STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505348	A. Building B. Wing	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Health Care Ctr	702 North 16th Avenue Yakima, WA 98902

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on interview and record review the facility failed to ensure implementation of their abuse prohibition policy/procedures components of resident protection, identification, reporting and investigating for 1 of 3 residents (Resident 47) reviewed for abuse/neglect. This failure placed the resident at an increased risk for unidentified abuse/neglect, retaliation from the alleged perpetrator and the potential for continued exposure to abuse and/or neglect. Findings included . Review of the State Operations Manual, Appendix PP, dated 08/08/2024, the Code of Federal Regulations 483.12 (b)(1), F607, The Facility must develop and implement written policies and procedures that: Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of residents property, showed that in order to .provide protections for the health, welfare and rights of each resident residing in the facility . the facility must develop and implement components of screening, training, prevention, identification, investigation, protection and reporting/response. Review of the facility's policy titled, Abuse/Neglect/Misappropriation/Exploitation, revised October 2022, showed The purpose of the policy was to prevent, identify, report and investigate abuse, neglect and exploitation. The policy showed that to protect resident and keep them safe the alleged perpetrator would be immediately suspended, and a trusted person would stay with the resident in an area where they felt safe. Additionally, to identify abuse, facility staff were to monitor suspicious occurrences, patterns or trends that may constitute abuse. <Resident 47> Review of the medical record showed the resident was admitted on [DATE] with diagnoses including heart failure and depression. The 07/24/2024 comprehensive assessment showed the resident was cognitively intact and able to make their needs known. (continued on next page)

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/01/2024 at 11:27 AM, Resident 47 stated that Staff I, Nursing Assistant (NA), on the night shift was rough and impatient when turning and providing care to them. Resident 47 stated they were unsure of the date happened a month and a half ago, but had informed Staff F, Charge Nurse, about Staff I roughly moving and turning them during cares. Resident 47 stated that Staff F informed the resident about how they talked with the night shift staff member, and they were no longer allowed to come into the resident's room. Resident 47 stated (Staff I) took care of me this week and (Staff I) was nice but sometimes comes back in a different mood and I'm afraid (Staff I) might do it again (referring to Staff I being rough and impatient with turning/providing cares to Resident 47). Record review of the facility staffing schedules/room assignments for September and October 2024 showed that Staff I was working the night shift and assigned to care for Resident 47's on 09/29/2024, 09/30/2024, and 10/01/2024. During an interview on 10/02/2024 at 12:13 PM, Staff G, Licensed Practical Nurse, stated Resident 47 had allegation of rough handling during cares against Staff I and that investigations had been conducted. Staff G stated Staff I was not supposed to be going into Resident 47's room when they were working. Staff G stated Staff I had been going into Resident 47's room even though they were told not to. Additionally, Staff G stated that Staff E, Social Service Assistant (SSA), was investigating Resident 47's continued concerns about Staff I not being allowed into the resident's room. Review of a progress note on 10/02/2024 at 9:30 AM showed, Staff E, SSA, interviewing Resident 47. Staff E stated, Follow up with resident regarding care concerns per resident no issues or concerns. Does not want a particular NAC in her room however reports no abuse or neglect just personal preference. Will continue to monitor and follow as needed. During an interview on 10/02/2024 at 12:36 PM, Staff E, stated they followed up about a specific NA that Resident 47 did not want to care for them anymore. Staff E stated they followed up after concerns were conveyed to them by Staff H, NA, who had received the concern from Resident 47 the morning of 10/02/2024. Staff E stated when they had interviewed Resident 47 that morning, they understood it as Staff I's and Resident 47's personalities did not mix well. During an interview on 10/02/2024 at 1:07 PM, Staff H, NA, stated that Resident 47 made a comment to them the morning of 10/02/2024 about not having night shift NA, Staff I, come into their room anymore. Staff H stated Resident 47 made allegations Staff I would wake (Resident 47) up at all hours of the night and bruised the resident's arm with turning and was bossy with the resident. Staff H stated Resident 47's concerns had been ongoing and