STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505361	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Americana Health & Rehab Ctr	917 7th Avenue Longview, WA 98632

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47518 Based on interview and record review, the facility failed to ensure residents and/or resident representatives were informed and provided consent before administering an influenza vaccination for 1 of 5 sampled residents (24) reviewed for right to be informed to make treatment decisions. This failure placed residents and/or resident representatives at risk of not being fully informed of the risks and benefits before making decisions about vaccinations and a diminished quality of life. Findings included . Record review of the facility's policy entitled, Prevention and Control of Seasonal Influenza, updated 01/04/2023, showed, .Influenza Prevention Vaccination . 5. Documentation in EHR [Electronic Health Record] on consent or declination for each resident. Resident 24 was admitted to the facility on [DATE]. The modification of Quarterly Minimum Data Set assessment, dated 11/14/2024, documented Resident 24 was moderately cognitively impaired and received this year's influenza vaccination on 10/04/2024. The October 2024 Electronic Medication Administration Record showed Resident 24 received Fluarix Quadrivalent Intramuscular Suspension . (an influenza vaccination) on 10/04/2024. Review of Resident 24's EHR did not show a consent was signed from the resident or the resident's representative for the administration of an influenza vaccination given on 10/04/2024. On 12/17/2024 at 9:53 AM, Staff C, Infection Preventionist and Registered Nurse (RN), said there was not a consent signed for this year's influenza vaccine for Resident 24 and there should have been. At 9:58 AM, Staff B, Director of Nursing Services and RN, said residents should have a consent signed yearly before giving an influenza vaccination. Reference WAC 388-97-0260 (1)-(3)

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934 Based on observation, interview and record review, the facility failed to ensure residents were free from physical restraints for 1 of 2 sampled residents (19) reviewed for physical restraints. This failure placed residents at risk for injury and a decreased quality of life. Findings included . Resident 19 was admitted to the facility on [DATE]. The Admission's Minimum Data Set (MDS) assessment, dated 10/23/2024, indicated Resident 19 was moderately cognitively impaired. On 12/12/2024 at 1:49 PM, Resident 19's bed was observed to be against the wall. Resident 19 said there was a little gap, but he was ok with it. On 12/16/2024 at 9:54 AM, Resident 19 was observed lying in bed on his back. The bed was up against the wall. On 12/17/2024 at 10:04 AM, Resident 19 was observed lying in bed on his back. The bed was up against the wall. At 12:27 PM, Staff K, MDS Coordinator and Registered Nurse (RN), said the bed against the wall should have a consent, order and be part of the care plan. At 12:39 PM, Staff E, Resident Care Manager (RCM) and Licensed Practical Nurse, said they did an evaluation to ensure the resident's movement was not restricted when the bed was against the wall. Staff E said there would be an order, and it was put into the care plan. Staff E said she could not find a consent and it was not in the care plan. At 1:03 PM, Staff E said she spoke with the resident's RCM and was told Resident 19's bed was not supposed to be against the wall. At 1:22 PM, Staff B, Director of Nursing Services and RN, said Resident 19's bed was not supposed to be up against the wall. Staff B said staff should be monitoring the beds and following the care plan. If staff moved the bed then they should move it back to its original space. Reference WAC 388-97-0620 (1)(b)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46751 Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan for anticoagulant side effect monitoring (a high-risk, blood thinning medication) for 1 of 5 sampled residents (150) reviewed for comprehensive care plans. This failure placed residents at risk for complications, unmet care needs and a diminished quality of life. Findings included . The facility's policy entitled, Anticoagulation Therapy, updated 07/2014, documented: Residents who are on anticoagulation therapy are monitored to deliver proper care and treatments. This includes monitoring residents for any signs or symptoms of complications from the medication(s) utilized. Resident 150 was admitted to the facility on [DATE]. The Admission Minimum Data Set assessment, dated 11/27/2024, documented the resident was alert and oriented. Resident 150's electronic health record (EHR) documented the following order, dated 11/21/2024: Apixaban Oral Tablet (Apixaban). Give 5 mg [milligram] by mouth two times a day related to PAROXYSMAL ATRIAL FIBRILLATION [a type of atrial fibrillation (upper chambers of the heart beat irregularly and rapidly) that occurs in episodes]. Resident 150's Care Plan, dated 11/21/2024, did not have documentation of anticoagulant therapy or side effects monitoring. Review of Resident 150's EHR did not show orders for addressing anticoagulant side effect monitoring. On 12/12/2024 at 2:12 PM, Resident 150 was observed to be sitting up in bed, with significant discoloration of lower extremities. Resident 150 said she was not concerned, but was unable to provide further information about the discoloration. On 12/17/2024 at 11:08 AM, Staff M, Licensed Practical Nurse, said any resident receiving an anticoagulant was monitored daily for a number of possible issues including bruising and bleeding. Staff M said anticoagulant therapy and side effect monitoring were part of residents' care plans. Staff M was unable to provide documentation of Resident 150's care planned anticoagulant therapy. At 2:29 PM, Staff B, Director of Nursing Services and a Registered Nurse, said Resident 150's care plan should have been updated to include anticoagulant therapy and side effects monitoring. Staff B was unable to provide documentation of care planned anticoagulation side effect monitoring for Resident 150. Reference WAC 388-97-1020 (1), (2)(a)(b)

