| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505346 | A. Building<br>B. Wing | 08/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Cheney Care Center | 2219 North 6th Street<br>Cheney, WA 99004 |

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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 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 2 of 5 sampled residents (Resident 34 and 29), reviewed for unnecessary medications, were informed of the potential risks associated with the use of psychotropic medications (medications that can affect the mind, emotions, and behaviors) and that their consent was obtained prior to administering psychotropic medications. This failure placed the residents at risk of not being fully informed of the potential risks and benefits of taking the medications.Findings included <Resident 29><br><br>The 06/28/2025 quarterly assessment documented Resident 29 had diagnoses that included Parkinson's disease (a disorder of the nervous system that affected movement), malnutrition, and anxiety. Resident 29 was severely cognitively impaired and took medications for depression and anxiety (psychotropic medications) daily. A family member had been designated to make decisions for the resident.<br><br>A review of provider orders documented on 06/30/2025, an order was given to administer mirtazapine, a psychotropic medication used to treat depression but was prescribed for Resident 29 to stimulate appetite, daily at bedtime.<br><br>Review of the July and August 2025 medication administration record (MARs) documented Resident 29 received mirtazapine as prescribed.<br><br>Review of consents showed there had been no consent that described the risks and benefits of the medication obtained at the time mirtazapine was prescribed for Resident 29.<br><br><Resident 34><br><br>The 06/11/2025 quarterly assessment documented Resident 34 had diagnoses which included depression. In addition, the assessment showed the resident received psychotropic medication to treat the symptoms of the depression.<br><br>On 08/15/2025 at 10:03 AM, Resident 34 was observed lying in bed in their room. When asked how they were doing, Resident 34 stated they felt depressed, and was taking medications to treat their depression.<br><br>A review of the Order Summary Report from 02/27/2024 through 08/31/2025 documented the psychotropic medications escitalopram and mirtazapine were prescribed to Resident 34 when they admitted to the facility on [DATE]. In addition, the report documented the physician prescribed an additional psychotropic medication (Wellbutrin) on 11/06/2024.<br><br>(continued on next page) |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Medication Administration Records (MARs) from February 2024 through August 2025 documented the medications had been administered to Resident 34 as prescribed.<br><br>Review of Resident 34's record found an Informed Consent for Psychotropic Medication form for escitalopram and mirtazapine had been completed and signed by Resident 34 on 02/29/2024, two days after the medication was prescribed and Resident 34 began taking the medication.<br><br>Additional record review found no documentation an informed consent related to the Wellbutrin was discussed, either verbally or written, with the resident prior to the resident receiving the medication.<br><br>In an interview on 08/15/2025 at 3:15 PM, Staff D, Registered Nurse, stated informed consents for psychotropic medication needed to be obtained before the resident received the medication.<br><br>In an interview on 08/18/2025 at 12:20 PM, Staff B, Director of Nursing, confirmed informed consents needed to be obtained prior to the resident receiving the medication, and upon admission when a resident admitted with orders for psychotropic medications.<br><br>Reference: WAC 388-97-0300(3)(a), -0260, -1020(4)(a-d) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Office of the State Long-Term Care Ombudsman received written notification of a hospital transfer and/or discharge, for 3 of 3 sampled residents (Residents 50, 7, and 2), reviewed for hospitalization/discharge. This failure placed the residents at risk of not having access to additional advocacy services from the State Long-Term Care Ombudsman. Findings included.<br><Resident 50><br><br>The 07/07/2025 entry assessment documented Resident 50 admitted to the facility from the hospital. Review of nursing progress notes documented on 07/10/2025, Resident 50 was sent to the hospital to be evaluated after experiencing difficulty breathing despite using supplemental oxygen. Additional record review found no documentation that showed the State Long-Term Care Ombudsman had been notified of the resident's transfer to the hospital, as required. <Resident 2><br><br>Review of the record documented Resident 2 was initially admitted on [DATE]. The 05/24/2025 admission comprehensive assessment was not completed. The 06/05/2025 discharge assessment documented Resident 2 had diagnoses that included hip fracture and dementia and was severely cognitively impaired.<br><br>A review of nursing progress notes documented the following: On 06/05/2025 at 7:00 AM, a nursing assistant notified the nurse that they heard Resident 2 call out and found the resident on the floor on their left side. Resident 2 was assessed and then transferred to the bathroom for toileting. Once finished, Resident 2 complained of left hip pain, was unable to bear weight and unable to stand from the toilet. Emergency Medical Services was called, and Resident 2 was transferred to the hospital at 7:30 AM. The resident remained at the hospital for surgical repair of a hip fracture then returned to the facility on [DATE].