to beat slower) and a calcium channel blocker (a medication that causes the heart and arteries to relax) due to their high BP related to kidney failure.</p> <p>Observations during medication pass on 10/01/2024 at 9:45 AM showed Staff FF (Licensed Practical Nurse) prepared medications for Resident 72. During the preparation, Staff FF was observed to administer double the ordered dose of Resident 72's beta-blocker and omitted the ordered dose of the resident's calcium channel blocker. Staff F documented Resident 72's BP of 130/75 into the computer and stated they were ready to administer the medications to Resident 72. The medication administration was stopped, and Staff FF confirmed they mistakenly doubled Resident 72's beta-blocker and omitted the resident's calcium channel blocker. In an interview at this time, Staff FF stated giving BP medications incorrectly could negatively affect a resident's condition.</p> <p>In an interview on 10/04/2024 at 2:13 PM, Staff B (Director of Nursing) stated it was their expectation staff administer medications as ordered.</p> <p>Refer to F758 Free from Unnecessary Psychotropic Medication.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Refer to F759 Free Of Medication Error Rates 5 Percent Or More.</p> <p>REFERENCE: WAC 388-97-1060(3)(k)(iii).</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46479</b></p> <p>Based on observation, interview, and record review the facility failed to ensure drugs and biologicals were secured, dated when opened, expired medications and biologicals were disposed of timely in accordance with professional standards, medications were stored at bedside only for assessed residents, and ensure medication carts were locked and secured when staff were not present for 2 of 4 medications carts, 1 of 2 medication rooms, and 1 shower room. These failures placed residents at risk for receiving expired medications and access to unsecured, prescription medications.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>Review of the facility's Medication Storage policy, dated 01/2024, showed medications and biologicals would be stored properly to support safe, effective drug administration. The medication supply would only be accessible to licensed nursing personnel. The policy showed medications would be stored so that various routes of administration would be separated. Internally administered medications would be stored separately from medications such as creams, lotions, and ointments. Outdated and discontinued medications would be removed from stock.</p> <p>Review of the facility's Medication Storage - Bedside Medication Storage policy, dated 01/2024, showed bedside medication storage was only permitted for residents who were able to self-administer medications upon a doctor's order and when deemed appropriate by nursing staff.</p> <p>&lt;Unlocked Medication Carts&gt;</p> <p>Observation on 10/03/2024 from 5:00 AM to 5:12 AM showed the Southwest and [NAME] medication carts unlocked. Both carts contained over-the-counter medications and prescription medications containing resident information, unsecured by staff. There were two unsecured medications sitting on top of the Southwest cart. There were no staff or residents observed in the hallways during this time.</p> <p>In an interview on 10/03/2024 at 5:12 AM, Staff Q (Registered Nurse) stated they were the nurse assigned to the Southwest and [NAME] medication carts that night. Staff Q stated they just returned from their break did not remember to lock the carts. Staff Q stated they should not leave the medication carts unlocked. Staff Q stated they should not leave medications on top of the cart, unattended.</p> <p>In an interview on 10/04/2024 at 10:43 AM, Staff B (Director of Nursing) stated it was important to ensure medication carts were locked for resident safety. Staff B stated residents could have access to medications they were not supposed to have when carts were unsecured and unattended. Staff B stated medication carts should be locked when not attended by licensed nurses.</p> <p>&lt;Southwest/West Medication Room&gt;</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 09/30/2024 at 1:56 PM of the Southwest/West medication room showed one vial of tuberculin (serious, highly transmissible respiratory illness) testing solution in the medication fridge. The vial was opened and did not have an open or discard date.</p> <p>In an interview on 09/30/2024 at 1:56 PM, Staff R (Registered Nurse) confirmed the tuberculin vial should contain an open date. Staff R stated they believed the solution was good for 30 days once opened.</p> <p>In an interview on 10/04/2024 at 10:44 AM, Staff B stated it was their expectation tuberculin vials were dated upon opening.