STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505355	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Post Acute	414 - 17th Southeast Auburn, WA 98002

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44295 Based on observation, interview, and record review the facility failed to provide assistance with Activities of Daily Living (ADLs) to include teeth brushing, transfers out of bed, and assistance with eating for 1 of 3 dependent residents (Residents 1) reviewed for ADL's. The failure to provide assistance with teeth brushing, transfers out of bed and eating to dependent residents, placed residents at risk for decreased intake, weight loss, poor hygiene, skin breakdown, embarrassment, and a diminished quality of life. Findings included . Review of the facility policy titled, ADL Care for Dependent residents, undated, showed the facility would provide appropriate treatment and services for dependent residents to ensure all ADL needs were met on a daily basis while attaining or maintaining the resident's highest practicable physical, mental and psychosocial well-being. Each resident's physical functioning would be assessed, included in the Care Plan (CP), and the CP interventions would be monitored on an on-going basis for effectiveness and would be reviewed as necessary. <Resident 1> Review of a quarterly Minimum Data Set (MDS, an assessment tool), dated 05/01/2024, showed Resident 1 admitted to the facility on [DATE]. The MDS showed Resident 1 was able to make their needs known, had no behaviors of rejection of care, and had diagnoses including a history of a brain bleed with left sided weakness, heart failure, high blood pressure, diabetes, disease of the stomach, and acid reflux. The MDS showed Resident 1 was assessed with loss of liquids or food from their mouth when eating or drinking, had no weight loss, and required moderate assistance with eating meals and oral hygiene. Review of a functional abilities and goal assessment, dated 01/31/2024, showed Resident 1 was assessed to require supervision or touching assistance with eating and the had ability to use utensils to bring food and liquids to the mouth. The assessment showed Resident 1 required maximum assistance with oral hygiene and was dependent on staff for bed to chair transfers. Review of Resident 1's Physicians Orders (PO) showed a PO, dated 02/02/2024, that directed staff to get Resident 1 out of bed for all meals and assist with feeding during each meal. Review of a PO, date 02/06/2024, showed Resident 1 was referred to speech therapy for coughing during eating related to a history of a brain bleed. (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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Nursing Progress Note (NPN), dated 02/02/2024, showed staff documented that Resident 1 to be out of bed for each meal and assisted with feeding to prevent aspiration (inhalation of food or liquids into the lungs). Review of a Provider Progress Note (PPN), dated 02/14/2024, showed the provider noted Resident 1 with clear lungs and a cough. The PPN showed Resident 1 had dysphasia (difficulty swallowing), was seen consistently coughing during eating meals and directed staff Resident 1 was to be out of bed for all meals, sitting upright to prevent aspiration. Review of an ADL, self-care deficit Care Plan (CP), initiated on 01/29/2024, showed Resident 1 required limited assistance, by staff, for help with meals, was dependent on two staff assistance with a mechanical lift to transfer out of bed and into the wheelchair. The CP did not identify the amount of assistance Resident 1 required for oral hygiene. Review of Resident 1's ADL CP, revised on 05/13/2024, showed Resident 1 was able to feed themselves after set-up assistance when sitting up in the wheelchair and should be up in the wheelchair during all mealtimes. The CP showed Resident 1 required one person extensive assistance with oral care and directed staff to brush Resident 1's teeth and assist with rinsing their mouth after meals as needed. Review of ADL documentation, dated 02/2024, showed on 02/04/2024, 02/08/2024, and 02/20/2024 staff documented Resident 1 was independent with hygiene needs and required set up assistance only for teeth brushing. Review of the ADL documentation showed multiple nursing staff documented not applicable, indicating a transfer did not occur or left the documentation blank for transfers on 02/05/2024, 02/06/2024, 02/07/2024, 02/10/2024, 02/12/2024, 02/14/2024, 02/15/2024, 02/18/2024, 02/19/2024, 02/20/2024, 02/22/2024, 02/24/2024, 02/25/2024, 02/26/2024, and 02/29/2024. Review of the ADL documentation showed staff documented Resident 1 was independent with eating and required set up tray help from staff or left the documentation blank on 02/01/2024, 02/02/2024, 02/05/2024, 02/06/2024, 02/07/2024, 02/10/2024, 02/12/2024, 02/13/2024, 02/14/2024, 02/15/2024, 02/18/2024, 02/20/2024, 02/23/2024, 02/24/2024, 02/25/2024, 02/26/2024, 02/28/2024, and 02/29/2024. Similar findings were identified when 03/2024, 04/2024, and 05/2024 ADL documentation was reviewed and showed Resident 1 was not assisted as required on multiple occasions with oral hygiene, transfers out of bed, and supervision and assistance with meals. In an interview on 07/18/2024 at 1:30 PM, Staff C (Restorative Nursing Assistant) stated Resident 1 had difficulties swallowing, would cough and sneeze during meals, and staff had to remind Resident 1 to use a chin-tuck method (induces swallowing by bending the head, neck, and pulling the chin towards the body) when eating meals. Staff C stated Resident 1 would come down to the main dining room so staff could assist the resident and if Resident 1 did not come to the main dining room, they would request staff get Resident 1 up but the resident didn't always come down to the main dining room for meals. In an interview on 07/18/2024 at 1:45 PM, Staff D (Certified Nursing Assistant) stated the resident's CP should direct staff on the amount of assistance a resident required with teeth brushing, transfer and meals. Staff D stated residents should be offered teeth brushing twice daily. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/18/2024 at 2:00 PM, with Staff A (Administrator) and Staff B (Director of Nursing), Staff A stated Resident 1 had challenges with eating and was an aspiration (inhalation of food into the lungs) risk. Staff B stated if Resident 1 had a physician's order to be out of bed for all meals, they would expect Resident 1 to be out of bed for all meals and assisted by staff. Staff B stated the CP should reflect the amount of assistance a resident needed for ADL's and would expect staff to follow the CP. REFERENCE: WAC 388-97-1060(1)(c)