that Staff I was sometimes nice and then would sometime be rough with turning and cares towards the resident. Staff H stated the allegations against Staff I had been ongoing for about a month and a half, and that the resident's original allegation, of rough handling with turning/bruising the resident's arm by Staff I, had already been investigated by nursing staff. Additionally, Staff H stated now it was just a grievance from Resident 47 to not have Staff I care for or enter the resident's room. During an interview on 10/02/2024 at 1:35 PM, Staff F, Charge Nurse, stated Resident 47 had concerns about a night shift NA that was rude and rushed when providing cares. Staff F stated, it's been a few months since the resident had conveyed their concerns and that Staff I was not supposed to be going into Resident 47's room. Staff F stated they had informed Staff B, Director of Nursing Services (DNS), who came and talked with Resident 47. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/02/2024 at 10:15 AM, Staff B, DNS, stated they were unaware of the Resident 47's allegation of abuse regarding Staff I rough handling with turning/cares that were made. Staff B stated they had completed an investigation into skin complications in July 2024 but was not made aware of the resident allegations from any their staff at that time. Staff B stated Resident 47's statements were allegation of abuse that should have been reported, investigated and that Staff I should have been taken off the schedule to protect Resident 47 when the facility became aware of the abuse allegations. Staff B stated the correct process for protection of the resident from abuse and identification of potential abuse was not followed. Reference: WAC 388-97-0640(2)(a)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on interview and record review, the facility failed to report allegations of potential abuse and/or neglect to the State Agency, for 1 of 3 residents (Residents 47), reviewed for abuse/neglect. This failure placed the residents at risk for unidentified abuse/neglect, and the potential continued exposure to abuse and/or neglect. Findings included . Review of the facility's policy titled, Abuse/Neglect/Misappropriation/Exploitation, revised October 2022, showed The purpose of the policy was to prevent, identify, report and investigate abuse, neglect and exploitation. The policy showed that to protect resident and keep them safe the alleged perpetrator would be immediately suspended, and a trusted person would stay with the resident in an area where they felt safe. Additionally, to identify abuse, facility staff were to monitor suspicious occurrences, patterns or trends that may constitute abuse <Resident 47> Review of the medical record showed the resident was admitted on [DATE] with diagnoses including heart failure and depression. The 07/24/2024 comprehensive assessment showed the resident was cognitively intact and able to make their needs known. During an interview on 10/01/2024 at 11:27 AM, Resident 47 stated that Staff I, Nursing Assistant (NA), was rough/impatient when providing cares to them and they had received bruises from Staff I's rough care. Resident 47 stated they had informed Staff F, Charge Nurse, that Staff I was roughly turning them during cares. Additionally, the resident stated, I told (Staff I) they were going to hurt somebody (referring to the way that Staff I was rough when providing cares) and (Staff I) said, well it might be you. Review of the facility incident log for March through September 2024 showed that Resident 47 allegation of abuse towards Staff I had been logged or reported to the State Agency. During an interview on 10/02/2024 at 12:13 PM, Staff G, Licensed Practical Nurse, stated Resident 47 had allegation of rough handling during cares against Staff I and they thought that the reporting and investigating into the resident's allegation had already been completed. During an interview on 10/02/2024 at 1:07 PM, Staff H, NA, stated Resident 47 had made previous allegations that Staff I would wake the resident up at all hours of the night, bruised the resident's arm with turning and was bossy with the resident. Staff H stated Resident 47's concerns had been ongoing and that some nights Staff I was nice but then other nights the staff was rough with turning and cares towards the resident. Staff H stated they thought the resident's allegation of abuse had already been reported by nursing staff. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/02/2024 at 1:35 PM, Staff F, Charge Nurse, stated that Resident 47 had concerns about a night shift NA that was rude and rushed when providing cares. Staff F stated, it's been a few months since the resident had conveyed their concerns and did not remember Resident 47 stating that Staff I was rough when turning and caring for them. Staff F stated they had reported it to Staff B, Director of Nursing Services (DNS). During an interview on 10/02/2024 at 10:15 AM, Staff B, DNS, stated they were unaware of the Resident 47's allegation of abuse regarding Staff I's rough handling with turning/cares that were made. Staff B stated Resident 47's statements were allegation of abuse that should have been reported and they were unsure of why they were not informed by facility staff. Staff B stated the correct process was not followed and they would be reporting Resident 47's allegation of abuse to the State Agency. Reference: WAC 388-97-0640(5)(a)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on interview and record review, the facility failed to conduct a thorough investigation into an allegation of abuse for 1 of 3 residents (Resident 47), reviewed for abuse and neglect. This failure placed the residents at risk for unidentified abuse, unmet care needs, and the potential for continued exposure to abuse and/or neglect. Findings included . Review of the facility's policy titled, Abuse/Neglect/Misappropriation/Exploitation, revised October 2022, showed The purpose of the policy was to prevent, identify, report and investigate abuse, neglect and exploitation. The policy showed that all alleged incidents of abuse were to be thoroughly investigated in order to determine what occurred and would begin as soon as the incident was identified and the alleged victim protected. <Resident 47> Review of the medical record showed the resident was admitted on [DATE] with diagnoses including heart failure and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The 07/24/2024 comprehensive assessment showed the resident was cognitively intact and able to make their needs known. During an interview on 10/01/2024 at 11:27 AM, Resident 47 stated that Staff I, Nursing Assistant (NA), was rough/impatient when providing cares to them and they had received bruises from Staff I's rough care. The resident stated they had informed facility staff about the incident but could not remember the exact date that the incident occurred. Review of the facility incident investigation log for March through September 2024 showed no investigation into Resident 47's allegation of abuse towards Staff I had been completed. During an interview on 10/02/2024 at 12:13 PM, Staff G, Licensed Practical Nurse, stated they were aware of Resident 47's allegation abuse. Staff G stated that Resident 47 alleged that Staff I treats (Resident 47) rough when providing cares/turning the resident. During an interview on 10/02/2024 at 1:35 PM, Staff F, Charge Nurse, stated that Resident 47 had concerns about a night shift NA that was rude and rushed when providing cares. Staff F stated that it had been two to three months since the resident had conveyed their concerns. Staff F stated they had reported Resident 47's concerns to Staff B, Director of Nursing Services (DNS). During an interview on 10/02/2024 at 10:15 AM, Staff B, DNS, stated they were not made aware of Resident 47's allegation of abuse regarding Staff I's rough handling when turning/providing cares. Staff B stated Resident 47's statements were allegation of abuse that should have been investigated right after the allegations were made. Staff B stated the correct process was not followed and Resident 47 should have been protected by removing Staff I from the schedule pending an investigation. Reference: WAC 388-97-0640(6)(a)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642 Based on interview and record review, the facility failed to ensure the Minimum Data Set [(MDS) assement tool] accurately reflected the status for 6 of 7 sampled residents (Resident 32, 84, 79, 3, 29 and 96) reviewed for accuracy of assessments. This failure placed the residents at risk for unidentified and/or unmet care needs. Findings included . <Resident 32> Review of Resident 32's medical record showed the resident admitted to the facility on [DATE] with diagnoses including left hip fracture and heart failure. The comprehensive assessment dated [DATE], showed Resident 32 required moderate assistance with their transfers and activities of daily living (ADLs). Review of the 5-day MDS assessment, dated 07/03/2024, showed section N, Medications, indicated Resident 32 was taking an anticoagulant (medication used to prevent and treat blood clots by interfering with the bloods ability to form clots). Review of Resident 32's physician orders showed the resident was prescribed clopidogrel bisulfate [an antiplatelet (medication used to stop specific blood cells called platelets from sticking together and forming a clot)] ordered 06/27/2024, and was not receiving any anticoagulant medications. <Resident 84> Review of Resident 84's medical record showed the resident admitted to the facility on [DATE] with diagnoses including lung cancer and stroke. The comprehensive assessment, dated 08/27/2024, showed Resident 84 required substantial assistance with their transfers and ADLs. Review of the 5-day MDS assessment, dated 08/27/2024, showed section N, Medications, indicated Resident 84 was taking an anticoagulant medication. Review of Resident 84's physician orders