

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Cheney Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2219 North 6th Street Cheney, WA 99004	

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 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>27590</p> <p>Based on interview and record review, the facility failed to provide a bed-hold notice (a notice to inform residents of their right to pay the facility to hold their room/bed while they were hospitalized), to the resident and/or their representative at the time of discharge, or within 24 hours of transfer to the hospital, for 4 of 4 sampled residents (Resident 1, 3, 6, and 7), reviewed for hospitalization . This failure placed residents at risk for a lack of knowledge regarding the right to a bed-hold while they were hospitalized .</p> <p>Findings included .</p> <p><Resident 1></p> <p>The 11/20/2024 quarterly assessment documented Resident 1 was admitted with a history of a stroke, anxiety and depression. The resident was able to make needs known.</p> <p>Review of nursing progress notes, dated 09/16/2024, showed Resident 1 was transferred to the hospital due to complaints of increased numbness to their lower legs and pain in their hand.</p> <p>Additional record review showed no documentation the resident had been provided a bed-hold notice.</p> <p><Resident 3></p> <p>The 12/20/2024 admission assessment documented Resident 3 was admitted with Parkinson's Disease (a progressive disorder that affects movement, balance, and coordination) and a history of a stroke. The resident had difficulty making their needs known.</p> <p>Review of nursing progress notes, dated 02/03/2025, showed Resident 3 was screaming, swinging their cane in the air, and would not calm down. The facility was concerned about safety of staff and other residents and transferred the resident to the hospital for an evaluation.</p> <p>Additional record review showed no documentation the resident had been provided a bed-hold notice.</p> <p><Resident 6></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 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The 11/30/2024 assessment documented Resident 6 was admitted with history of a stroke, anxiety, and depression. The resident was able to make their needs known.</p> <p>Review of nursing progress notes, dated 01/01/2025, showed Resident 6 continued to exhibit confusion, had diarrhea, vomiting and unstable vital signs. The resident was transferred to the hospital for an evaluation.</p> <p>Additional record review showed no documentation the resident had been provided a bed-hold notice.</p> <p><Resident 7></p> <p>The 12/11/2024 quarterly assessment documented Resident 7 was admitted with fractures and depression. The resident had difficulty making their needs known.</p> <p>Review of nursing progress notes, dated 01/11/2025, showed Resident 7 had confusion, was lethargic (feeling tired, sluggish), and had tremors (involuntary shaking movement). The resident was sent to the hospital for an evaluation.</p> <p>Additional record review showed no documentation the resident had been provided a bed-hold notice.</p> <p>On 02/13/2025 at 11:34 AM, Staff C, Licensed Practical Nurse (LPN), stated they did not give the bed-hold policy to residents transferred to the hospital. Staff C stated it would be something the Resident Care Manager (RCM) or Social Services Director (SSD) would give the residents.</p> <p>On 02/13/2025 at 1:55 PM Staff A, Director of Nursing (DNS) and Staff B, Resident Care Manager (RCM), were interviewed. Staff A stated the residents received their first copy of a bed-hold during the admission process. If a resident was transferred to the hospital, a second notification should be given to the resident or their representative. Currently the facility didn't have a clear process and residents were given the information verbally.</p> <p>Reference: WAC 388-97-0120(4)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>27590</p> <p>Based on interview and record review, the facility failed to consider re-admission for 1 of 4 sampled residents (Resident 3), reviewed for hospitalization . This failure placed the resident at risk for increased anxiety related to being placed in an unfamiliar environment, and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of a facility form titled Transfer and Discharge ., revised on 12/24 documented emergency transfers/discharges were initiated by the facility for medical reasons to an acute care setting such as a hospital, for the immediate safety and welfare of a resident. The resident will be permitted to return to the facility upon discharge from the acute care setting. In a situation where the facility initiates discharge while the resident is in the hospital following emergency transfer, the facility will have evidence that the resident's status at the time the resident seeks to return to the facility .</p> <p>Review of the Admission assessment, dated 12/20/2024, showed Resident 3 was admitted with diagnoses which included a stroke, Parkinson's Disease (a progressive disorder that affects movement, balance, and coordination). The resident had difficulty making their needs known.</p> <p>Review of Nursing Progress notes, dated 02/03/2025, showed the resident was at their doorway screaming and began swinging their cane at Staff A, Director of Nursing (DNS). Resident 3 was asked to calm down and continued to scream unintelligibly and swinging their cane. Staff A was fearful of immediate safety for staff and residents. Resident 3 walked down the hallway, swinging their cane and yelling, and exited the front of the building. The police and Emergency Medical System (EMS) came to the facility and transferred the resident to the hospital. Staff A informed EMS the facility could not manage the resident' aggression and would not take them back.