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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** 44295 Based on interview, and record review, the facility failed to ensure 1 of 3 residents (Resident 1) reviewed received the necessary care and services in accordance with professional standards of practice. The facility failed to ensure Physician Orders (PO) were reviewed, clarified and implemented upon admission and after a physician visit, and failed to document on new pressure ulcers (PU, injury to the skin and underlying tissue due to prolonged pressure on the skin). These failures caused Resident 1 to experience skin breakdown, and placed all residents at risk for skin breakdown, pain, and diminished quality of life. Findings included . <Resident 1> Review of a quarterly Minimum Data Set (MDS, an assessment tool), dated 05/01/2024, showed Resident 1 admitted to the facility on [DATE] after transferring from another nursing facility. The MDS showed Resident 1 was able to make needs known, able to make themselves understood, and able to understand others. The MDS showed Resident 1 had no behaviors, was incontinent of bowel and bladder, and had diagnoses including a history of stroke (brain bleed) with left sided upper and lower extremity paralysis, heart failure, diabetes, hypothyroidism, liver failure, diseases of the stomach, and dementia. The MDS showed Resident 1 was dependent on staff assistance for transfers out of bed with a mechanical lift, bed mobility, bathing, and toileting. Review of facility discharge transfer PO, dated 01/24/2024, showed no treatment orders were included on the transfer orders. Review of transfer PO's showed a 01/23/2023 PO for Resident 1 to receive a high protein diabetic snack nightly and directed staff to give half a sandwich or a protein shake, a 07/10/2023 PO for Resident 1 to receive a liquid nutritional supplement four times daily for weight management, and a 01/23/2023 PO for heel protectors to both feet when in bed to promote skin integrity during the day and evening shift. Review of Resident 1's PO's, dated 01/29/2024, showed staff did not implement or clarify resident 1's PO for a high protein diabetic snack nightly, liquid nutritional supplement four times daily, or for heel protectors to prevent skin breakdown. A 02/05/2024 PO showed staff put in a PO for Resident 1 to have a nightly diabetic snack, the snack did not include high protein, and was implemented six days after Resident 1 admitted to the facility. A PO, dated 02/22/2024, showed staff put in a PO for liquid protein supplement one time daily for wound healing, the PO was put in 23 days after admission and was one fourth of the dose they previously received prior to admission to the facility. A PO, dated 02/28/2024, showed staff were directed to use moon boots (special heel protectors) on Resident 1's feet, the PO was put in place 29 days after Resident 1 admitted to the facility. Review of a facility admission assessment, dated 01/29/2024, showed Resident 1 was assessed with no skin injuries upon admission. Review of a Braden Scale (predicts PU risk), dated 01/29/2024, showed Resident 1 was assessed at moderate risk for PU development (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a physician progress note, dated 02/01/2024, showed the physician ordered baseline thyroid lab testing and directed staff to completed with the next set of labs. Review of Resident 1's record showed no labs were completed while Resident 1 resided at the facility. Review of a skin and wound evaluation, dated 02/20/2024, showed Resident 1 was identified with a new PU, assessed as a stage two (an open area involving deeper layers of skin) to their buttocks that was acquired at the facility three weeks after admission. Review of a PO, dated 02/27/2024, directed staff to provide wound care to Resident 1's first and second toe on their right foot. The PO did not identify the type of wound present. Review of a PO, dated 03/26/2024, directed staff to provide wound care to Resident 1's fifth toe on the left foot. Review of a PO, dated 05/17/2024, directed staff to monitor an open area on Resident 1's left heel and to ensure Resident 1 is wearing heel protectors when in bed. Review of a PO, dated 05/19/2024, showed two days after the wound was discovered, PO's were put in that directed staff to provide wound care to Resident 1's left heel. Review of Resident 1's nursing progress notes (NPN), dated 02/02/2024 through 03/05/2024, showed no documentation from staff when Resident 1 was discovered with a new PU. During an interview on 07/18/2024 at 2:00 PM, Staff B (Director of Nursing Services), stated they were not sure why all the PO's were not implemented and would expect all PO's to be implemented or clarified as needed when a resident is transferred to the facility. Staff B stated the facility did baseline labs and would expect staff to implement PO's after a physician visit. Staff B acknowledged there was no NPN for Resident 1's PU's and would expect staff to document a NPN that included potential cause of the wound, preventative measures implemented, and notification to the physician, and Resident 1's collateral contacts. REFERENCE: WAC 388-97-1060(b)(3)(b)