showed the resident was prescribed aspirin (an antiplatelet medication) ordered 08/21/2024, and was not receiving any anticoagulant medications. <Resident 79> Review of Resident 79's medical record showed the resident admitted to the facility on [DATE] with diagnosis including heart disease. The comprehensive assessment dated [DATE], showed Resident 79 required moderate assistance with their transfers and ADLs. Further review of the comprehensive MDS assessment, dated 07/27/2024, showed section N, Medications, indicated Resident 79 was taking an anticoagulant medication. Review of Resident 79's physician orders showed the resident was prescribed clopidogrel bisulfate (an antiplatelet medication) ordered 07/21/2024, and was not receiving any anticoagulant medications. <Resident 3> (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 3's medical record showed the resident admitted to the facility on [DATE] with diagnoses including atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) and heart failure. The comprehensive assessment, dated 08/02/2024, showed Resident 3 required substantial assistance with their transfers and ADLs. Further review of the comprehensive MDS assessment, dated 08/02/2024, showed section N, Medications, indicated Resident 3 was taking an anticoagulant medication. Review of Resident 3's physician orders showed the resident was prescribed clopidogrel bisulfate (an antiplatelet medication) ordered 07/12/2024, and was not receiving any anticoagulant medications. <Resident 29> Review of Resident 29's medical record showed the resident admitted to the facility on [DATE] with diagnoses including bipolar disorder (a brain disorder that causes changes in a person's mood, energy, or ability to function), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (a feeling of worry, nervousness, or unease). The comprehensive assessment, dated 10/28/2023, showed Resident 29 required substantial assistance with their transfers and ADLs. Review of the MDS assessment, dated 10/28/2023, showed section A, indicated the Pre-Admission Screening and Resident Review (PASRR) did not reflect that Resident 29 should be considered and/or assessed by the state level II PASRR process (a process to evaluate the need for additional support services for residents who have serious mental illness and/or intellectual disability). Further review of the medical record showed Resident 29 had a completed PASRR, dated 09/27/2018, which indicated a PASRR level II should be completed. <Resident 96> Review of Resident 96's medical record showed the resident admitted to the facility on [DATE] with a primary diagnosis of a fractured left hip. The comprehensive assessment, dated 08/14/2024, showed Resident 96 required substantial assistance with their transfers and partial assist with ADLs. Review of the 5-day MDS assessment, dated 08/14/2024, showed section A indicated Resident 96's discharge status was to a critical access hospital. Review of the resident discharge summary, dated 09/06/2024, showed the resident had discharged to home with family. During an interview, on 10/07/2024 at 2:37 PM, Staff J, Resident Care Manager/ Licensed Practical Nurse, stated Resident 96 had discharged from the facility to home with family. Staff J stated, yes I do the resident discharges. Staff J reviewed the MDS assessment and stated, I sure did .I marked the discharge to the hospital; the resident went home with his family. During an interview, on 10/04/2024 at 2:03 PM, Staff C, Assistant Director of Nursing Services (ADON) acknowledged that the medications were coded incorrectly on the MDS assessments for Residents 32, 84, 79, and 3, and did not reflect the residents' status accurately. Staff C stated, it appears that we need to do some education with our Resident Care Managers. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 10/04/2024 at 2:11 PM, Staff B, Director of Nursing Services, stated the expectation was the resident assessments were to be accurate. Additionally, Staff B stated they were aware of the MDS discrepancies and Staff C would be providing education to the Resident Care Managers and making the corrections immediately. Reference: WAC 388-97-1000 (1)(b) 43280

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39652 Based on interview, and record review the facility failed to ensure residents received treatment and services in accordance with professional standards of practice regarding monitoring of their cardiac status (issues related to the functioning of the heart). This included daily weights and physician notification of weight changes greater than three or more pounds (ibis, a unit of measure) in a 24-hour period for 1 of 2 residents (Resident 1) reviewed for quality of care. These failures placed residents at an increased risk for unidentified complications and a deterioration in their health status. Findings included . <Resident 1> Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including; congestive heart failure (a condition in