</p> <p>During an interview on 02/13/2025 at 1:55 PM, Staff A stated the resident was sent to the hospital because they were a threat to staff and residents. Staff A informed EMS they were not taking the resident back. A discharge notice was sent to the hospital at the time of discharge.</p> <p>Reference: (WAC) 388-97-0120(4)(b)</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27590</p> <p>Based on observation, interview, and record review, the facility failed to ensure Pre-Admission Screening and Resident Review (PASARR, a screening required to be completed prior to admission to a nursing home that looked for indicators that one may have a serious mental illness) were completed for 3 of 5 sampled residents (Resident 1, 3, and 7), reviewed for PASARR's. Resident 1 and 3 were not referred for a Level II evaluation (an assessment that made recommendations about specialized services needed to determine the best setting to meet a person's behavioral health needs) and Resident 7 did not have a PASARR completed prior to admission to the facility, as required. This failure placed the residents at risk for a decline in their mental health and a decreased quality of life.</p> <p>Findings included .</p> <p><Resident 1></p> <p>Review of the quarterly assessment, dated 11/20/2024, showed Resident 1 was admitted with a history of a stroke, anxiety and depression. The resident was able to make their needs known. Resident 1's mood assessment showed they had little interest in doing things, felt down, felt bad about themselves and thoughts they would be better off dead. The resident was admitted on an antidepressant and antianxiety medication.</p> <p>Review of the resident's PASARR dated 08/19/2024, indicated Resident 1 had indicators they had a serious mental illness and required a PASARR level II review.</p> <p>Further review of the Electronic Medical Record (EMR) had no documentation to show the facility requested a Level II review from the PASARR coordinator.</p> <p>On 01/29/2025 at 12:05 PM, Resident 1 was laying in bed with a hospital gown. The resident stated the facility was pushing him to violence and he had hit a staff member about a week ago with their back scratcher. The facility told them if they hit someone again, they would call the police. Resident 1 stated they were trying to not get angry. The resident was tearful during the conversation.</p> <p><Resident 3></p> <p>Review of the Admission assessment, dated 12/20/2024, showed Resident 3 was admitted with diagnoses which included a stroke, Parkinson's Disease (a progressive disorder that affects movement, balance, and coordination), and a history of suicide attempt. The resident had difficulty making their needs known. The mood assessment showed the resident had little interest in doing things, felt down and bad about themselves, and had thoughts they were better off dead. The resident was admitted on an antidepressant.</p> <p>Review of the PASARR, dated 12/13/2024, indicated Resident 3 had indicators they had an intellectual disability or related condition, and required a PASARR level II review from the Development Disability Administration (DDA).</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>27590</p> <p>Based on observation, interview, and record review, the facility failed to ensure behavioral health needs were identified and met for 2 of 4 sample residents (Resident 1 and 3), reviewed for behavioral-emotional health. Failure to assess residents behavioral needs, identify individual resident responses to stressors and develop person-centered interventions placed residents at risk for unidentified behavior triggers, unmet behavioral needs, and diminished quality of life.</p> <p>Findings included .</p> <p><Resident 1></p> <p>According to the admission assessment, dated 08/23/2024, Resident 1 had diagnoses to include a stroke with left sided weakness, anxiety and depression. Resident 1 had difficulty making their needs known. The resident had hallucinations (where you hear, see, smell, taste or feel things that appear to be real but only exist in your mind). The resident's mood assessment showed they felt bad about themselves, felt down, depressed, or hopeless, and had little interest in doing things. The resident took antidepressant and antianxiety medication.</p> <p>Review of the Pre-Admission Screening and Resident Review (PASARR, a screening required to be completed prior to admission to a nursing home that looked for indicators one may have a serious mental illness), dated 08/19/2024, indicated Resident 1 had a serious mental illness and required a PASARR level II review (an assessment that made recommendations about specialized services needed to determine the best setting to meet a person's behavioral health needs).</p> <p>Additional review of the record showed no Level II assessment had been completed.</p> <p>Review of the resident's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for August 2024, the resident was taking an antidepressant twice a day and an antianxiety medication every 8 hours as needed. The resident had antianxiety and antidepressant side effect monitors to be done each shift. A progress note was to be written if side effects were observed and an intervention included. There was nothing to show non-medication interventions were attempted prior to medicating the resident, no target behaviors identified, and no person-centered interventions in place.</p> <p>Review of the provider notes, dated 09/09/2024, documented the resident was on the maximum dose of medication for their depression. The provider requested a referral be placed for mental health counseling.</p> <p>On 09/13/2024, the provider again documented the resident needed outside psychiatric follow up due to being on the maximum antidepressant dosage and requested a referral for mental health counseling.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Social Services Director (SSD) notes, dated 09/10/2024 to 09/16/2024, showed contact was attempted to an outside mental health provider but the facility was waiting for a call back. There were no further notes found to show a mental health provider had been reached.