</p> <p>&lt;West Medication Cart&gt;</p> <p>Observation on 09/30/2024 at 2:12 PM of the [NAME] medication cart showed a prescription anti-platelet medication for a resident who discharged on [DATE]. The [NAME] medication cart also had an uncontained a bottle of topical antifungal powder next to oral medications.</p> <p>In an interview at that time, Staff M (Licensed Practical Nurse) confirmed the discharged resident's medication and removed the medication from the cart. Staff M confirmed the antifungal powder should not be stored with the oral medications.</p> <p>In an interview on 10/04/2024 at 10:44 AM, Staff B stated oral and topical medications should be stored separately.</p> <p>47836</p> <p>&lt;East Medication Cart&gt;</p> <p>Observation on 09/30/2024 at 1:55 PM of the East medication cart showed an 08/31/2024 expired lubricating jelly and eight medicated patches that expired 08/2024 with one of them opened and placed back into their box. In an interview at this time, Staff H (Licensed Practical Nurse) stated they were expected to dispose of all expired medications immediately upon expiration. The East medication cart drawers had spilled sticky liquids in the bottom of them and the outside of the cart was dirty with splatters.</p> <p>During a change of shift narcotic count observation on 09/30/2024 at 2:27 PM, Staff H was counting off with Staff OO (Registered Nurse). During this observation, review of the East wing narcotic count book showed multiple medications transferred to other pages without the new page or the prescription number being documented. Staff H stated they were expected to complete documentation for all the boxes/questions on the narcotic book page. Staff H stated they should have documented which page the medication was transferred to and the prescription number so they could accurately keep track of the medication.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 10/04/2024 at 8:59 AM Staff B (Director of Nursing) stated they expected staff to place expired medications in a box in the medication room that identified them as expired medications and return them to the pharmacy as soon as possible. Staff B stated they expected staff to complete all boxes on the narcotic page, including the page they transferred to and the prescription number, when staff were transferring a medication from one page to another. Staff B stated it was important to document all the boxes to be able to keep track of the narcotic medications.</p> <p>43642</p> <p>&lt;Medications at Bedside&gt;</p> <p>&lt;Resident 53&gt;</p> <p>Observations on 10/04/2024 at 9:26 AM showed two brown pills in a clear medicine cup at Resident 53's bedside. Resident 53 stated, oh, I was supposed to take those.</p> <p>In an interview on 10/04/2024 at 9:28 AM, Staff W (Licensed Practical Nurse) removed the medications at Resident 53's bedside and stated they should not be left unsecured in a resident room.</p> <p>50511</p> <p>&lt;Unsecured Medications in Shower Room&gt;</p> <p>Observation on 09/29/2024 at 09:23 AM west shower room door was unlocked. Observed showed an unlocked cabinet in the shower room contained five bottles of various resident's prescription medicated shampoo bottles.</p> <p>In an interview on 10/02/2024 12:02 PM, Staff N (Certified Nursing Assistant) stated the medicated shampoos were not locked in the cabinet. Staff N stated they thought the cabinet was too high for residents to reach.</p> <p>In an interview on 10/02/2024 at 12:00 PM, Staff M (Licensed Practical Nurse) stated the medication shampoos should be locked up.</p> <p>In an interview on 10/04/2024 at 09:33 AM, Staff B stated prescription shampoo should be locked up and out of reach of residents. Staff B stated if staff saw medication or chemicals that were unsecured, they should make sure these items were locked up and kept out of reach.</p> <p>REFERENCE: WAC 388-97-1300(2).</p> <p>45941</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>43642</p> <p>Based on interview and record review, the facility failed to obtain timely laboratory services to meet the needs of 1 (Resident 3) of 5 residents reviewed for unnecessary medications. Failure to obtain physician ordered blood tests for residents who were assessed to require this service, placed residents at risk for delayed treatment and services.</p> <p>Findings included .</p> <p>&lt;Resident 3&gt;</p> <p>According to a 06/29/2024 Annual Minimum Data Set (an assessment tool), Resident 3 had multiple medically complex diagnoses including heart failure, high blood pressure, diabetes (a chronic disease in which the body has trouble controlling blood sugars), lung disease, and a thyroid disorder.