STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arlington Health and Rehabilitation	620 South Hazel Street Arlington, WA 98223

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110 Based on interview and record review the facility failed to provide necessary care and services to prevent neglect for 1 of 3 residents (Resident 1) reviewed for abuse and neglect. Licensed staff was aware of the change in condition and abdominal pain experienced by Resident 1 yet did not conduct a thorough assessment or consult with the physician timely and left the resident alone in their room and in pain during the night shift with door closed for at least 30 minutes. The lack of addressing the residents needs placed all residents at risk for neglect. Review of the facility policy titled, Abuse and Neglect, undated stated the facility has effective procedures to protect and prevent neglect of residents .licensed nurses, and nurse management staff are responsible for the supervision of facility staff to identify inappropriate behaviors such as . ignoring residents and ensuring that staff are providing care as identified in the residents plan of care . The facility defines neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Resident 1 admitted to the facility on [DATE] with diagnoses including atrial fibrillation (irregular heartbeat), long term use of anti-coagulant (medication that thins the blood), diabetes (medical condition in which the body doesn't use insulin properly), and history of stroke. The significant change in condition Minimum Data Set (MDS - an assessment tool) assessment, dated 05/11/2024 showed the resident had intact cognition, no refusals of care, and was dependent on staff for toileting, and personal care. Review of Resident 1's medical record on 08/01/2024 showed that the resident had a change in condition between 07/22/2024 and 07/24/2024. The resident had experienced increased abdominal pain without relief. Review of Resident 1's vitals (measurements of body's basic functions i.e. heart rate, blood pressure, oxygen saturation, temperature, and respiratory rate) report showed the last time the residents blood pressure, temperature and pulse were checked was on 07/23/2024 at 3:52 PM, by the Nursing Assistant Certified (NAC) at the beginning of their shift. The medical record did not reflect any vital assessments were completed on the night shift 07/23/2024 11:00 PM - 07/24/2024 6:00 AM. (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: 505351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
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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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a nursing progress note dated 07/22/2024 at 9:45 PM, showed Resident 1 had experienced abdominal discomfort, received an antacid (medication to reduce abdominal discomfort) twice without relief. Review of a nursing progress note dated 07/23/2024 at 4:56 AM, showed Resident 1 continued to experience abdominal discomfort. Review of a nursing progress note dated 07/23/2024 at 1:51 PM, showed Resident 1 had only experienced small bowel movements the last 48 hours, and that the resident needed to be assessed. No assessment was documented. Review of a nursing progress note dated 07/23/2024 at 11:44 PM, showed Resident 1 continued to have abdominal pain, and bowel sounds were slow. Review of a nursing progress note dated 07/24/2024 at 2:20 AM, showed Resident 1 had been restless all night, had called out for assistance multiple times, nursing staff were unable to relieve discomfort with antacids. Staff documented that the resident was calling out, crying and disruptive to their roommate. The note stated staff had to remove Resident 1's roommate from the room as the roommate was in distress from the resident's constant calling out. There was no documentation of additional assessments or that the physician was notified until approximately two hours later. The medical record showed that the resident experienced increased abdominal discomfort and pain until they were found on 07/24/2024 at 6:00 AM covered in dark, brown vomit, with right lower abdominal pain and decreased breath sounds noted. Review of Resident 1's progress notes dated 07/22/2024 at 9:45 PM, 07/23/2024 at 4:56 AM, 1:51 PM, and 11:44 PM, showed the resident had experienced abdominal discomfort, and pain. Review of Resident 1's progress note dated 07/24/2024 at 2:20 AM showed the resident was restless all night, calling out for assistance multiple times, and the nurse was unable to relieve their discomfort. The note stated the crying became so disruptive they removed the roommate from the room as it was causing them distress. Review of the progress note on 07/24/2024 at 4:19 AM showed a fax communication to the physician that stated the resident had increased abdominal discomfort, loose stools, and increased restlessness, and requested the nutritional supplement by placed on hold to do possible abdominal discomfort. Review of Resident 1's progress notes on 07/24/2024 at 6:46 AM, the day shift (07/24/2024 6:00 AM - 2:00 PM) showed the nurse noted that at 6:00 AM the resident was found to have vomited a dark brown coffee ground like substance. The day shift nurse assessed the resident, notified the physician and the resident was sent to the hospital. Review of Resident 1's hospital records dated 07/24/2024 the physician note time stamped at 3:43 PM on 07/24/2024 showed that the resident had passed away. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on 08/06/2024 at 7:56 AM, Staff C, Nursing Assistant Certified (NAC) stated that at the start of their shift at 11:00 PM, they were told Resident 1 had been uncomfortable, having pain and discomfort in their abdomen and back. Staff C stated that the resident was calling out all shift, placing their call light on as soon as they would leave the room. Staff C stated they were in and out of the room all night, it was a long night. Staff C stated the resident would call the staff's name out, cry, and yell out constantly to the point that it was disrupting the roommate, so staff moved the roommate to another room down the hall. Staff C stated when they got ready to start their last rounds between 4:00 AM and 5:00 AM the nurse [Staff D, License Practical Nurse (LPN)] told them that they would take care of Resident 1 for them as they needed a break. Staff C stated they did not go back into Resident 1's room the rest of their shift. Staff C stated that they did notice around 5:00 AM Resident 1's door was shut, they could not recall if the call light was on. Staff C stated they gave report to the next shift around 6:00 AM, and that was then they learned Resident 1 had vomited and the resident was going to be sent to the hospital. In an interview on 08/06/2024 at 11:10 AM, Staff D, Licensed Practical Nurse (LPN) stated they were aware that the resident had been experiencing increased abdominal pain and discomfort for the last couple of days when their shift started on 07/23/2024 at 11:00 PM. Staff D stated they did not assess the resident for the source of the abdominal pain, and did not assess the residents vitals on their shift (07/23/2024 11:00 PM - 07/24/2024 6:00 AM). Staff D stated they thought the nutritional supplement drink the resident had been taking might be the source and that was what they communicated to the physician when they sent a fax on 07/24/2024 at 4:19 AM. Staff D stated they should have called the physician and notified them of the increase in abdominal pain and change in condition timelier. In an interview on 08/07/2024 at 2:33 PM, Staff B, Director of Nursing Services (DNS), stated their expectation was that when any resident experienced a change in condition that all licensed staff were to complete a thorough assessment of the resident, notify the physician on the phone immediately after they assessed the resident, and follow all physician orders. Staff B stated that Resident 1 did not have a thorough assessment for their change in condition, and that communication with a fax was inappropriate at that time of the concern. Refer to WAC 388-97-0640(1)(3)(c)

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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 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** 44110 Based on interview and record review, the facility failed to ensure policies and procedures for timely reporting of an unexpected death were in place for 1 of 3 residents (Resident 1) reviewed for abuse/neglect. The facility failed to report to the state agency when a resident was sent to the hospital and unexpectedly died hours later. This failure by the facility to identify, report, and investigate an allegation of potential abuse or neglect placed residents at risk of being victims of unidentified and uninvestigated abuse and/or neglect and limited the thoroughness of investigations. Findings included . Review of the facility policy titled, Abuse and Neglect, undated stated the facility will report allegation of abuse and neglect to the appropriate authorities . Allegations of abuse and neglect will be reported to the Department of Social and Health Services (DSHS) following the nursing home reporting guidelines the Purple Book. Review of the Nursing Home Guidelines, The Purple Book, [DATE] (sixth edition) showed all unexpected deaths possibly related to abuse or neglect, or not related but suspicious must be reported to the DSHS hotline, logged on the state reporting log, notification of law enforcement, and coroners' office. Resident 1 admitted to the facility on [DATE]. The resident discharged to an area hospital on [DATE], the resident passed away hours after discharge. Review of Resident 1's significant change in condition Minimum Data Set (MDS - an assessment tool) assessment, dated [DATE] showed the resident had intact cognition, no refusals of care. Review of Resident 1's care plan showed the residents discharge plan dated [DATE] was to return to their independent living senior apartment. Review of Resident 1's medical record showed the resident had a change in condition between [DATE] and [DATE]. Emergency medical services were notified, and the resident was sent out to the hospital. Review of Resident 1's hospital records dated [DATE] showed that the resident arrived at the hospital at 7:57 AM. The physician note read they attempted to stabilize the resident, but the resident would likely only survive a few more hours. The physician note time stamped at 3:43 PM on [DATE] showed that the resident had passed away. Review of the facility state reporting log on [DATE], for [DATE] showed no entry for Resident 1 and their unexpected death. Review of the Complaint Resolution Unit [(CRU) Washington State Reporting Hotline Center], on [DATE] showed no report from the facility for Resident 1's unexpected death. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:07 AM Staff B, Director of Nursing Services (DNS) was asked to provide the facility investigation of the unexpected death for Resident 1. At 1:55 PM, an undated summary of an investigation for the unexpected death of Resident 1 was provided by Staff B. The investigation summary showed that the resident did not receive care and services timely or thoroughly to prevent harm to the resident. In a joint interview on [DATE] at 2:33 PM, with Staff A, Administrator and Staff B, DNS, Staff B stated they learned that the resident had passed away around 3:00 PM on [DATE]. Staff B agreed that the licensed staff did not provide timely care and services to Resident 1, who was ultimately sent to the hospital and passed away hours later. Staff A stated that they were advised that they were not required to report the unexpected death of Resident 1 by their corporation. Staff A and Staff B were not aware that the Purple Book showed on Appendix D, under reporting guidelines for Nursing Homes that an unexpected death required, DSHS hotline report, logged on the state reporting log within 5 days, notify law enforcement and notify the coroner. Refer to WAC [DATE](2)(b)(5)(6)(c)

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Respond appropriately to all alleged violations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44110

Based on interview and record review, the facility failed to conduct a thorough investigation for three of three residents (1, 2, and 3) reviewed for complete and thorough investigations. The facility failed to thoroughly investigate an unexpected hospitalization that led to the death of Resident 1 and failed to thoroughly investigate two allegations of abuse towards residents (2 and 3) that involved the same staff member [Staff I, Nursing Assistant Certified (NAC)]. This failure to investigate timely and thoroughly placed residents at risk of being victims of unidentified and uninvestigated abuse and/or neglect.

Findings included .

Review of the facility policy titled, Abuse and Neglect, undated stated the facility will utilize the nursing home reporting guidelines the Purple Book, October 2015 edition to investigate all allegations of abuse, and/or neglect . the facility social services, Director of Nursing services (DNS), or administrator will investigate and act to protect residents and will closely monitor residents.

Review of the Nursing Home Guidelines, The Purple Book, October 2015 (sixth edition) stated the investigation process was to find out what occurred, and make necessary changes to the provisions of care and services to prevent reoccurrence . investigations should involve all potential witnesses . a thorough investigation should answer who, what, where, when, why and how, and establish a reasonable cause or known source of the incident.

<RESIDENT 1>

Resident 1 admitted to the facility on [DATE] with diagnoses to include atrial fibrillation (irregular heartbeat), long term use of anti-coagulant (medication that thins the blood), diabetes, and history of stroke. The significant change in condition Minimum Data Set (MDS - an assessment tool) assessment, dated 05/11/2024 showed the resident had intact cognition, no refusal of care, was dependent on staff for toileting, and personal care. The resident discharged to an area hospital on 07/24/2024, the resident passed away hours after discharge.

Review of Resident 1's medical record showed the resident had a change in condition between 07/22/204 and 07/24/2024. Emergency medical services were notified, and the resident was sent out to the hospital.