<br><br>There was no documentation in the record that the Ombudsman had been notified of Resident 2's discharge to the hospital as required.<br><br>In an interview on 08/18/2025 at 1:27 PM, Staff B was asked if the Ombudsman was notified when residents were transferred to the hospital or discharged from the facility. Staff B stated the facility was not aware that notification needed to be sent to the Ombudsman and confirmed it had not been.<br><br><Resident 7><br><br>In a review of Resident 7's records, it was documented that they were admitted to the facility on [DATE] from the hospital. Review of the 08/08/2025 Transfer-Discharge report documented Resident 7 was discharged home for meeting their rehabilitation goals. In an interview on 08/18/2025 at 1:27 PM, Staff B, Director of Nursing, explained that no notification to the Ombudsman was sent for discharges because there was a confusion about who was responsible for sending the notifications.<br><br>Reference (WAC) 388-97-1020(2)(a-d) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 3 of 5 sampled residents (Residents 34, 4, and 2), reviewed for Pre-admission Screening and Resident Review (PASRR, an assessment completed prior to admission into a skilled nursing facility to determine whether a resident with a diagnosis of a serious mental illness needed specialized mental health services) was completed prior to admission, accurately, and if indicated, a referral for a PASRR Level II (a more in-depth screening assessment) had been made. Failure to ensure PASRR was completed accurately for Residents 34 and 4, and failure to ensure a PASRR was completed for Resident 2 after their decision to reside at the facility following an exempted hospital stay (being admitted to the facility directly from the hospital after receiving acute inpatient care, and an expected length of stay at the nursing facility of 30 days or less), placed the residents at risk for a diminished quality of life and unidentified care needs related to their mental health. Findings included.<Resident 4><br><br>Review of the record documented Resident 4 was admitted on [DATE]. The 06/18/2025 comprehensive admission assessment documented Resident 4 had diagnoses that included depression and anxiety.<br><br>On 06/05/2025, a Level I PASRR screening was completed, and incorrectly documented Resident 4 had no serious mental illness and that a Level II evaluation to determine what behavioral health needs the resident might need once a resident at the facility was not indicated.<br><br><Resident 2><br><br>Review of the record documented Resident 2 was admitted to the facility on [DATE]. A Level I PASRR screening completed on 05/23/2025 documented that Resident 2 had a serious mental illness but was exempt from having a Level II evaluation because the resident was expected to remain at the facility for less than 30 days. On 08/11/2025 at the beginning of the recertification survey, Resident 2 still resided the facility.<br><br>Further record review found no notes from the facility management or from the Social Worker that a referral for a Level II evaluation was sent after the resident continued to reside at the facility past the 30-day exemption period.<br><br><Resident 34><br><br>The 06/11/2025 quarterly assessment documented Resident 34 had diagnoses that included depression and received medication to treat the symptoms of depression.<br><br>Review of the progress notes from 02/27/2024 through 08/18/2025 documented Resident 34 admitted to the facility on [DATE] and on 01/11/2025 was sent to the hospital for evaluation due to increased confusion. The resident was readmitted to the facility on [DATE].<br><br>Review of Resident 34's record found a Level I PASRR had been completed prior to the resident's initial admission to the facility. An updated Level I PASRR was completed on 02/14/2025 after changes were made to the prescribed psychotropic medications. Section 1A of the form documented Resident 34 had serious mental illness indicators and a mood disorder, however, Section IV documented Resident 34 did not show any indicators of serious mental illness, and no Level II evaluation was indicated.<br><br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 08/18/2025 at 10:07 AM, Staff C, Assistant Director of Nursing, stated a Level I PASRR needed to be completed prior to a resident's admission to the facility, and if positive for serious mental illness indicators, a referral for a Level II evaluation needed to be made. Staff C acknowledged that Resident 2 should have had another PASRR completed after their stay extended past 30 days.<br><br>In an interview on 08/18/2025 at 12:13, Staff B, Director of Nursing, confirmed the PASRR assessment needed to be completed as stated by Staff C. After discussion and review of Resident 34's record, Staff B acknowledged a Level II PASSR referral should have been completed.