</p> <p>Review of Resident 3's September 2024 Medication Administration Records showed a 09/05/2024, STAT [immediate] order for a Complete Blood Count (CBC - a comprehensive blood test), a Comprehensive Metabolic Panel (CMP - a blood test that measures chemical balance in your blood), and a Thyroid-Stimulating Hormone level (TSH - a blood test to measure how well the thyroid is functioning) related to the resident having feelings of constant exhaustion and sleepiness. This lab order was signed as completed by staff on 09/05/2024. The MAR showed a second lab order from 09/11/2024 for staff to obtain a CMP, CBC, TSH, and vitamin D level related to weight loss. This lab order was signed as completed by staff on 09/12/2024.</p> <p>Record review showed no test results for the labs ordered by the provider on 09/05/2024 or 09/11/2024 in Resident 3's records.</p> <p>In an interview on 10/04/2024 at 11:27 AM, Staff J (Resident Care Manager) stated their expectation was for lab tests to be obtained if they were ordered. Staff J stated a STAT order should be called to the lab and was usually obtained the same day it was ordered by the physician. A routine lab order would be expected to be obtained on the next scheduled lab day. Staff J reviewed Resident 3's records and confirmed there were no lab test results for the ordered labs on 09/05/2024 or 09/11/2024. Staff B stated they would call the lab to obtain further information.</p> <p>In an interview on 10/04/2024 at 11:40 AM, Staff J stated they called the lab, and no lab tests were performed for Resident 3's 09/05/2024 or 09/11/2024 orders. Staff J stated they were unable to locate lab requisition slips or documentation as to why the labs were not obtained as ordered.</p> <p>In an interview on 10/04/2024 at 12:02 PM, Staff B (Director of Nursing) stated they should, but do not currently have a system in place to check or audit the receipt of lab test results after the test was performed. Staff B stated their expectation was for documentation to be in place and follow up to occur if a lab test was not completed. In an interview on 10/04/2024 at 2:13 PM, Staff B stated lab tests were an important part of monitoring a resident's condition and were used to determine if a resident required interventions to be implemented. Staff B stated it was their expectation lab tests would be obtained as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>REFERENCE: WAC 388-97-1620(2)(b)(i)(ii).</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>42203</p> <p>Based on observation, interview, and record review the facility failed to ensure food and drinks served to residents were stored and distributed under sanitary conditions for 1 of 1 facility kitchen. The failure to store canned and frozen food appropriately, ensure food was covered when distributed in the hall, and ensure the ice machine was clean, placed residents at risk for spoiled food and foodborne illness.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;According to the facility's February 2011 Dented Cans policy, all canned food items should be inspected by dietary staff upon delivery. The policy showed cans with significant dents should not be used and instead returned to the vendor</p> <p>&lt;Dry Storage&gt;</p> <p>Observation of the facility's dry food storage area on 09/29/2024 at 9:27 AM showed one large can of apricots, one large can of sliced apples, and three cans of diced pears that were all significantly dented. In an interview at that time Staff CC (Food and Nutrition Service Aide) stated cans with dents should be discarded. Staff CC said the dented cans should not be in the dry storage.</p> <p>43642</p> <p>&lt;Uncovered Food&gt;</p> <p>Observations on 09/29/2024 at 1:05 PM showed staff passing out lunch trays on the East unit from a meal tray cart. Staff pulled a meal tray out of the cart, with an uncovered dessert, and carried the tray past three other rooms and residents to deliver to a resident.</p> <p>Observations on 09/29/2024 at 1:09 PM showed staff passing out lunch trays on the South [NAME] unit from a meal tray cart. This unit was currently experiencing a contagious respiratory outbreak. Staff pulled a meal tray out of the cart, with an uncovered fruit cup, and carried the tray past three rooms to deliver. Staff returned and pulled out another meal tray out of the cart, with an uncovered dessert, and carried the tray past three rooms to deliver.</p> <p>On 09/30/2024 at 8:26 AM, staff were observed carrying a breakfast tray on the East unit, past two rooms and the nurse's station, prior to delivering the meal tray to a resident. Observations at this time showed a sign posted on the side of the meal tray cart that directed staff to bring the cart to each room to deliver meal trays rather than carrying trays through the hallways.</p> <p>45941</p> <p>Observation on 10/03/2024 at 8:50 AM showed the ice machine in the main kitchen was not clean, had mold, black, sticky debris along the opening of the inside the ice machine that was able to be scratched off.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 10/03/2024 at 8:52 AM, Staff T (Dietary Manager) observed and confirmed the mold inside the ice machine and stated it should be clean. Staff T stated they would check with the maintenance staff about the ice machine cleaning schedule.