Review of Resident 1's hospital records dated 07/24 2024 showed that the resident arrived at the hospital at 7:57 AM. The physician note time stamped at 3:43 PM on 07/24/2024 showed that the resident had passed away.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/07/2024 at 1:55 PM, received an undated summary of an investigation for the unexpected death of Resident 1. The investigation lacked information that showed the licensed nurse [Staff D, Licensed Practical Nurse (LPN)] failed to timely and thoroughly assess the resident. The investigation stated that the licensed nurse notified the physician, however the summary failed to show that the communication came hours after the resident had been experiencing a change in condition and that method of communication used, was for non-emergent concerns (fax machine). The investigation summary stated the resident was calm throughout the night, however the residents medical record and witness statements showed the resident was distressed, crying out, and in pain all night. The investigation failed to show that the resident did indeed unexpectedly pass away and did not determine whether abuse and neglect had been ruled out related to the residents unexpected death. <RESIDENT 2> Resident 2 admitted to the facility on [DATE] with diagnoses to include depression, lung disease, and heart failure. The quarterly MDS dated [DATE] showed the resident had mild cognition impairment, no refusal of cares, was dependent for toileting, and was frequently incontinent (lack of control) of their bladder. Review of the facility state reporting log for July 2024 showed on 07/27/2024 at 6:55 PM, the Resident 2 had an allegation of abuse and/or neglect. Review of the facility investigation signed by Staff B, Director of Nursing Services (DNS) on 08/01/2024 (six days after the allegation) showed that Resident 2 had alleged that Staff I, NAC refused to assist them with the care they needed, when they had an episode of incontinence overnight and required assistance to change, they're under garments, and bedding. The investigation included a witness statement from another staff member that showed the resident's roommate (Resident 4, a resident with intact cognition) overheard the conversation between the resident and Staff I and could confirm the allegation. The investigation lacked any interview or questioning of Resident 4. The statement by Staff I, (alleged staff member) stated they told the resident Your independent, and usually do it all yourself. The investigation included a questioner, where four other residents were asked indirect question about their care, no interviews were done with other residents regarding Staff I and the care they provided at the facility. The investigation did not show that the physician or family/Power of attorney (POA) was notified of the allegation. The investigation showed that Staff I was educated on providing all necessary care to residents and that abuse was ruled out. Review of Resident 2's care plan dated 03/15/2024 stated that the resident had slight impaired cognition and staff were directed to ask yes or no questions, cue, re-orient and supervise as needed, and to break task up into one step at a time. The care plan did not show that the resident was involved in an allegation of abuse and/or neglect and could have possible psychosocial harm. Review of Resident 2's medical record on 08/01/2024 showed no documentation that the physician or the family/POA were notified of an allegation of abuse/or neglect. There was no monitoring for potential psychosocial harm related to the allegation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/01/2024 at 1:05 PM, Resident 4 stated they overheard their roommate (Resident 2) calling for assistance one night. Resident 4 stated a heavy set, loud speaking, female NAC entered the room. Resident 4 stated they overheard the NAC tell their roommate You should be able to do that on your own, and that is not the kind of care we do here. Resident 4 stated they left the room and was not sure if they ever came back. Resident 4 stated when they required assistance and Staff I showed up, they would request they get another NAC because they did not feel Staff I, could assist them alone. Resident 4 stated no one from the facility came to talk to them about what happened to Resident 2, and no one from the facility ever asked how Staff I provided care. <RESIDENT 3> Resident 3 admitted to the facility on [DATE] with diagnoses to include osteoarthritis (degenerative disease of the joints that causes pain and lack of movement), and bladder disorder. The quarterly MDS dated [DATE] showed the resident had intact cognition, no refusal of cares, and was dependent on staff for toileting, and required moderate assist for bed mobility. Review of the facility state reporting log for July 2024 showed on 07/31/2024 at 3:00 PM, the Resident 3 had an allegation of abuse and/or neglect. Review of the facility investigation signed by the Staff B, Director of Nursing Services on 08/02/2024, showed that Resident 3 alleged that Staff I, NAC had been rough when providing care to them in bed, after an episode of incontinence. The investigation showed that the Resident 3 was interviewed by the Staff B, and Staff J, Social Services where the resident confirmed that Staff I, had used to much strength on them when truing and repositioning the resident in bed. The investigation showed a