<br><br>Reference: WAC 388-97-1915(1)(2)(a-c) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on observation and interview, the facility failed to ensure medication was administered per professional standards of practice for 1 of 8 sampled residents (Resident 31) reviewed during one medication administration observed. Specifically, a licensed nurse left medications at the resident's bedside without observing the medications being taken. This failure placed the residents at risk of not receiving the ordered medication and placed all residents at potential risk of medication errors.Findings included .The 01/20/2024 facility Medication Administration policy documented medications were to be administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice. The policy documented the nurse was to observe the resident take the medications.During an observation on 08/18/2025 at 10:22 AM, Staff G, Licensed Practical Nurse (LPN), prepared the medication Fosfomycin Tromethamine (an antibiotic) by mixing it with water for Resident 31. After giving Resident 31 other medications and watching them swallow them, Staff G handed Resident 31 the cup containing the Fosfomycin Tromethamine mixed with water and instructed Resident 31 to work on drinking it. Staff G stated they would check in with the resident later then left the room without watching the resident consume the medication.In an interview on 08/18/2025 at 10:47 AM, Resident 31 stated they had consumed the medication Staff G had left with them and stated that Staff G had not returned to check on them to see if they had taken the medication. The cup that had contained the medication was observed to be empty at that time. In an interview on 08/18/2025 at 11:40 AM, when asked why they had left the medication with Resident 31 and did not watch them take it, Staff G stated that the resident had the cup containing the medication in their hand, so they assumed the resident was going to consume it. Staff G confirmed they had not checked to see if the resident had taken the medication. When asked, Staff G stated it was not normal practice to leave medication with a resident and not watch the resident consume it. Staff G stated they shouldn't have left the medication with the resident unsupervised because there was no way to guarantee the resident took the medication.Reference: WAC 388-97-1620(2)(b)(i)(ii)(6)(b)(i) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>Based on observation, interview and record review, the facility failed to consistently provide bathing and personal hygiene/grooming for 1 of 2 sampled residents (Resident 41) reviewed for activities of daily living (ADLS). Failure to provide bathing, shaving and nail care placed Resident 41 at risk for poor personal hygiene, diminished quality of life and unmet care needs. Findings included . The 07/11/2025 quarterly assessment documented Resident 41 had diagnoses which included stroke and diabetes. Resident 41 needed assistance from nursing staff to complete ADLs for bathing and personal hygiene/grooming tasks such as nail care and shaving. On 08/11/2025 at 11:45 AM, Resident 41 was observed lying in bed watching television. Resident 41's hair appeared greasy, facial stubble covered their cheeks, chin and upper lip, and the fingernails of both hands were long with black debris underneath them. When asked if they had any concerns about their care, Resident 41 stated it had been a week since they were last bathed. Staff would inform Resident 41 that they were on the bath schedule for the day, but the bath often wasn't provided. On 08/13/2025 at 9:41 AM, Resident 41 was again observed with greasy hair, facial stubble, and long fingernails with black debris underneath them. Resident 41 stated they were scheduled to be bathed sometime that day. At 12:29 PM, Resident 41 still had greasy hair, facial stubble, and long dirty nails. Resident 41 stated staff had started to get them ready for a shower, but then lunch trays arrived, so the shower was postponed until after lunch. At 2:51 PM, Resident 41's hair and fingernails were observed to be clean, but the nails were still long, and the resident remained unshaved. Resident 41 stated they had been bathed, but there had not been enough time to be shaved, and the staff promised to shave them tomorrow. Resident 41 then raised their right hand up and stroked the facial stubble and stated they hoped they could wait because it started to get itchy when it was not done. When asked when nail care was done, Resident 41 stated because they were diabetic, their fingernails were trimmed by the nurse, and when they had asked earlier, the nurse stated their nails would be trimmed tomorrow. Subsequent observations of Resident 41 unshaved and with long fingernails were made on 08/14/2025 at 9:12 AM, 08/15/2025 at 10:11 AM, and 08/18/2025 at 10:27 AM. Review of the ADL care plan found interventions that informed nursing staff of Resident 41's care needs related to bathing, toileting, oral care and dressing, but no interventions or instructions related to Resident 41's personal hygiene/grooming needs, preferences, or assistance required from nursing staff related to nail care or shaving, were included. Review of the bathing records from 07/16/2025 through 08/04/2025 documented Resident 41 was showered on 07/16/2025, 07/19/2025, 07/30/2025, and 08/04/2025, a total of four showers provided out of seven showers scheduled. The documentation further showed that 11 days had lapsed from the shower on 07/19/2025 until Resident 41 received the shower on 07/30/2025. No documentation was found that showed Resident 41 had refused to be bathed. Review of the personal hygiene/grooming records during the same time period documented the type of assistance Resident 41 needed to maintain personal hygiene but did not include what type of personal hygiene the resident received. In addition, the documentation indicated Resident 41 had refused assistance twice but did not specify which type of personal hygiene was refused. In an interview on 08/18/2025 at 10:16 AM, Staff F, Nursing Assistant, stated nail care and shaving were completed during morning cares and when a resident was bathed, unless the resident was diabetic, then the nurses trimmed the nails. Staff F further stated when a resident missed a shower, the next shift offered to bathe them, and Sundays were shower make-up days to provide bathing for any that had been refused or missed. In