</p> <p>In an interview on 10/03/2024 at 10:02 AM, Staff T stated maintenance staff were supposed to clean the ice machine every month and the last time the ice machine was cleaned was August 2024. Staff T stated the ice machine should be cleaned and there should not be mold inside the ice machine.</p> <p>REFERENCE: WAC 388-97-1100(3), -2980.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>47836</p> <p>Based on interview and record review, the facility failed to ensure residents records were complete and accurate and readily accessible for 3 of 20 residents (Resident 16, 43, &amp; 45) whose records were reviewed. The facility failed to ensure Task Care Record documentation was complete and accurate. Failure to ensure residents records were complete and accurate placed residents at risk for unmet care needs and inaccurate assessments.</p> <p>Findings included .</p> <p>&lt;Resident 16&gt;</p> <p>Review of Resident 16's August 2024 Task Care Records (documentation of resident specific cares offered/provided) showed staff failed to document multiple cares on multiple days. Similar findings were noted on Resident 16's September 2024 and October 2024 Task Care Records.</p> <p>&lt;Resident 43&gt;</p> <p>Review of Resident 43's July 2024 Task Care Records showed staff failed to document multiple cares on multiple days. Similar findings were noted on Resident 43's August 2024, September 2024, and October 2024 Task Care Records.</p> <p>&lt;Resident 45&gt;</p> <p>Review of Resident 45's June 2024 Task Care Records showed staff failed to document multiple cares on multiple days. Similar findings were noted on Resident 45's July 2024, August 2024, September 2024, and October 2024 Task Care Records.</p> <p>In an interview on 10/03/2024 at 9:14 AM Staff BB (Resident Care Manager) stated Staff B (Director of Nursing) reviewed the staff Task Care Records and notified staff of their missing documentation. Staff BB stated it was important for the Task Care Records to be documented accurately to ensure residents were getting the cares they were assessed to require.</p> <p>In an interview on 10/04/2024 at 8:59 AM Staff B stated Resident's 16's August, September, and October 2024 Task Care Records were not accurate or complete. Staff B stated Resident's 43's July, August, September, and October 2024 Task Care Records were not accurately documented or complete. Staff B stated Resident's 45's June, July, August, September, and October 2024 Task Care Records were not accurately documented or complete. Staff B stated they expected staff to accurately document the cares provided after completion/offered. Staff B stated they expected staff to complete their care documentation by the end of their shift or leaving work. Staff B stated accurate and thorough documentation in resident records was important to ensure they didn't miss any cares that needed to be provided.</p> <p>REFERENCE: WAC 388-97-1720(1)(a)(i-iv)(b).</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p>45941</p> <p>Based on interview and record review, the facility failed to ensure the arbitration agreement was explained in a form and manner that the resident and/or their representative understood for 4 of 5 residents (Resident 37, 48, 35, &amp; 59) reviewed for arbitration (a procedure used to settle a dispute using an independent person mutually agreed upon by both parties) agreement. This failure placed residents at risk of lacking understanding of the legal document signed, forfeiture (loss or giving up of something) of the right to a jury or court, and a diminished quality of life.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>The facility's updated September 2022 Arbitration Agreement policy in the Admission Agreement packet showed the admissions coordinator would review the arbitration agreement with the resident upon admission to the facility. The policy showed the admissions coordinator was responsible for any questions the resident had about the contract.</p> <p>&lt;Resident 37&gt;</p> <p>According to the 04/09/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 37 was alert and oriented with an intact memory. The assessment showed Resident 37 had adequate vision and hearing, and had clear speech during communication.</p> <p>Review of a 04/03/2024 electronically signed arbitration agreement showed Resident 37's name was captured in the signature line and indicated the resident was bound by the terms and condition of the agreement.