which the heart does not pump blood as well as it should), diabetes (a condition that causes elevated blood glucose) and history of a cerebral vascular accident (lack of blood supply to an area in the brain which results in brain damage). Review of the most recent comprehensive assessment dated [DATE] showed the resident was cognitively intact and required substantial assistance from staff for activities of daily living such as toileting, dressing, transferring between surfaces and mobility. Record review of Resident 1's October 2024 physicians orders showed an order dated 06/12/2024 in which the resident was to have daily weights to monitor their cardiac status. The order included instructions to contact the physician if the resident had a weight gain of three lbs or greater in a 24-hour period. Review of Resident 1's July 2024 medication administration record (MAR) showed nine missed daily weights on 07/01/2024, 07/02/2024, 07/08/2024, 07/09/2024, 07/10/2024, 07/11/2024, 07/19/2024, 07/23/2024 and 07/30/2024. Additionally, on 07/25/2024 the resident had a documented weight of 160 lbs and the following day on 07/26/2024 their weight was 165 lbs which was a greater than three lbs of weight gain in 24 hours. Review of Resident 1's progress notes (PN) dated 07/26/2024 showed that the physician had not been notified of the weight gain. Record review of Resident 1's August 2024 MAR showed seven missed daily weights on 08/14/2024, 08/22/2024, 08/23/2024, 08/24/2024, 08/26/2024, 08/28/2024 and 08/31/2024. Further review showed on 08/29/2024 the resident's weight was 162 lbs. and on 08/30/2024 the resident's weight was 166 lbs. which was greater than three lbs. of weight gain. Review of the PN dated 08/30/2024 showed that Resident 1's physician had not been notified of the resident's greater than three lbs. of weight gain. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 1's September 2024 MAR showed their daily weights had been missed seven times during the month on 09/01/2024, 09/05/2024, 09/09/2024, 09/14/2024, 09/15/2024, 09/28/2024 and 09/29/2024. Further review showed the resident's weight on 09/27/2024 was 157 lbs. and the next documented weight was on 09/30/2024 which was 164 lbs. showing seven lbs. of weight gain in three days. Record review of the PN dated 09/30/2024 showed Resident 1's physician had not been notified of the weight gain or an assessment of the resident's cardiac status completed. Review of Resident 1's October 2024 MAR showed the resident had currently missed daily weights three times on 10/01/2024, 10/05/2024 and 10/06/2024. Further review showed the weight on 10/04/2024 was 160 lbs and on 10/07/2024 the resident's weight was 165 lbs indicating five lbs of weight gain over several days. Review of the residents PN dated 10/10/2024 showed the physician had not been notified of the weight gain or an assessment of the resident's cardiac status completed. During an interview on 10/07/2024 at 9:14 AM, Staff M, Registered Nurse, stated the physician should have been called for the weights that showed a three lbs. or more of weight gain. Staff M stated they had not contacted the physician related to Resident 1's weights but probably should have or at least had re-weighs completed to verify the accuracy of the data. During an interview on 10/07/2024 at 9:30 AM Staff N, Licensed Practical Nurse/Charge Nurse stated Resident 1's weight should have been completed daily and if the resident's weights showed an increase of three or more lbs. then the physician should have been notified. Reference: WAC 388-97-1060(1)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on interview and record review, the facility failed to ensure residents who were trauma survivors received culturally competent, trauma informed care complete with identified experiences and preferences regarding potential triggers (a stimulus that could prompt a recall of a previous traumatic event even if the stimulus itself is not traumatic or frightening) that may cause re-traumatization (a reliving of the traumatic experience) for 1 of 3 residents (Resident 47) reviewed for trauma informed care. This failure placed the resident at risk for unidentified triggers and re-traumatization. Findings included . Review of the facility's policy titled, Trauma Informed Care, revised October 2022, showed the purpose was to .ensure that residents who are trauma survivors receive culturally competent, trauma-informed care .in order to eliminate or mitigate (to make less severe or painful) triggers that may cause re-traumatization of the resident. The policy showed the facility promoted an environment of healing/recovery rather that practices or services that may inadvertently (without knowledge or intent) re-traumatize a resident and Examples of Trauma: Prolonged family violence .Assault/Abuse-including sexual/physical/emotional .Characteristics: Detailed memories, Reliving the event .Misperceptions (a wrong or incorrect understanding or interpretation)/overreactions .sleep