statement from Staff I's that denied the allegation. The investigation included the same questioner as other allegation (involving Resident 2 and Staff I on 07/27/2024) it did not direct any questions or concerns to the care that Staff I provided at the facility. The investigation lacked any interviews with any other staff that worked with Staff I. The investigation did not show that the physician or family/Power of attorney (POA) was notified of the allegation. The investigation stated that Staff I was given education on the level of strength they are to provide to residents and that abuse was ruled out. Review of Resident 3's care plan showed a focus revised 10/21/2021 that the resident had an activities of daily living deficit related to pain, weakness and impaired mobility. It directed staff to provide minimum of one person assistance for bed mobility and directed staff to use the draw sheet for turning and repositioning. The care plan did not reflect that the resident could have possible psychosocial harm related to the allegation of neglect. Review of Resident medical record on 08/01/2024 showed no documentation that the physician or the family/POA were notified of an allegation of abuse/or neglect. The medical record showed one progress note three days after the allegation that showed the licensed staff were monitoring for potential psychosocial harm related to the allegation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/01/2024 at 2:48 PM, Resident 3 stated that Staff I had come into their room to provide them assistance with incontinence care in their bed. Resident 3 stated that Staff I began to shove their fist into their back to push them over to the side. Resident 3 stated they pleaded with Staff I to use the draw sheet, as it was causing them a lot of pain to be pushed over on their back by their hands. Resident 3 stated that Staff I said to them, I don't need to use the draw sheet, I know what I am doing I have been doing this for [AGE] years. Resident 3 stated they reported that Staff I was rough with them and that they did not want Staff I to provide them care anymore. In a phone interview on 08/06/2024 at 7:53 AM, Staff I stated they had worked at the facility for just over three months. Staff I was asked about the allegation that involved them and Resident 2. Staff I stated they did not understand why the resident had complained about them. Staff I confirmed they were talking loud to the resident, and that they did say to the resident you should be able to do that yourself. Staff I stated they were told by Staff B, DNS that they had ruled out abuse and that they could return to the facility. Staff I stated that Staff B phoned them regarding another allegation that involved Resident 3 and stated the resident had alleged that I was not gentle with them. Staff I stated they had been accused of being rough earlier in the month, so they felt they had tried extra hard to be gentle. Staff I stated Staff B, DNS called them and gave them a short education about providing care to residents and using a gently touch. Staff I stated they were supposed to return to work on the 1st of August, however Staff B called them again and told me I was not a good fit for the facility, and that they had let me go. In an interview on 08/07/2024 at 10:55 AM, Staff J, Social Services stated their role during allegations of abuse and/or neglect investigations was usually to interview other like residents. Staff J stated they spoke with Staff B, DNS and was directed by them on who to interview and what to ask regarding the investigations for Resident 2 and Resident 3. Staff J was asked if Resident 3 had requested to have Staff I as their caregiver anymore, Staff J did not provide any information other than confirm Staff I no longer worked for the facility. Staff J stated they never spoke with Resident 2 regarding their allegation of neglect. In an interview on 08/07/2024 at 11:50 AM, Staff H, Licensed Practical Nurse/Patient Care Coordinator stated all residents that have any allegation of abuse or neglect should be monitored for psychosocial harm for at least 72 hours. Staff H stated all investigations of abuse and/ or neglect should include a notification to the physician, and family or POA if necessary. Staff H stated they were involved with the unexpected death of Resident 1, there role was to obtains statements from the staff and then provided those to Staff B for further investigation. Staff H stated they were out sick and did not assist in the investigations for Resident 2 or Resident 3. Staff H stated Staff B usually does all the investigations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a joint interview on 08/07/2024 at 2:33 PM, Staff A, Administrator and Staff B, DNS, were asked what the process for any allegation of abuse and/or neglect was at the facility. Staff B stated the staff were instructed to contact them immediately, they report the allegation to the state hotline, and then start an investigation. Staff B stated all residents with allegations of abuse and/or neglect should be monitored for latent injuries and/or psychosocial harm every shift and documented in the medical record. Staff B stated all investigations should include a notification to the physician, and family or POA if necessary. Staff B stated that for the allegation involving Resident 2, Staff A, and themself spoke with Resident 2 and their conclusion was that it was a