</p> <p>In an interview on 10/02/2024 at 9:30 AM, Resident 37 stated staff asked them to sign so many papers upon admission, they could not remember signing an arbitration agreement or knew what the arbitration agreement was about. Resident 37 was presented with a copy of their signed arbitration agreement and the resident read the details. Resident 37 stated, .waiving my right to a court hearing, now why would I do that? Resident 37 stated if that was the case, they would not want anyone taking away their right. When asked if the admissions coordinator educated them about the facility's arbitration agreement and/or gave them enough time to read through the contract before having them sign the agreement, Resident 37 stated, No, I do not remember anyone discussing this agreement with me. If I knew it, I would not agree to it.</p> <p>&lt;Resident 48&gt;</p> <p>According to the 04/23/2024 Admission MDS, Resident 48 was alert and oriented with an intact memory. The assessment showed Resident 48 had no issues with their vision or hearing and had clear speech during communication.</p> <p>(continued on next page)</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 48's arbitration agreement showed the contract was electronically signed by the resident on 04/18/2024.</p> <p>In an interview on 10/02/2024 at 9:41 AM, Resident 48 stated they did not remember signing an arbitration agreement or knew what an arbitration agreement was about. Resident 48 stated the pile of paperwork they were presented with upon admission was very overwhelming and it was difficult to keep up with all the papers. Resident 48 was presented with a copy of their signed arbitration agreement and the resident read the details. Resident 48 stated they did not remember ever signing this paper and why would they sign this paper. Resident 48 stated they did not remember any staff member talking to them about this agreement.</p> <p>&lt;Resident 35&gt;</p> <p>According to the 05/11/2024 Admission MDS, Resident 35 was alert and oriented with an intact memory. The assessment showed Resident 35 had no vision or hearing issues and had clear speech during communication.</p> <p>Review of Resident 35's arbitration agreement showed the contract was electronically signed by the resident on 05/10/2024.</p> <p>In an interview on 10/02/2024 at 10:48 AM, Resident 35 stated they did not remember anyone talking to them about the arbitration agreement. Resident 35 stated they did not remember signing an arbitration agreement or knew what an arbitration agreement was about. Resident 35 stated the facility staff might have talked to their family member but not to them. Resident 35 wanted this surveyor to talk to their family (spouse).</p> <p>In an interview on 10/02/2024 at 12:01 PM, Resident 35's spouse stated they did not know what an arbitration agreement was and no one in the facility talked to them about an arbitration agreement. Resident 35's family stated their spouse would never sign an arbitration agreement if they knew what the contract was about.</p> <p>&lt;Resident 59&gt;</p> <p>According to the 12/21/2023 Admission MDS, Resident 59 was alert with an impaired memory, impaired vision, but had clear speech during communication.</p> <p>Review of Resident 59's arbitration agreement showed the contract was electronically signed by the resident's representative on 12/15/2023.</p> <p>In an interview on 10/02/2024 at 11:49 AM, Resident 59's representative stated they did not sign an arbitration agreement with the facility. Resident 59's representative was explained with a copy of their electronically signed arbitration agreement. Resident 59's representative stated they may have signed upon admission, but they did not remember signing an arbitration agreement at all. Resident 59's representative stated if they knew what an arbitration agreement was, they would never sign an arbitration agreement.</p> <p>(continued on next page)</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 10/02/2024 at 12:52 PM, Staff L (Admission Assistant) stated they were responsible for the facility's arbitration agreement process, and they assisted residents to sign the admission papers including the arbitration agreement upon admission. Staff L stated they explained the details about an arbitration agreement to residents/their representatives before they sign an arbitration agreement.</p> <p>In an interview on 10/04/2024 at 10:21 AM, Staff K (Admission Director) stated it was important to ensure the residents had full understanding of the arbitration agreement because it involved giving up their right to court. Staff K stated they were unsure where the disconnect was with all the residents arbitration agreement and they needed to do a better job explaining the contract in a form and manner that the resident best understood.</p> <p>REFERENCE WAC: 388-97-1620(2)(a)(b)(i), -0180(1-4).