</p> <p>Review of the 11/20/2024 quarterly assessment documented Resident 1 had delusions (false beliefs that are held with strong conviction, despite evidence to the contrary) and resisted care. In addition to the resident's mood assessment on admission, the resident now had thoughts they would be better off dead and felt bad about themselves.</p> <p>Review of Resident 1's comprehensive care plan identified the following care areas:</p> <p>-On 12/05/2024 - Mood and Behavior: Resident had been diagnosed with depression and anxiety with psychoactive medications (substances that affect the brain and alter perception and cognition) to treat. Interventions included attempt Gradual Dose Reduction (GDR, an assessment to show if a resident's dose could be lowered) per protocol and monitor side effects of the medications every shift.</p> <p>-On 01/09/2025 - the care plan was revised due to a history of holding down their call button to keep it on continuously, especially during the night, and not needing help. Interventions included 30 minute checks. It was documented the resident was made aware if they pushed the call button in between checks, staff may not be able to answer it.</p> <p>-On 01/23/2025 - the care plan was revised due to a history of physical aggression toward staff such as hitting with objects and using racially insensitive dialogue. Interventions included redirecting the resident when hitting or using insensitive statements and notify the nurse or SSD.</p> <p>There was nothing found to show target behaviors had been identified for the resident and no person-centered interventions in place.</p> <p>A review of nursing progress notes from 09/02/2024 to 11/30/2024 showed the resident had reported they were anxious on several occasions. The nurses documented the resident frequently used the call light and was inpatient.</p> <p>On 10/13/2024 it was documented the resident's dog had passed away and the resident was very emotional but had stabilized.</p> <p>On 11/11/2024, a note was written by Staff A, Director of Nursing (DNS). Staff A met with the resident related to a comment they had made about a nursing assistant the night before. The resident had reported they felt they had a stroke and according to the resident, the nursing assistant responded the nurses are too busy, and the hospital won't do anything for you. The nurse was interviewed and stated they had gone in and evaluated the resident for a stroke and there was no signs of one. The nurse reported to Staff A the resident got very anxious in the evenings and would work themselves up to thinking they were dying. Staff A contacted the provider.</p> <p>On 11/15/2024 the provider visited Resident 1 and documented to continue the current antianxiety medication because the resident stated it controlled their anxiety.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/06/2025, Staff A met with family to discuss Resident 1's continued anxiety. The family member reported the resident's anxiety had been an ongoing issue for Resident 1 due to traumatic events that had occurred in their life: divorce, loss of their farm, and loss of a farming career.</p> <p>Review of the resident orders showed the resident was started on a different antianxiety medication on 01/09/2025. The medication was slowly being increased as the prior medication was being decreased.</p> <p>During record review, there was no document to show an interdisciplinary team (IDT) had assessed the resident for their response to stressors, develop person-centered individualized interventions or evaluate the effectiveness of the resident's medication regimen.</p> <p>On 01/29/2025 at 12:05 PM, Resident 1 was laying in bed with a hospital gown on. The resident stated he felt staff were pushing them into violence. When asked, the resident stated about a week ago two staff members came in their room. Resident 1 stated at one point one of the staff member's put their fists up, so Resident 1 hit them with their back scratcher. The resident stated they were told if they hit another staff member again, the police would be called. The resident stated they felt bad they hit the staff member and was trying to be calmer. The resident was tearful during the conversation. The resident was asked about their antianxiety medication and they stated they were recently started on a new one but it hadn't helped their anxiety yet.</p> <p>During an interview on 02/13/2025 at 11:10 AM, Staff F, Certified Nursing Assistant (CNA), stated they had worked at the facility quite a while and knew most of the residents and their behaviors. They would also be told about behaviors at shift change or by the nurse. As far as interventions, they would try different things like reapproaching or making sure the residents needs were being met. Staff F stated they didn't take care of Resident 1 but assisted in answering the call light since it was on a lot and could be overwhelming for the resident's CNA.</p> <p>On 02/13/2025 at 12:20 PM, Staff E, Licensed Nurse (LN), stated there was an area in the computer they would chart on behaviors for residents on psychotropic or antidepressant medication. Staff E stated resident care plans would have the target behaviors and individualized interventions. Staff E said Resident 1 would make different types of statements and when Staff E would talk with the resident, the resident would say no one paid attention to them, or no one loved them.</p> <p>On 02/13/2025 at 12:55 PM, Staff G, CNA, stated they knew about resident behaviors from the residents care records, reported from the nurse or report from the CNA at the start of their shift. Interventions would depend on type of the behavior like redirecting. Staff G stated they had a good relationship with Resident 1 and didn't see a lot of behaviors, mostly call light use, and they would reassure the resident. At times Resident 1 would be teary or down and Staff G would report it to the nurse.