disturbance . Additionally, the policy showed residents would be screened and assessed for a history of trauma, potential triggers identified, development/implementation of a care plan with preventative interventions and routine review a resident's care plan would be performed to ensure trauma informed care was being provided. <Resident 47> Review of the medical record showed the resident was admitted on [DATE] with diagnoses including heart failure, depression and insomnia (sleep disorder that makes it hard to fall asleep, stay asleep, or get enough sleep). The 07/24/2024 comprehensive assessment showed the resident was cognitively intact and able to make their needs known. During an interview on 10/01/2024 at 11:27 AM, Resident 47 stated that Staff I, Nursing Assistant (NA), was rough and impatient when providing cares to them, was sometimes nice, but then other times was the opposite of nice. Resident 47 stated they reported this to Staff F, Charge Nurse, a month and a half ago. The resident stated they were worried about Staff I's mental state (an emotion or condition that greatly influences an individual's thought processes at a moment in time) and how it was up and down. Resident 47 stated they were afraid sometimes because Staff I's treatment toward them was unpredictable and Staff I's mood swings reminded Resident 47 of their significant other who was an alcoholic and had mood swings. Resident 47 stated they did not think that Staff I would physically abuse them like their significant other had, but Staff I's unpredictable mood swings triggered those traumatic memories. Review of Resident 47's medical record showed no trauma informed care assessment had been completed for the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505348	A. Building B. Wing	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Health Care Ctr	702 North 16th Avenue Yakima, WA 98902

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 47's care plan, dated 06/05/2023, showed the resident had a history of physical abuse as a child and a plan for the resident's trauma history was developed. No potential triggers were identified. Review of a progress note, dated 10/02/2024 at 9:30 AM, showed Staff E, Social Service Assistant (SSA), interviewed Resident 47 and documented, Follow up with resident regarding care concerns per resident no issues or concerns. Does not want a particular NAC in (Resident 47's) room however reports no abuse or neglect just personal preference. Will continue to monitor and follow as needed. During an interview on 10/02/2024 at 11:44 AM, Staff K, NA, stated they knew Resident 47 had a history of an abusive parent but was not aware of any potential triggers for the resident. During an interview on 10/02/2024 at 12:36 PM, Staff E, SSA, stated they had just followed up about a specific NA that Resident 47 did not want to care for them anymore earlier in the morning. Staff E stated when they had interviewed Resident 47 that morning, they understood the issue to be that Staff I and Resident 47's personalities did not mix well. Additionally, Staff E stated Resident 47 had a previous roommate that would yell/hit themselves and that would make Resident 47 upset. During an interview on 10/02/2024 at 12:47 PM, Staff D, Social Service Director and Staff E, stated Resident 47 had a history of verbal and physical abuse from the resident's parents. Staff D stated they had not completed a trauma informed care assessment on Resident 47 because we knew about (Resident 47's) trauma from 2019, but was not aware of the resident ever being married. Additionally, Staff D stated they had never assessed Resident 47 for potential triggers regarding their traumatic history. During an interview on 10/02/2024 at 1:07 PM, Staff H, NA, stated they remembered hearing Resident 47 was married and their significant other was physically abusive toward Resident 47. Staff H stated the resident's parent was also verbally abusive. Staff H stated they did not convey any information on the resident's traumatic events to any other staff because the resident's trauma history was already known. During an interview on 10/02/2024 at 1:35 PM, Staff F, Charge Nurse, stated Resident 47 expressed concerns about a night shift NA that was rude/rushed when providing cares two to three months prior. Staff F stated Resident 47 had a history of parents that were not good to the resident and a significant other that was also not good, .rude verbally maybe. Staff F stated they were not aware of any potential triggers for Resident 47 traumatic history. During an interview on 10/02/2024 at 10:15 AM, Staff B, DNS, stated the facility's process for trauma informed care with residents was to complete a trauma informed care assessment, which identify traumatic events in the resident's history, any possible triggers that would make them relive the traumatic event, and interventions to prevent that from happening. Staff B stated that Resident 47 should have had a trauma informed care assessment