misunderstanding by the resident. Staff A stated that they thought the resident was confused by the staff member, and so they were just speculating what could have happened. Staff B stated they never spoke with the resident's roommate (Resident 4) and that they were not aware of the statement in the investigation that was provided by the facility that Resident 4 had confirmed the allegation of neglect. Staff B stated they were not aware there was no notification to the physician, and family or monitoring for Resident 2. Staff A and Staff B were asked about the allegation regarding Resident 3. Staff B confirmed they used the same interviews for the previous investigation. Staff B confirmed the allegations were different and that they should have asked different resident and different questions directed at Staff I ability and competencies. Staff B confirmed there was no other witness statements obtained about the care and services that Staff I had been providing at the facility. Staff B confirmed that Staff I had a previous history of rough handling, and that it was possible they were rough with Resident 3. Staff B stated they were not aware there was no notification to the physician, and family or monitoring for Resident 2. Staff B stated they did provide education to Staff I on 08/01/2024, then after further discussion with Staff A, decided they were not a good fit for the facility and let me go. Staff A and Staff B were asked about the unexpected death of Resident 1. Staff A stated they were instructed that the death was not a reportable event and therefor did not complete an actual investigation of the death. Staff B confirmed the licensed nurse should have conducted a thorough assessment of Resident 1. Refer to WAC 388-97-0640(6)(a)(b)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110 Based on interview and record review, the facility failed to provide the needed assessments and timely treatment for 1 of 1 residents (Resident 1) reviewed for an unexpected hospitalization , who experiences ongoing abdominal pain and discomfort for at least two days to the extent that staff moved the roommate out of the room and closed the door because the resident was calling out in pain. The resident experienced harm when treatment was delayed for several hours and there was a lack of effective communication with the physician. The resident was sent to the hospital the next morning and passed away shortly after admission to the hospital. The disregard of the pain the resident experienced and recognizing the need to take timely action constituted an immediate jeopardy. On 08/15/2024 at 3:35 PM, the facility was notified of an IJ in F684. The facility removed the immediacy on 08/19/2024 after they terminated the staff that failed to assess, treat and timely notify the physician of Resident 1's acute change in condition. They audited the records of all residents, educated staff on what to do when a resident has a change in condition, educated staff on identifying abuse and neglect and implemented a plan of correction to sustain ongoing compliance. Findings included . Review of the facility policy titled, Notification Policy, revised 04/17/2020 states the facility should promptly notify the resident, their physician, and primary contact of changes in the residents condition or status .the nurse will notify the physician when there was a change in condition in their physical, mental, or psychosocial status, involvement in any incident, need to alter the residents treatment, and when necessary in the best interest of the resident. Resident 1 admitted to the facility on [DATE] with diagnoses to include atrial fibrillation (irregular heartbeat), long term use of anti-coagulant (medication that thins the blood), diabetes (medical condition in which the body doesn't use insulin properly), and history of stroke. The significant change in condition Minimum Data Set (MDS - an assessment tool) assessment, dated 05/11/2024 showed the resident had intact cognition, no refusals of care, was dependent on staff for toileting, and personal care. The MDS showed the resident was incontinent of bowel and bladder and was taking an anticoagulant medication. Resident 1's physician order for sustaining life (POLST) form dated 02/21/2024 showed that the resident choice indicated selective treatment that designated the primary goal was to treat medical conditions while avoiding invasive measures whenever possible. The resident chose to receive medical treatment, intravenous (IV) fluids (fluids administered through a needle and tubing injected directly into the vein), medications, and cardiac monitor as indicated. The resident chose to have airway support with oxygen and wanted to be transferred to hospital if indicated. Review of a nursing progress note dated 07/22/2024 at 9:45 PM, showed Resident 1 had experienced abdominal discomfort, received an antacid (medication to reduce abdominal discomfort) twice without relief. Review of a nursing progress note dated 07/23/2024 at 4:56 AM, showed Resident 1 continued to experience abdominal discomfort. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Arlington Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 620 South Hazel Street Arlington, WA 98223	