</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941</b></p> <p>Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the transmission of communicable diseases including COVID-19 (a highly transmissible infectious virus that causes respiratory illness and in severe cases, could cause difficulty breathing resulting in impairment or death) and other infections. The facility failed to do one or more of the following: consistently perform hand hygiene before and after resident care/contact; apply/remove Personal Protective Equipment (PPE) in accordance with the Transmission Based Precaution (TBP- implement precautions based on the means of transmission in order to prevent or control infection) signs posted outside of resident rooms; and maintain infection control during wound care and medication pass. These failures placed all residents and staff at risk for contracting and spreading communicable diseases, including COVID 19, during a COVID 19 outbreak in the facility.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's 09/06/2023 revised Prevention and Management of COVID- 19 policy, when TBPs were implemented, the Infection Preventionist (IP) determined the appropriate notification to be placed on the resident's room door sign identifying the type of isolation required (e.g. Airborne, Droplet, or Contact) to ensure staff and visitors were aware of the type of precautions required. The policy showed the facility followed Aerosol Contact Precautions during a COVID-19 infection outbreak. The sign showed all staff and visitors must wear an N-95 (a non-oil-based type of respirator with 95 percent efficiency) mask, eye protection, gown, and gloves, before entering the isolation room, use disposable equipment or disinfect shared equipment, and to keep the room door closed to prevent spreading the infection.</p> <p>&lt;PPE&gt;</p> <p>During survey, residents in the facility were placed on TBPs from the date of entrance on 09/29/2024, through 10/04/2024. TBP signage outside resident rooms instructed staff to don (put on) a gown, gloves, face shield and an N 95 mask prior to entering a resident room. Upon exit, signage directed staff to doff (remove) and dispose of the gown, N 95 mask, and gloves, and directed staff to disinfect their face shields prior to reuse.</p> <p>Observation on 10/01/2024 at 10:20 AM showed Staff DD (Medical Director) sitting on the [NAME] nurse's station. Staff DD had their mask below their nose, and had no face shield on.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 10/01/2024 at 10:22 AM, Staff DD stated they were aware of the facility's COVID outbreak and knew about the facility's policy for staff to wear N 95 mask and face shield or goggles inside the facility. Staff DD pulled their mask to their chin while talking to this surveyor. When asked if they were supposed to wear the N 95 mask properly and wear a face shield, Staff DD stated they were supposed to wear the mask properly and wear a face shield inside the facility, but they forgot to wear a face shield. Staff DD stated they pulled their mask down because they were sneezing. Staff DD fixed their mask towards their nose and stated they should wear the mask properly and wear face shield.</p> <p>In an interview on 10/03/2024 at 9:00 AM, Staff C (Infection Preventionist) stated they already talked to Staff DD a few times for not following the instructions regarding PPE. Staff C stated Staff DD should wear the mask properly and wear a face shield in the building.</p> <p>Observation on 10/03/2024 at 6:03 AM showed Staff Q (Registered Nurse) exiting resident room [ROOM NUMBER] wearing a gown, face shield, and N-95 mask. Staff Q removed the gown, sanitized their hands, and walked to the nurse's station. Staff Q did not clean the face shield when exiting the room and did not change their mask. room [ROOM NUMBER] had sign posted on the door for aerosol precautions and instructed staff to don a gown, gloves, face shield, and an N 95 mask prior to entering the resident's room. Upon exit, signage directed staff to doff and dispose of the gown, N 95 mask, and gloves, and to disinfect their face shields prior to reuse.</p> <p>In an interview on 10/03/2024 at 6:07 AM, Staff Q stated it was the facility's process to remove PPE including gloves, gowns, face mask and to clean the face shield when exiting the room. Staff Q stated they removed the gown and gloves inside the room, changed their mask inside the room, and did not clean their face shield. Staff Q stated they were supposed to clean their face shield, but they forgot. Staff Q stated they should follow the sign posted on the resident's door.</p> <p>In an interview on 10/03/2024 at 9:04 AM, Staff C stated the correct way to remove PPE was posted on the wall outside of the resident rooms. Staff C stated all staff were expected to follow the posted method of removal of PPE. Staff C stated face shields were expected to be cleaned after resident care when leaving the resident room. Staff C stated staff should change their masks when exiting the resident's rooms.</p> <p>43642</p> <p>&lt;PPE&gt;</p> <p>In an interview on 09/29/2024 at 9:36 AM, Staff A (Executive Director) stated the facility was having an outbreak of COVID and all staff were to wear fit-tested respirator masks and eye protection.