an interview on 08/18/2025 at 12:41 PM, Staff B, Director of Nursing, was informed of the observations of Resident 41 not being bathed or assisted with grooming consistently, and the lack of grooming/personal hygiene interventions in the resident's care plan. After reviewing Resident 41's record, Staff B stated it was the facility's expectation that bathing and grooming/personal hygiene were provided, and the care plan should include interventions related to the resident's care needs and preferences. Reference: WAC 388-97-1060 (2)(c) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to consistently follow care planned supervision interventions and fully evaluate the effectiveness of the fall prevention interventions in place for 1 of 3 sample residents (Resident 2) reviewed for accidents/hazards. This failure placed residents at risk for accidents and diminished quality of life.Findings included . Review of the facility policy titled, dated 01/20/2024, Fall Prevention Program policy documented each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. The nurse will indicate in the electronic medical record the resident's fall risk and initiate interventions on the resident's baseline care plan. Residents assigned low/moderate risk will have universal interventions implemented including clear pathways to the bathroom, bed lowered and locked, call light and frequently used items in reach, adequate lighting and assistive devices in good repair, and implement routine rounding schedule. For residents at high risk, low/moderate interventions were to be implemented, and additional interventions were to be provided including assistive devices, increased frequency of rounds, a sitter, if indicated, medication regimen review, low bed, alternate call system access, scheduled ambulation or toileting, family/caregiver education or therapy referral. Resident 2 was admitted on [DATE] and had diagnoses that included dementia, history of falls, and fracture of the left femur greater trochanter (the ball of the upper portion of the thigh bone) that did not require surgery. The 05/24/2025 comprehensive admission assessment was not completed.A 05/24/2025 nursing progress note documented Resident 2 arrived at the facility at 11:30 AM from the hospital for physical therapy related to a non-operative left femur fracture. The resident was oriented only to self and the current situation. The resident stated they had occasional back pain from their history of falls. They were oriented to their room and call light. The 05/24/2025 initial Personal Care Plan documented Resident 2 had confused cognition (mental action and understanding thoughts) and was a fall risk. Staff were to keep the bed in low position, call light in reach, and the resident needed frequent checks. The resident could bear weight as tolerated and required assistance of one staff and a two-wheeled walker to move in the room. Review of admission assessments, showed no individualized assessment of Resident 2's fall risk was completed on admission. A late entry progress note, Staff C, Assistant Director of Nursing/Resident Care Manager progress note effective 05/25/2025 at 7:33 AM documented they were notified Resident 2 attempted to transfer without assistance, that staff placed a floor mat, and that the care plan was updated.A 05/26/2025 at 6:58 PM nursing progress note documented staff notified the licensed nurse that Resident 2 fell in the Activities area. The fall was not witnessed; activity staff noticed when they saw the resident raising their arm up from the floor. The resident was on their bottom and no injuries were found. The 05/26/2025 Incident Report completed by Staff G, Licensed Practical Nurse (LPN), documented Resident 2 had an unwitnessed fall in the Activity area and Activity staff noticed when they saw the resident raising their arm. The resident was confused, had impaired memory, and was not injured. There were no investigation notes and no staff statements regarding the events.On 05/27/2025, after the resident fell, the Care Plan was updated to include Resident 2 was at risk for falls related to deconditioning and recent fall with hip fracture prior to admission. Interventions added on 05/27/2025 included anticipate and meet Resident 2's needs, be sure the call light was in reach and encourage the resident to use it, ensure the resident wears appropriate footwear when ambulating, fall mat at bedside for safety, ensure a safe environment, even floors free of clutter and spills, bed in low position and personal items in reach and toilet every two hours.On 06/02/2025, a late entry Staff C progress note effective 05/28/2025 at 10:43 AM was entered that documented they spoke to Resident 2 regarding the fall in the Activity area and the resident was unable to recall the events that took place; staff had already placed a fall mat at the bedside. The note stated that although activity staff were present, they did not witness the fall, but abuse and neglect were ruled out. The care plan was updated to include increased hourly supervision and toileting assistance. The resident had been toileted within one hour of their fall. On 06/05/2025 at 11:45 AM nursing progress note documented that the nurse went to the transitional care unit (TCU, where Resident 2 resided) at 7:00 AM and was informed that the resident fell. Staff had obtained Resident 2's vital signs at 6:40 AM, then the resident stated they wanted to sleep. Staff heard the resident call out at 6:55 AM and found the resident on the floor. The resident stated they had moved their fall mat that had an alarm pad on it |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on observation, interview