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a nursing progress note dated 07/23/2024 at 1:51 PM, showed Resident 1 had only experienced small bowel movements the last 48 hours, and that the resident needed to be assessed. No assessment was documented. Review of a nursing progress note dated 07/23/2024 at 11:44 PM, showed Resident 1 continued to have abdominal pain, and bowel sounds were slow. Review of a nursing progress note dated 07/24/2024 at 2:20 AM, showed Resident 1 had been restless all night, had called out for assistance multiple times, nursing staff were unable to relieve discomfort with antacids. Staff documented that the resident was calling out, crying and disruptive to their roommate. The note stated staff had to remove Resident 1's roommate from the room as the roommate was in distress from the resident's constant calling out. There was no documentation of additional assessments or that the physician was notified until approximately two hours later. Review of a nursing progress note dated 07/24/2024 at 4:19 AM, showed the nurse notified the physician by fax regarding Resident 1's constant abdominal discomfort, loose stools, and increased restlessness and crying out. The physician responded at 5:36 AM they would come by to see resident later that morning. Review of a nursing progress note dated 07/24/2024 at 6:46 AM, showed Resident 1 was found at the beginning of the shift (6:00 AM) to be vomiting a dark coffee colored substance The resident was short of breath with an oxygen saturation (amount oxygen was absorbed into the body) of 85% (residents' baseline was 96%). The nurse documented that the resident's lung sounds appeared decreased on the right and left side of their body, and that the right lower area of their abdomen was painful. The resident's hands, and feet were cold to touch. The resident was sent to the hospital. Review of Resident 1's vital sign (measurements of body's basic functions i.e. heart rate, blood pressure, oxygen saturation, temperature, and respiratory rate) report showed the last time the residents vitals were assessed was on 07/23/2024 at 3:52 PM. There was no documentation that the residents' vitals were assessed again until 6:00 AM on 07/24/2024, when the resident was found to be vomiting. In an interview on 08/06/2024 at 7:56 AM, Staff C, Nursing Assistant Certified (NAC) stated that at the start of their shift at 11:00 PM, they were told Resident 1 had been uncomfortable, having pain and discomfort in their abdomen and back. Staff C stated that the resident was calling out all shift, placing their call light on as soon as they would leave the room. Staff C stated they were in and out of the room all night, it was a long night. Staff C stated the resident would call the staff's name out, cry, and yell out constantly to the point that it was disrupting the roommate, so staff moved the roommate to another room down the hall. Staff C stated when they got ready to start their last rounds between 4:00 AM and 5:00 AM the nurse [Staff D, License Practical Nurse (LPN)] told them that they would take care of Resident 1 for them as they needed a break. Staff C stated they did not go back into Resident 1's room the rest of their shift. Staff C stated that they did notice around 5:00 AM Resident 1's door was shut, they could not recall if the call light was on. Staff C stated they gave report to the next shift around 6:00 AM, and that was then they learned Resident 1 had vomited and the resident was going to be sent to the hospital. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on 08/06/2024 at 11:10 AM, Staff D, LPN stated they have worked for the facility for about a year. Staff D stated they were educated by the facility that when a resident had a change in condition, they were to call and notify the physician. Staff D stated they were told in report at the start of their shift on 07/23/2024 at 11:00 PM that Resident 1 had been experiencing abdominal discomfort. Staff D stated during their shift the resident had been uncomfortable all night, was calling out, yelling and crying all night for staff to come into the room and help them. Staff D stated Resident 1's behavior was not their baseline and was disruptive to their roommate, so they moved the resident's roommate out of the room. Staff D stated they were aware that the resident had reported abdominal discomfort for a couple of days, as they worked the night before and the resident mentioned then they were having abdominal discomfort and pain then. Staff D was asked if they ever assessed the resident for the source of their abdominal pain and discomfort, Staff D stated they did not and realized that they should have checked the resident's vitals and conducted a head-to-toe assessment. Staff D stated they faxed the doctor; however, they should have called the physician earlier as the abdominal discomfort had been occurring for a couple of days. Staff D stated they probably needed further testing. Staff D confirmed that they shut the door to Resident 1's room between 5:00 AM - 5:30 AM on 07/24/2024 as they had been so disruptive to the other residents all night and was trying to allow the NAC's time to assist other residents. Staff D stated they did not check on the resident after they shut the door to the room. In an interview on 08/07/2024 at 10:08 AM, Staff G, Registered Nurse (RN) stated they have been employed at the facility for a little over a month. Staff G stated that they would call the physician if a resident had a change in condition, faxing the physician was for non-urgent needs. Staff G was receiving report from the overnight nurse (Staff D) when the day shift NAC approached them and stated that Resident 1 had coffee (dark brown) colored vomit all over them and was having difficulty breathing. Staff G stated they immediately went to the resident and assessed their vitals and completed a physical assessment. Staff G stated they asked another nurse to contact the physician to request to send the resident to the hospital. Staff G had not received report on Resident 1, stating they were not aware of the abdominal pain, and the restlessness of the resident until after they were sent to the hospital. In an interview on 08/07/2024 at 10:26 AM, Staff E, NAC stated they were not the staff that found Resident 1 on the morning or 07/24/2024. Staff E stated they arrived shortly after Staff G was assessing the resident. Staff E stated when they arrived in the room the resident was covered in dark brown vomit, the bed was a big mess. Staff E stated they assisted in cleaning the resident up, while they were preparing to send them to the hospital. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on 08/07/2024 at 11:27 AM, Staff F, NAC stated they were the staff member that found Resident 1 on the morning of 07/24/2024. Staff F stated when they came on shift, the previous NAC (Staff C) reported to them that Resident 1 had been calling out all night and was having abdominal pain and discomfort. Staff F stated when they started their shift, they noticed that Resident 1's door was shut. Staff F stated that they have worked with Resident 1 since they admitted and knew that the resident did not prefer their door shut. Staff F stated when they entered the room, the room was very cold, and they noticed that the window was open. Staff F stated that the resident had no covers on them, and their bare legs were exposed. The call light was not within the reach of the resident. Staff F stated the resident was covered in dark brown vomit, their lips were discolored, and their skin was very cold. Staff F stated the resident was saying help, help,. Staff F stated they tried to talk to the resident, but they were not making sense, and this was not Resident 1's baseline, so they ran to get a nurse. Staff F stated that Staff G, RN showed up immediately and began assessing the resident, and was preparing to send the resident to the hospital. Review of Resident 1's hospital records dated 07/24/2024 showed the resident presented to the emergency department (ED) at 7:57 AM on 07/24/2024. The physician note stated the resident presented with coffee-ground emesis (vomit), weakness, and low blood pressure. The ED physician documented that the resident appeared toxic and altered. The ED Physician documented that they were concerned with sepsis (blood infection) and septic shock (blood infection causes low blood pressure, widening of the blood vessels (vasodilation) and organ failure). Resident 1's laboratory blood result showed the resident had a high white blood cell (WBC) count that was indicative of an infection. The note stated that the resident had an acute critical illness with potential for imminent deterioration from septic shock and artery blockage to the abdominal organs. At 11:44 AM, the resident had been transferred to the intensive care unit. The physician noted that they had attempted to stabilize the resident, however the resident had been struggling to breath, and their heart rate was very low. The physician noted that they advised the family present that the resident was likely to only survive for a few more hours. At 3:43 PM the physician noted that Resident 1 had passed away. In an interview on 08/07/2024 at 11:50 AM, Staff H, LPN/Nurse Manager stated their expectation was the licensed staff would complete a vital sign assessment as well as a head-to-toe assessment of a resident whenever a resident was having a change in condition. Staff H stated they were not at the facility on the morning of 07/24/2024 and arrived after Resident 1 had been sent out to the hospital. Staff H stated they would have expected the nurse (Staff D) to have checked the resident's vitals and done a head-to-toe assessment on the resident during their shift. In a joint interview on 08/07/2024 at 2:33 PM, with Staff A, Administrator and Staff B, Director of Nursing Services (DNS), Staff B stated their expectation for all their staff was that the physician was called for any urgent matter or change in condition of the resident. Staff B stated that if a resident was having a change in condition, they expected their licensed staff to assess and monitor the resident continuously, notify the physician by calling them on the phone. Staff B was asked to clarify monitor and assess, and they stated they should be routinely checking their vitals and complete a head-to-toe assessment of the resident to report any findings to the physician. Staff B confirmed that Resident 1 was not properly assessed on the overnight shift of 07/23/2024 - 07/24/2024. Staff B was asked if they were aware that Resident 1's door was closed, and the call light was not within reach on the morning of 07/24/2024, Staff B did not offer any additional information. Staff B confirmed more should have been done for the resident. Staff A stated, In hindsight more should have been done to help the resident. Staff B stated they were alerted around 3:00 PM on the 24th that the resident had passed away. (continued on next page)

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