</p> <p>Observations on 09/29/2024 at 9:17 AM showed Staff W (Licensed Practical Nurse - LPN) walking in the hallway with their fit-tested respirator mask positioned under their nose. On 09/29/2024 at 11:54 AM, Staff W came out of a resident's room with their mask positioned under their nose.</p> <p>Observations on 09/30/2024 at 2:31 PM showed Staff I (Occupational Therapist) walking in the hallway wearing no eye shield or protective goggles. Staff I entered room [ROOM NUMBER], closed the door, and remained in the room until 2:59 PM without protective eyewear.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observations on 10/01/2024 at 10:10 AM showed Staff KK (Physical Therapist Assistant) exiting a resident's room with their eye protection worn on the top of their head, rather than covering the eyes for protection.</p> <p>Observations on 10/01/2024 at 11:15 AM showed Staff DD standing at the counter of the nurse's station on the East unit with no face shield. Residents were sitting nearby the nurse's station.</p> <p>Observations on 10/01/2024 at 11:20 AM showed Staff JJ (Housekeeping Aide) was exiting room [ROOM NUMBER], a room with an Aerosol precaution sign, due to the residents having COVID. Staff JJ changed their face shield, but did not change their mask. They were wearing a yellow adhesive mask. In an interview at this time, Staff JJ stated they wore masks they purchased themselves, and only changed them on their breaks due to the expense.</p> <p>In an interview on 09/29/2024 at 2:48 PM, Staff C stated they were in charge of infection control and stated their expectation was for staff in all departments to wear a fit-tested respirator mask and face shield or goggles when in the facility.</p> <p>&lt;TBP&gt;</p> <p>Observations on 09/29/2024 at 9:21 AM showed staff entering room [ROOM NUMBER], without a gown or gloves on, put on gloves once inside the room, and then closed the door. This room had a sign posted at the door which indicated the resident was on Contact Enteric precautions (a set of procedures that prevent the spread of germs that can cause intestinal upset). The sign directed staff to put on a gown and gloves prior to entering the room.</p> <p>Observations on 09/29/2024 at 1:09 PM showed the door to room [ROOM NUMBER] was open. Sign posted on the door indicated the resident was on Aerosol precautions. The sign directed staff to keep the resident's door closed.</p> <p>In an interview on 09/29/2024 at 2:48 PM, Staff C stated prior to entering a room of a resident on Aerosol precautions, staff were expected to put on all their PPE, dispose of their gown and gloves in the room prior to exit, after exit they were to clean their shield, and change their fit-tested respirator mask to a new one. Staff C stated the door should be shut if a resident was on Aerosol precautions, to help reduce the risks of spreading infection.</p> <p>Observations during medication pass on 10/01/2024 at 9:28 AM showed Staff FF (LPN) put on PPE to deliver medications to a resident on Aerosol precautions due to a contagious respiratory infection. Upon exiting the resident's room, Staff FF changed their face shield but kept the same fit-tested respirator mask on they wore inside the isolation room. Staff FF walked from the unit with several COVID positive residents over to another unit on the other side of the building while wearing the same soiled mask. While Staff FF was preparing medications for another resident, they touched their soiled mask with their hand, touched the medication cart keys, and then put them back in their pocket.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observations on 10/03/2024 at 7:45 AM showed Staff II (LPN) put on PPE to enter room [ROOM NUMBER] to assist a resident with medication administration. This room had a posted Contact Enteric precaution sign at the door which gave directions for staff to wash their hands with soap and water upon leaving the room. Upon finishing, Staff II removed PPE, exited the room and returned to their medication cart to use hand sanitizer. Staff did not wash their hands with soap and water as the posted sign directed.</p> <p>Observations on 10/03/2024 at 7:48 AM showed Staff EE (Certified Nursing Assistant - CNA) put on a gown and gloves prior to entering room [ROOM NUMBER]. This room had a posted Contact Enteric precaution sign at the door which gave directions for staff to wash their hands with soap and water upon leaving the room. Staff EE provided toileting assistance to the resident and upon finishing, removed their gown and gloves, and only used hand sanitizer when exiting the room. Staff did not wash their hands with soap and water as directed, and then went into room [ROOM NUMBER] to provide assistance.