and record review, the facility failed to ensure consistent communication with the dialysis center regarding fluid restrictions occurred for 1 of 1 sample residents (Resident 19) reviewed. This failure placed the resident at risk of fluid weight gain, fluid overload and unintended health consequences.Findings included .The 07/08/2025 facility Hemodialysis policy documented the facility provided necessary care and treatment consistent with professional standards and the resident's person-centered care plan to meet the special medical, nursing and psychosocial needs of residents receiving dialysis. The facility was to coordinate and collaborate with the dialysis facility to ensure there was ongoing communication and collaboration for the implementation of the dialysis care plan by nursing home and dialysis staff. The 06/25/2025 annual comprehensive assessment documented Resident 19 had diagnoses that included end-stage renal disease (ESRD, kidney failure) and was dependent on dialysis (a mechanical way of removing waste from the body when the kidneys no longer functioned). The resident was cognitively intact and was independent for most of their activities of daily living (ADLs). On 08/13/2025 at 11:30 AM, Resident 19 was in their room seated on the edge of their bed. They stated they had just returned from their dialysis treatment. Resident 19 stated they did not eat while they were at dialysis because they left so early in the morning, so they were hungry when they got back. There were potato chips, a hard-boiled egg and fruit cocktail on their overbed table, partially eaten. A large, lidded mug full of water was on the table, and an unopened can of soda and unopened bottle of water were on the nightstand. Resident 19 stated they were only supposed to drink small amounts of fluids but was unsure how much and who monitored this.On 08/15/2025 at 9:37 AM, Resident 19 was out of the facility for their dialysis treatment. The resident's breakfast tray was left on the overbed table. An empty coffee mug was observed, and there were two juice glasses, one containing water and one containing apple juice on the tray left with the lids on at this time. A review of Resident 19's care plan documented the following:-the resident received dialysis related to kidney failure; staff were to monitor the dialysis access site every shift, monitor labs, obtain vital signs and weights per protocol, and report any signs of bleeding or infection to the provider and report any significant changes in pulse and respirations immediately.-The resident had nutritional problems related to ESRD dependent on dialysis; staff were to provide a General Renal diet, with thin fluid consistency, provide 1ounce (oz) prostat (a protein supplement) in 4-6 oz water twice daily between meals, provide and serve supplements as ordered, and monitor meal intake and record. The Registered Dietician (RD) was to evaluate and make diet changes. The care plan and provider orders did not include oral fluid restrictions, or interventions to monitor the amounts of fluid consumed. A review of the July and August 2025 Medication/Treatment Administration Records (MAR/TAR) had no entries documented for Resident 19's fluid intake. A review of Nursing Assistant (NAC) documentation of Fluid Intake for the previous 30 days from 08/17/2025 showed varied intake amounts and many shifts with blanks and omissions. The NAC documentation for Fluids Given PRN (as needed or requested) had no data documented. During a telephone interview on 08/18/2025 at 9:21 AM, the dialysis center Registered Dietician stated they had talked with Resident 19, and the resident was supposed to be on a fluid restriction of 1200 milliliters (ml) daily. The RD stated the resident chose to drink more than that and often went to restaurants with friends and family. The RD stated they tried to converse with nursing staff at the facility quarterly, but they had not spoken with the long- term care facility's Registered Dietician. During an interview on 08/18/2025 at 10:06 AM, Staff O, RD, stated if the dialysis center had dietary or fluid recommendations for a resident, nursing staff were the ones to enter any of those orders. Staff O was not aware an oral fluid restriction was recommended for Resident 19 and stated they had not communicated with the dialysis center. During an interview on 08/20/2025 at 10:56 AM, Staff G, Licensed Practical Nurse, stated for any resident getting dialysis treatments, they monitored those residents for bleeding from their access site, monitored their vital signs and weights, and it was important to monitor for fluid balance and fluid intakes. Staff G stated Resident 19 kind of knew that they were not to overdo their fluids, but Staff G was uncertain if the facility or the dialysis center determined if the resident required a fluid restriction. They had cared for other residents who needed dialysis and those residents had their fluids monitored, but Resident 19 did not, and Staff G was unsure why.During an interview on 08/20/2025 at 1:07 PM, Staff C, Assistant Director of Nursing, Resident Care Manager, stated they communicated with the dialysis center using a sheet that went to dialysis with the resident. The sheet was returned with any comments from the dialysis staff or new orders and the nurse on the floor reviewed it once returned. At times, the dialysis center might |

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|---|---|---|---|