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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** 46751 Based on interviews and record reviews, the facility failed to ensure bowel interventions were initiated for 1 of 6 sampled residents (35) reviewed for quality of care related to constipation. This failure placed residents at risk for discomfort, health complications and a diminished quality of life. Findings included . The facility's policy entitled, Bowel Protocol, updated 03/2018, documented the following interventions: If a resident does not have a bowel movement for three days, the nurse administers the physician ordered bowel program. In the event the Center has no specific bowel program the nurse administers medication as ordered as follows: --Administer Milk of Magnesia [laxative] per physician order on day four. --If Milk of Magnesia offers no results, administer a stimulant laxative suppository (Bisacodyl, etc.) per physician order on the next shift, during waking hours only. --If resident continues to have no results from suppository, administer an enema on the next shift, during waking hours only. --If no result from enema, notify physician. Resident 35 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set Assessment, dated 11/19/2024, documented the resident was alert and oriented. The December 2024 Bowel and Bladder Elimination task sheet documented Resident 35 had a BM (bowel movement) on 12/04/2024 at 1:59 PM, and did not have another BM until 12/08/2024 at 1:59 PM, over 96 hours (4 days) since his last BM. The December 2024 Bowel and Bladder Elimination task sheet documented Resident 35 had a BM on 12/08/2024 at 8:06 PM, and did not have another BM until 12/13/2024 at 1:59 PM, over 113 hours (over 4 1/2 days) since his last BM. Resident 35's December 2024 Medication Administration Record (MAR), and December 2024 Progress Notes, did not show the bowel protocol was initiated. On 12/17/2024 at 10:57 AM, Staff M, Licensed Practical Nurse, said if a resident did not have a BM in three days, the bowel protocol was triggered, and documented on the MAR. Staff M said refusals were documented as well. Staff M stated, [Resident 35] wasn't given any milk of mag [magnesia] since September. He should have been on my list. I should go give him something. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 2:27 PM, Staff B, Director of Nursing Services and Registered Nurse, said the BM protocol should have been initiated per facility bowel policy for Resident 35. Staff B was unable to provide additional documentation showing Resident 35's bowel interventions. Reference WAC 388-97-1060 (1), (3)(c)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50416 Based on observation and interview, the facility failed to label medications with the date first accessed in 2 of 3 medication storage areas (Ocean Side medication storage room and Ocean Side medication cart) reviewed for medication storage and labeling, and the facility failed to ensure medications were kept secure when observed on a bedside table for 1 of 1 sampled residents (6) reviewed for medication storage. These failures placed residents at risk of receiving compromised/ineffective medications, medication errors and diminished quality of life. Findings included . On 12/12/2024 at 3:22 PM, the Ocean Side medication room was observed with Staff K, Licensed Practical Nurse (LPN). A multi dose vial of purified protein derivative (a solution used in Tuberculosis [TB] skin test to diagnose TB) was observed in the medication refrigerator without a date showing when it was first accessed. At 3:30 PM, the Ocean Side medication cart was observed with Staff K. Two multi dose vials of insulin (Humulin and Lispro - medication used to treat chronic disease that affects how the body uses glucose (sugar) for energy) were observed without a date showing when they were first accessed. On 12/13/2024 at 8:39 AM, Resident 6 was observed to have a medicine cup with a variety of pills on her bedside table while she was eating her breakfast. After observing the medications on Resident 6's bedside table, Staff E, Resident Care Manager and LPN, said the medication should have been administered before the assigned nurse left the room. Staff E said it was her expectation the nurse remained with Resident 6 until all medications were ingested; and if the resident was not ready, the nurse should have taken the medication away and secured them until Resident 6 was ready to take them. On 12/13/2024 at 10:53 AM, the Ocean Side medication cart was reviewed with Staff L, LPN. A multi dose vial of Insulin (Lispro) was observed without a date showing when it was first accessed. Staff L said multi dose vials without dates showing when they were first accessed were supposed to be discarded to avoid administering medications that may be unsafe to the residents. On 12/17/2024 at 10:01 AM, Staff B, Director of Nursing Services and