</p> <p>In an interview on 10/04/2024 at 10:17 AM, Staff C stated it was their expectation staff follow the TBP signs posted and to wash their hands with soap and water when exiting a room with Contact Enteric precautions in place in order to reduce the risk of spreading contagious infections</p> <p>&lt;Uncleanable Surfaces&gt;</p> <p>Observations on 09/29/2024 at 12:15 PM showed a vinyl cover over a linen cart across from room [ROOM NUMBER]. The cover had cracked material at the creases, exposing the material underneath. Similar observations of the cracked material on the linen cart were made on 09/30/2024 at 8:30 AM, and 10/01/2024 at 9:28 AM.</p> <p>In an interview on 10/04/2024 at 10:17 AM, Staff C stated the linen cart covers should not have cracked, uncleanable surfaces.</p> <p>&lt;Medication Administration&gt;</p> <p>Observations during medication pass on 10/01/2024 at 9:28 AM showed Staff FF preparing medications for a resident. During preparations, one pill missed the cup and landed on top of the medication cart. Staff FF picked up the pill with their bare fingers, placed it inside the medication cup, and then delivered it to a resident for administration.</p> <p>In an interview on 10/04/2024 at 10:17 AM, Staff C stated staff should absolutely not touch medications with their bare fingers and their expectation was for staff to use sanitizer and gloves when touching pills directly.</p> <p>47836</p> <p>&lt;Hand Hygiene&gt;</p> <p>&lt;Resident 16&gt;</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an observation and interview on 10/02/2024 at 10:01 AM Staff G (CNA) was providing Resident 16 personal care after a Bowel Movement (BM). Staff G placed double gloves on, cleaned BM off Resident 16's skin then removed the top layer of gloves and proceeded to place a clean brief on Resident 16. Staff G stated they should not wear two pairs of gloves and should perform hand hygiene between dirty and clean cares, but they did not. Staff G stated it was important to perform hand hygiene between dirty and clean cares and glove change for infection control purposes.</p> <p>In an observation and interview on 10/02/2024 at 10:17 AM Staff E (LPN) provided wound care to Resident 16. Staff E was observed to remove the resident's soiled bandages, clean the wound, and change their gloves without performing hand hygiene before placing the new bandage on Resident 16's wounds. Staff E stated they should have washed their hands after removing the dirty gloves and before they placed the new gloves on, but they did not. Staff E stated hand hygiene was important between glove change to prevent infections.</p> <p>In an interview on 10/04/2024 at 9:38 AM Staff C stated they expected staff to wash hands with soap and water between dirty and clean cares during wound care, peri care, and before and after glove change. Staff C stated hand hygiene before and after glove change and between dirty and clean care was important to prevent infections.</p> <p>&lt;Soiled Linen and Garbage Disposal&gt;</p> <p>In an observation and interview on 10/03/2024 at 5:08 AM Staff Z (CNA) had bags full of dirty linen and garbage placed on the floor in the hall outside of rooms 120, 121, &amp; 124. Staff Z stated they did not normally put the garbage and dirty linens on the floor in the hallway and stated they should not place bags of garbage and dirty linen on the floor because doing so could increase the risk of infections.</p> <p>In an interview on 10/04/2024 at 9:38 AM Staff C stated they expected staff to remove garbage and soiled linens from the resident's rooms immediately. Staff C stated setting the bags of garbage and dirty linens on the floors in the hallways was placing residents at risk of infection.</p> <p>42203</p> <p>&lt;Transmission Based Precautions&gt;</p> <p>According to a 09/21/2024 progress note, Resident 34 tested positive for COVID-19 on that date. The note showed necessary precautions were put in place for Resident 34.</p> <p>According a 09/21/2024 progress note Resident 25 was placed on aerosol contact precautions on that date related to their roommate Resident 34 testing positive for COVID-19. A 09/28/2024 progress note showed Resident 25 tested positive for COVID-19 on that date.</p> <p>Observation on 09/30/24 02:23 PM showed an Aerosol Contact Precaution sign outside room [ROOM NUMBER], both residents in that room were isolated. The sign directed anyone entering the room to put on a gown, gloves, eye protection and an N-95 respirator prior to entering the room. The sign directed everyone to remove all their PPE before leaving the room and replace their eye protection and respirator. At that time Staff O (CNA) heard one of the residents in the room cry out. Staff O already wore eye protection and a respirator and put on a gown and gloves prior to entering the room room.</p> <p>(continued on next page)</p>		

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