| | 505346 | A. Building<br>B. Wing | 08/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Cheney Care Center | 2219 North 6th Street<br>Cheney, WA 99004 |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>Based on observation, interview and record review, the facility failed to ensure medications were administered as ordered for 1 of 1 sample residents (Resident 19) reviewed for dialysis care. Specifically, alternative arrangements were not made with the provider causing Resident 19 to have doses of their medications omitted on the mornings of their dialysis sessions. This failure placed the resident at risk for unintended health consequences and decreased quality of life.Findings included .The 06/25/2025 annual comprehensive assessment documented Resident 19 had diagnoses that included end-stage kidney disease dependent on dialysis (a mechanical way of removing waste from the body when the kidneys no longer functioned), diabetes and high blood pressure. Resident 19 was independent for most activities of daily living, was cognitively intact and had dialysis treatments every Monday, Wednesday, and Friday.Resident 19 had the following medication orders:-hydralazine 10 milligrams (mg) three times daily for high blood pressure-Calcium acetate 667 mg, two capsules three times daily with meals to lower levels of phosphorous in the blood.Review of the medication administration record (MAR) showed Resident 19 did not receive morning doses of hydralazine or calcium acetate on 08/01/2025, 08/06/2025, 08/08/2025, 08/11/2025, 08/13/2025, and 08/15/2025. An administration code AB was entered on the MAR. The code key showed AB signified Resident 19 was absent from the facility. A review of progress notes had no entries that the provider was notified of the omitted doses of hydralazine and calcium acetate. On 08/15/2025 at 11:14 AM, Resident 19 was observed scooting in the hall in their wheelchair. Resident 19 stated their dialysis sessions went well. The resident stated they left the faciity on dialysis days at 5:00 AM, so did not bring food with them. They stated they did not receive breakfast so were hungry and tired so they ate and napped when they returned to the facility. During an interview on 08/20/2025 at 12:21 PM, Staff G, Licensed Practical Nurse, stated Resident 19 had several medications ordered to take in the morning. If the resident returned too late from dialysis, they missed those and got the next dose at lunch. Staff G stated medications were not sent to dialysis with the resident. Staff G stated to their knowledge, no one had discussed Resident 19's medications with the provider. They would need the orders or the administration times changed. Staff G stated Resident 19's blood pressure was all over the place so it was important for the resident to get their medications. During an interview on 08/20/2025 at 1:07 PM, Staff C, Assistant Director of Nursing, stated nurses had a wide range of times medications were able to be administered, so Resident 19 might be able to receive their medications when they returned from dialysis. Staff C stated they expected nurses would be communicating with the providers when the resident had not been receiving their medications. During an interview on 08/20/2025 at 3:12 PM, Staff B, Director of Nursing, stated if Resident 19 missed medications on the days they went to dialysis they expected nurses to discuss this with the provider so the orders could be adjusted. Reference: WAC 388-97-1060(3)(k)(iii) |

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| Cheney Care Center | 2219 North 6th Street<br>Cheney, WA 99004 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>Based on observation, interview and record review, the facility failed to consistently monitor the medication refrigerator temperatures for 1 of 1 medication storage rooms to ensure they were at safe storage levels. This failure placed residents at risk for receiving compromised or ineffective medication. Findings included. The 01/20/2023 article titled Storage and Handling of Immunobiologics published by the Center for Disease Control, documented failure to follow recommended storage and refrigerator temperatures for immunobiologics (a medicinal preparation made from living organisms and their products, such as a serum or vaccine) reduced or destroyed their potency which resulted in inadequate or no immune response in the recipient. Refrigerator storage temperatures needed to be kept between 36 through 46 degrees Fahrenheit and prompt immediate action needed to occur when the temperature was out of range. During the review of the medication storage room with Staff E, Infection Preventionist, on 08/20/2025 at 9:06 AM, the medication refrigerator temperature log form was observed to be posted on the refrigerator and included documentation for June through August 2025. Review of the form found refrigerator temperatures were not documented nine times in June 2025, 11 times in July 2025, and 9 times in August 2025. Review of the dates when the temperatures had been documented showed they were within normal, safe levels. The refrigerator contained 10 boxes of unopened tuberculin solution, an injectable solution used to screen for Tuberculosis, a lung infection. When asked about the missing temperature values, Staff E stated it was the responsibility of the night shift nurse to check and record the refrigerator temperatures daily to ensure the temperature was at safe levels. Staff E acknowledge the temperatures had not been consistently monitored. Reference (WAC): 388-97-1300 (2), 2340 |

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| | 505346 | A. Building<br>B. Wing | 08/20/2025 |