</p> <p><Resident 3></p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Admission assessment, dated 12/20/2024, showed Resident 3 was admitted with diagnoses which included a stroke, Parkinson's Disease (a progressive disorder that affects movement, balance, and coordination), and depression. The resident had difficulty making their needs known. Resident 3's mood assessment showed the resident had little pleasure in doing things, felt down, depressed, and hopeless, had trouble falling asleep, and thoughts of being better off dead. No behaviors were identified.</p> <p>Review of the PASARR, dated 12/13/2024, showed Resident 3 had indicators they had an Intellectual Disability and required a PASARR level II review.</p> <p>Additional review of the record showed no Level II assessment had been done</p> <p>The resident's care plan, dated 12/16/2024, identified the resident was diagnosed with depression and had a history of a suicide attempt. The resident was taking psychoactive medication for depression. Staff were to attempt GDR per protocol, monitor side effects of the anti-depressant, and do hourly supervision for safety. There was no target behaviors or person-centered interventions found in the care plan.</p> <p>The resident's MAR and TAR's were reviewed for December 2024 and January 2025. The resident was taking an antidepressant and was on medication for insomnia. There was an antidepressant monitor and staff were to put a +/- . A progress note was to be written only if the resident had a side effect observed and an intervention they tried. There was no monitors that non-medication interventions were in place, no target behaviors identified, and no person-centered interventions.</p> <p>During record review, there was no document to show an interdisciplinary team (IDT) had assessed the resident for their response to stressors, develop person-centered individualized interventions or evaluate the effectiveness of the resident's medication regimen or interventions.</p> <p>During an interview on 01/29/2025 at 10:35 AM, Resident 3 was sitting in a wheel chair in their room. The resident did not make eye contact during the interview. Resident 3 stated they had recently gone out to visit with their wife and they fought. The resident said they ended up walking to their brother's house. The police found the resident and brought them back to the facility.</p> <p>On 02/13/2025 at 11:30 AM, Staff D, CNA, stated they would be told about a resident's behaviors during report at the start of their shift and there would be behaviors on the resident care record. Staff D was asked about interventions for behaviors and stated if a resident refused care or was hitting they would reapproach them later. Staff D stated the only behavior they had seen for Resident 3 was when they had an outburst and was swinging their cane and yelling. Prior to the incident, the resident was pleasant.</p> <p>On 02/13/2025 at 11:34 AM, Staff C, LN, stated residents on psychotropic medication would have their behaviors monitored in the computer. If there was a behavior outside of what they were charting on for medication, like loss of a loved one, they would put the resident on alert and chart on them for 3-5 days. A new behavior from a resident would be placed in progress notes and the Resident Care Manager (RCM) would be notified. Staff C stated Resident 3 would often have their phone on speaker and would be fighting with their wife, they would both be yelling at one another. After those phone calls, the resident would be agitated and would stand at their door yelling for things. Staff C stated they would keep their distance from Resident 3 and calmly ask what they needed.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/13/2025 at 1:55 PM, Staff A, Director of Nursing (DNS) and Staff B, RCM were interviewed. Staff A stated social services was responsible for coordinating behavioral health services and would complete trauma informed assessments on admit. Social services also sent PASARR Level II's to the evaluator. Staff A stated the facility had not had a social worker for the last 6 months, which was about the time Resident 1 had been referred to a mental health provider. Staff A and B were asked if residents had target behaviors in place with individualized interventions and they stated they were in the residents care plans. When asked how Resident 1 was provided behavioral or emotional support, Staff B stated staff remained positive with the resident and would encourage the resident to get out of their room to walk. Some staff provided a fidget device for the resident, which helped them to not push the call light so often when the resident didn't need anything. When asked about how behavioral or emotional support was provided to Resident 3, Staff B stated they didn't have a full background on the resident but because they had attempted suicide prior, they were put on increased supervision. Staff B stated activities tried to engage the resident to help with socialization and they made sure the resident went to church in the community, when they wanted. Staff A was asked about documentation from an IDT team to show residents behaviors were being discussed, person-centered care plans developed, and an evaluation of the effectiveness of medications or interventions in place. Staff A stated there had been a period of time without psychoactive meetings since there hadn't been a SSD. Staff A stated they had been doing a more informal meeting and residents were discussed in the morning meeting. The pharmacist also reviewed resident medications and would let them know if a GDR was needed. An order would then be obtained and the team would be updated as well as the care plan.</p> <p>Reference: No associated WAC</p>		