that identified/care plan the residents potential triggers. Staff B stated Resident 47's perception of Staff I's mental state being up and down could be a potential trigger of the resident's trauma from their abusive significate other, and the correct process was not followed. Reference: WAC 388-97-1060(3)(e)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39652 Based on interview and record review the facility failed to ensure that 1 of 5 residents (Resident 1) reviewed for unnecessary medications, had an acceptable indication for use for a psychoactive medication (a class of medication that affects brain activity of mental functioning and behavior). Resident 1 was prescribed an antipsychotic medication (a psychoactive medication primarily used to treat psychosis with a high risk for adverse side effects [ASE's]) with no acceptable mental health diagnosis or identified individualized target behaviors to justify the use of an antipsychotic. This failure placed Resident 1 at increased risk for deterioration in their mental and physical health status. Findings included . Record review of a facility policy titled, Behavior Management/Psychotropic Medication Overview, dated 10/2022 showed, .When psychotropic medications are ordered, an appropriate diagnosis must have been obtained .Behavior monitoring will be documented when an antipsychotic medication is ordered . Psychotropic medication use will be reviewed at least quarterly to determine appropriateness of continued use . Record review of an Alzheimer's Society 2024 guidance showed, antipsychotic drugs are used to treat people who are experiencing severe agitation, aggression or distress from psychotic symptoms such as hallucinations or delusions and; antipsychotic drugs do not help with other behaviors such as: Distress and anxiety Repetitious vocalizations Social withdrawal Possible negative effects of antipsychotics include: Drowsiness or confusion Shaking, unsteadiness and reduced mobility Worse than usual dementia symptoms Higher risk of infection (in the chest or urinary tract) Higher risk of fall with fractures Higher risk of blood clots and stroke (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 1> Review of the resident's medical record showed they were admitted to the facility on [DATE] with mental health diagnoses including dementia without behavioral disturbances or psychotic features, anxiety (a feeling of worry, nervousness, or unease) and depression (a mood disorder that causes a feeling of sadness and loss of interest). The most recent comprehensive assessment, dated 09/18/2024, showed the resident was cognitively intact with anxiety and moderate depression. The assessment did not identify that the resident had issues with psychosis. Review of Resident 1's physician orders, dated October 2024, showed the resident was taking several psychoactive medications including an antidepressant medication used to treat their depression, an antianxiety medication used to treat their anxiety and an antipsychotic used to treat their anxiety. There was no diagnosis or an associated behavior documented in the medical record to show that an antipsychotic medication was clinically indicated for use. Record review of Resident 1's August 2024 through 10/06/2024 behavior monitor flow sheets (a sheet that provides documentation of identified target behaviors associated with the resident's mental health diagnoses) showed the resident's identified behaviors were sadness and hopelessness related to depression, worrying and ruminating (to think consistently and for a long period about something) related to anxiety. The sheets did not identify any behaviors associated with psychosis to justify the use of an antipsychotic medication. Further review of the resident's behavior monitor flow sheets for August and September 2024 showed the resident had no documented behaviors related to sadness, hopelessness, worrying or ruminating. The resident's most current behavior monitor flow sheet dated 10/01/2024 to 10/06/2024 also showed no documented behaviors had occurred. Record review of Resident 1's psychoactive medication review meeting, dated 09/19/2024, showed the resident was unaware of when they were started on the antipsychotic. The review showed the diagnosis for the use of the antipsychotic was anxiety and dementia. The targeted behaviors were identified as sadness and hopelessness. There was no other clinical indication or justification for the use of Resident 1's antipsychotic medication. During an interview on 10/04/2024 at 11:36 AM, Staff D, Social Services Director, stated Resident 1 was admitted to the facility on several psychoactive medications including an antipsychotic. Staff D stated they were unable to find a provider note for the use of Resident 1's antipsychotic except for a diagnosis of anxiety. Staff D was asked if there were identified target behaviors that would justify the use of an antipsychotic medication and they replied no. Reference: WAC 388-97-1060 (3)(k)(i)