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| Cheney Care Center | 2219 North 6th Street<br>Cheney, WA 99004 |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>Based on observation and interview, the facility failed to serve food that was palatable and had an appetizing appearance, and temperature for 2 of 2 meals observed and 1 of 1 test tray sampled. This failure resulted in the potential for all residents to have decreased appetite and decreased quality of life.Findings included .In an interview on 08/11/2025 at 11:33 AM, Resident 34 stated the food was bad and did not look good.In an interview on 08/11/2025 at 11:55 AM, Resident 48 stated that the food was terrible. They said it had no seasoning, everything was bland, and the appearance was unappetizing.During an observation on 08/11/2025 at 12:00 PM, a lunch tray was delivered to Resident 16. After seeing the food, Resident 16 stated it did not look very appetizing, took a bite then requested a cheeseburger.During an observation of the lunch meal on 08/11/2025 at 12:14 PM, in the main dining room, the food served was light brown pasta and light brown meat in a light brown gravy, dull green peas or green beans, and brown apple juice. The food lacked bright and varied colors.The lunch meal test tray on 08/15/2025 at 12:41 PM, was observed to consist of meatloaf, scalloped potatoes, zucchini, cottage cheese, plain yogurt, and apple juice. Per the Food and Drug Administration, the holding temperature for hot food was to be served above135 degrees Fahrenheit and cold food was to be served at less than 41 degrees Fahrenheit. The temperatures, in degrees Fahrenheit of the hot food items, served on the lunch test tray were: meatloaf 129, Scalloped potatoes 120.9, zucchini 114, and the cold food items were cottage cheese 57.3, yogurt 58.4, and apple juice 64.9. The food items were mostly brown and off-white in color.In an interview on 08/15/2025 at 2:45 PM, Staff M, Dietary Manager, stated that they had received complaints from residents and families about the appearance of the food and that sometimes they also thought the food did not look appetizing. Staff M stated when the food was all the same color, it did not look appetizing and something should have been switched in order to have different colors and make it look better. Reference: WAC 388-97-1100(1)(2) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation and interview, the facility failed to label and date food products in 2 of 2 resident snack refrigerators. This failure placed the residents at risk for food borne illness and decreased quality of life. Findings included .During an observation on 08/15/2025 at 3:04 PM, the resident snack refrigerator in the nurses' main charting room, contained six hard-boiled eggs in a plastic bag which was not labeled with a name or date. During an observation on 08/15/2025 at 3:08 PM the resident snack refrigerator on the transitional care unit contained six hard-boiled eggs in a plastic bag, and a bottle of honey mustard dressing, which were not labeled with a name or date.In an interview on 08/20/2025 at 9:18 AM, Staff M, Dietary Manager, stated the resident snack refrigerators were checked daily by the prep cook for proper labeling of food items and expiration dates. Staff M stated it was important for food items to be labeled and dated so the staff knew how long the item had been in the refrigerator and to whom it belonged. They stated unlabeled/undated food items would be discarded.Reference: WAC 388-97-1100(3) |

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| | 505346 | A. Building<br>B. Wing | 08/20/2025 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure enhanced barrier precautions (EBP, use of personal protective equipment such as disposable gowns and gloves to prevent the spread of antibiotic-resistant bacteria or other infectious organisms) was implemented when indicated for 3 of 4 sampled residents (Residents 19, 31, and 48) reviewed. Additionally, Infection Prevention policies were not reviewed annually as required. These findings placed residents and staff at risk of spreading or acquiring infectious bacteria, and at risk of continued use of outdated policies and procedures.Findings included . The Centers for Disease Control and Prevention (CDC) April 2024 Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) documented MDROs may be indirectly transferred from resident to resident during high-contact care activities that included dressing, bathing/showering, transferring, providing hygiene, changing linens, device care, wound care or toileting. The use of gowns and gloves was indicated for nursing home residents with wounds and/or indwelling medical devices as well as for residents with MDRO infection or colonization. Enhanced Barrier Precautions<Resident 19>The 06/25/2025 annual comprehensive assessment documented Resident 19 had diagnoses that included osteomyelitis (infection of bone tissue), gangrene (death of tissue related to lack of blood supply or infection), and carrier of Methicillin-resistant Staphylococcus aureus (MRSA, a MDRO resistant to the antibiotics used to treat staph infections). Resident 19 was dependent on dialysis (a mechanical way of ridding the body of urinary waste when the kidneys no longer functioned) and was independent for most activities of daily living (ADLs).On 08/11/2025 at 1:36 PM, Resident 19 was observed sleeping in their room. There was no signage or PPE at the entrance to the resident's room that indicated EBP was implemented. On 08/12/2025 at 9:01 AM, Resident 19 was resting in bed. A bandage that had bloody drainage on it was on the floor by the resident's wheelchair. <Resident 31>A review of the record documented Resident 31 was admitted on [DATE] and had diagnoses that included urinary tract infection. On 08/12/2025, an order was entered for staff to use EBP every shift related to the