Registered Nurse, said it was her expectation nurses did not administer medications without a date showing when they were first accessed. Staff B said nurses were expected to discard multi dose vial medications without an open date. Reference WAC 388-97-1300 (2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46751 Based on observation, record review and interview, the facility failed to ensure food items were labeled and dated when opened in 1 of 2 kitchen refrigerators, and in 1 of 1 nourishment refrigerators/freezers reviewed for proper food storage. This failure placed residents at risk for cross-contamination, food borne illness, and a diminished quality of life. Findings included . The facility's policy entitled, Nursing Unit Refrigerator Storage Guide, updated ,d+[DATE], documented, Label all resident food with Name, Room Number, Use By Date. Packaged foods when opened are labeled with use by date. The manufacturer's expiration date is the 'Use By' for unopened items. Use by dates should not exceed the manufacturer's expiration or best 'use by' date. <Kitchen Refrigerator> On [DATE] at 10:18 AM, the top left corner of the kitchen walk in refrigerator was observed with the following undated, unlabeled, used items: 1. Plastic bag of celery sticks 2. Plastic bag of carrot sticks with RO [received on] [DATE] written on the bag 3. Cardboard box containing Rosemary, dated [DATE] At 10:21 AM, Staff N, Dietary Manager, said the items in the refrigerator should have been dated. Staff N was not able to say how long they had been in the refrigerator. Staff N was then observed throwing out the three items. Staff N stated, RO, it's received on, and should not be eaten. <Nourishment Refrigerator/Freezer> On [DATE] at 2:21 PM, the nourishment refrigerator/freezer in central supply room was observed with the following undated, or expired, items: 1. Pumpkin pie, with use by date of [DATE] 2. Quarter sheet of cake, with use by date of [DATE] 3. Jar of 16 oz (ounce) sour cream, with expiration date of [DATE] 4. Plastic container of coffee creamer, with illegible expiration date 5. Partially consumed [NAME] in the Box ice cream shake 6. Ziplock bag containing unknown food items, with use by ,d+[DATE] written on the bag. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 2:27 PM, Staff N stated, It's on the kitchen staff to re-stack the items in the fridge. When asked whether the items in question were safe to consume, Staff N stated, No. Staff N was then observed throwing out the items. At 2:42 PM, Staff B, Director of Nursing Services and Registered Nurse, said she expected food in the refrigerators and freezers to be dated and labeled per facility policy. Staff B stated, It should be dated right away. Reference WAC [DATE] (3) & -2980

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50416 Based on observation, interview, and record review, the facility failed to implement Enhanced Barrier Precautions (EBP) during wound care for 1 of 2 sampled residents (33) reviewed for infection prevention and control. This failure placed residents at risk for contracting infectious diseases and a decreased quality of life. Findings included . Review of the Centers for Medicare and Medicaid Services (CMS) Memorandum (Ref: QSO-24-08-NH), dated 03/20/2024, with the subject of: Enhanced Barrier Precautions in Nursing Homes documented .EBP recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status . For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, and wound care of any skin opening requiring a dressing . Review of the facilities EBP policy documented .Enhanced Barrier precautions are initiated to reduce transmission of multidrug resistant organisms (MDRO's). Initiated for residents known to be colonized or infected with a MDRO or have open wound or indwelling medical devices . Resident 33 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set Assessment, dated 09/19/2024, documented Resident 33 was alert and oriented. Resident 33's electronic health record (EHR) showed the following order: To right heel wound: Paint with betadine, allow to dry, cover with calcium alginate and dry gauze. NO foam. Wrap foot with roll gauze. Change daily, every day shift for Heel wound. Active 11/27/2024. On 12/12/2024 at 12:09 PM, Resident 33 was observed in bed and had a white wound dressing to his right foot secured with elastic net wound dressing. The dressing was observed to have a brown discoloration at the bottom of the foot. At 12:15 PM, an EBP signage or personal protective equipment (PPE) were not observed on Resident 33's door or room entrance. On 12/13/2024 at 2:17 PM, an EBP signage or PPE were not observed on Resident 33's door or room entrance. Resident 33 had a clean dry dressing to the right foot. On 12/16/2024 at 10:46 AM, Staff C, Infection Preventionist and Registered Nurse (RN), stated, If wounds are contained, they [residents] don't necessarily go on precautions. [Resident 33's] wound does not have drainage therefore he does not need EBP. At 10:52 AM, an EBP signage or PPE were not observed on Resident 33's door or room entrance. Resident 33 had a clean dry dressing to the right foot. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:07 AM, Resident 33 stated [Staff G, Licensed Practical Nurse,] changed my dressing this morning. At 11:26 AM, when asked about Resident 33's wound care, Staff G stated, I did the dressing this morning with the resident. When asked about the use of PPE, Staff G said she used gloves while assisting Resident 33 with his wound care. Reference WAC 388-97-1320 (2)(b)