use of a urinary catheter (a tube inserted into the bladder that allowed urine to drain into a collection bag). On 08/12/2025, the care plan was updated to include EBP. Staff were instructed to use gowns and gloves with all close resident contact. On 08/11/2025 at 2:41 PM, Resident 31 was seated in a wheelchair in their room visiting family. A urinary catheter collection bag was observed hung below the resident on the frame of their wheelchair. There was no signage or PPE receptacle at the entrance to the resident's room and none in their room that indicated EBP was implemented. During an observation and interview on 08/18/2025 at 2:50 PM, Resident 31 was seated on the edge of their bed. The urinary catheter collection bag was observed hanging on the frame of the bed. A bin of PPE was observed by the sink area. Resident 31 was asked if staff wore gowns or gloves when they assisted with caring for the resident's catheter. Resident 31 stated they did not remember staff wearing the gowns, so probably not. <Resident 48>A review of the record documented Resident 48 was admitted on [DATE] and had diagnoses that included enlarged prostate and urinary retention. A review of provider orders documented Resident 48 had a urinary catheter inserted on 08/01/2025. On 08/14/2025, an order was entered for Resident 48 to be on EBP related to use of a urinary catheter. During an observation and interview on 08/14/2025 at 12:16 PM, Resident 48 was observed seated in a recliner watching television. A urinary catheter collection bag was observed hanging on the edge of the garbage can next to the resident's recliner. Resident 48 stated the catheter had been inserted a couple of weeks ago because they had difficulty urinating and trying to do so made them extremely short of breath. They had problems with leaking urine as well. Resident 48 stated staff wore gloves when assisting with the catheter, but they had not seen any staff wearing gowns. There was no signage posted at the entrance to the resident's room or a bin of PPE in the room or at the entrance. During an interview on 08/20/2025 at 2:11 PM, Staff E, Registered Nurse, Infection Prevention, stated when a new admission arrived, they reviewed report sheets to look for the presence of wounds, oxygen use, or catheters. They also reviewed the 72-hour report. Staff E stated they were not aware Resident 48 had a catheter inserted as it occurred on a Friday when they were not at work. Staff E stated when they were not at work, the nurses were expected to implement EBP. Staff E stated a bin of PPE had been present in Resident 31's room since their admission on [DATE] and stated they were not aware Resident 19 had a diagnosis that they were a carrier of MRSA and stated, I missed that. Staff E stated they felt they had a pretty good system in place for identifying those |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>Based on interview and record review, the facility failed to develop procedures that ensured staff were educated on the risks, benefits and potential side effects of the COVID-19 (a virus that caused serious illness or even death) vaccine, that staff were offered information on obtaining the vaccine, and that the COVID-19 vaccination status of staff was maintained for 1 of 1 sampled staff (Staff H) reviewed. This failure placed staff and residents at risk of being uninformed of their vaccination choices, and at risk of becoming ill with COVID-19.Findings included.The 01/20/2024 facility COVID-19 Vaccination policy documented it was the policy of the facility to offer their residents and staff the COVID-19 vaccine to minimize the risk of acquiring, transmitting or experiencing complications from the COVID-19 virus. Staff documentation related to the COVID-19 vaccination was to include at a minimum:-education regarding the risks, benefits and side effects of the vaccine-the offering of the vaccine or information on obtaining the vaccine-documentation of any religious or medical exemption-the vaccine status of staff. During an interview on 08/20/2025 at 8:38 AM, Staff H, Nursing Assistant, was asked if they had been provided any information regarding the COVID-19 vaccine. Staff H stated they had been employed by the facility for 4 years and thought they were offered the vaccine when hired but was unable to recall. Staff H stated they did not remember receiving education regarding the vaccine or the risks or benefits of it. During an interview on 08/20/2025 at 9:49 AM, Staff E, Infection Prevention, was asked for documentation of COVID-19 vaccination education and vaccine status for staff H. Staff E stated they only offered staff an influenza vaccine and that staff were given information regarding Hepatitis vaccination, but not COVID. They can get their own insurance to pay for that. Staff E stated Human Resources kept a document from hire and also kept track of staff testing for Tuberculosis. During a follow-up interview on 08/20/2025 at 2:11 PM, Staff E stated they did not keep track of staff COVID-19 vaccinations. They were unable to ask staff what their vaccination status was because of HIPAA (the Health Insurance Portability and Accountability Act, a law meant to protect private health information.) During an interview on 08/20/2025 at 3:11 PM, Staff B, Director of Nursing, was asked what the facility's program for staff COVID-19 vaccinations was. Staff B stated they were unsure. At 3:40 PM, Staff B followed-up, and stated Staff N, Human Resources Director, discussed COVID-19 vaccinations with new employees, but acknowledged that did not include any employees that had been employed at the facility for longer periods.Reference: WAC 388-97-1320(1)(a) |