STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505367	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Springs Care and Rehabilitation	4007 Tieton Drive Yakima, WA 98908

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to send a copy of a notice of transfer/discharge to the representative of the Office of the State Long Term Care (LTC) Ombudsman (a person that advocates for residents in nursing homes) for 3 of 3 residents (Residents 2, 3, and 4) reviewed for notice of transfer/discharge. This failed practice placed the residents at risk for lack of access to an advocate that could inform them of their options and rights, and to ensure the resident advocacy agency was aware of the facility practices and activities related to a transfer or discharge. Findings included . Review of a policy titled, Admission, Transfer and Discharge - Facility Initiated Transfers and Discharges, undated, showed the facility would send a copy of the notice of transfers or discharges to a representative of the Office of the State Long-Term Care Ombudsman. <Resident 2> Review of the medical record showed Resident 2 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease [(COPD) a group of lung diseases that block airflow and make it difficult to breathe], respiratory failure, and anxiety. Review of the 07/01/2024 comprehensive assessment showed Resident 2 was cognitively intact. Review of the medical record showed Resident 2 was transferred to an emergency room for evaluation and treatment on 08/02/2024. There was no documentation that the facility had notified the LTC Ombudsman of the transfer. <Resident 3> Review of the medical record showed Resident 3 was admitted to the facility with diagnoses of COPD, high blood pressure, and emphysema (a type of lung disease that causes breathlessness). The 07/04/2024 comprehensive assessment showed Resident 3 was cognitively intact. Review of Resident 3's medical record showed they were transferred to an acute care hospital for evaluation and treatment on 07/15/2024. There was no documentation in the record that the LTC Ombudsman was notified of the facility-initiated transfer. (continued on next page)

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 4> Review of the medical record showed Resident 4 was admitted to the facility with diagnoses including COPD and diabetes (a group of diseases that result in too much sugar in the blood). The 05/27/2024 comprehensive assessment showed Resident 4 had a moderately impaired cognition. Review of Resident 4's medical record showed they were transferred to an acute care hospital emergency roiagnom on [DATE]. There was no documentation that the LTC Ombudsman was notified of the transfer. During an interview on 08/13/2024 at 1:49 PM, the Regional LTC Ombudsman stated they had not received any notices of transfers/discharges from the facility for quite some time. During an interview on 08/13/2024 at 3:43 PM, Staff B, Social Services Director, stated they were responsible for providing notification of transfer/discharge to the LTC Ombudsman. They stated they had been doing that every Friday but had not been providing the notifications consistently. During an interview on 08/14/2024 at 12:57 PM, Staff A, Administrator, stated when there was a facility-initiated transfer/discharge, the notice of transfer/discharge should be transmitted to the LTC Ombudsman on a weekly basis, per the facility protocol. Reference: WAC 388-97-0120(5)

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. 45117 Based on interview and record review, the facility failed to develop and implement an effective discharge planning process that addressed the resident's goals and needs, that involved the resident and the interdisciplinary team [(IDT) a group of healthcare professionals from different disciplines to help residents receive the care they need] for 1 of 3 residents (Resident 5) reviewed for discharge planning process. The failure to develop and implement a plan consistent with the resident's needs and expressed discharge goals, placed the resident at risk for decreased self-worth and dissatisfaction with their living situation. Findings included . <Resident 5> Review of the medical record showed Resident 5 was admitted to the facility with diagnoses including a stroke, diabetes (a group of diseases that result in too much sugar in the blood), and anxiety. The 05/14/2024 comprehensive assessment showed Resident 5 required moderate/maximum assistance of one staff member for activities of daily living. The assessment also showed Resident 5 had a moderately impaired cognition. During an interview on 08/13/2024 at 9:57 AM, Resident 5 stated their plan was to return to their home. They stated their representative had everything set up for them to return to their home in June 2024, including two caregivers, but the discharge had fallen through. Resident 5 stated they had no additional discharge planning with Staff B, Social Services Director (SSD), since June 2024. Staff 5 stated I just want to be able to go home and feel independent. During an interview on 08/13/2024 at 3:43 PM, Staff B stated they were responsible for the discharge process. They stated their process included care planning the resident's goals for discharge. Staff B stated when Resident 5 first admitted to the facility, their goal was to return home. They stated a month or two ago, they had planned for Resident 5 to discharge to their home. Staff B stated the Resident's Representative was hesitant about Resident 5 discharging to their own home and/or discharging to the RR's home, despite having caregiver support in place. At that time, Resident 5 did not have a safe place to discharge to as there were legal issues with their home. Review of Resident 5's 08/03/2024 comprehensive care plan, showed no documentation of a discharge care plan. Review of Resident 5's medical record showed no documentation identifying the resident needs for discharge, re-evaluation of those needs, and updates to the care plan. Review of the 05/14/2024 comprehensive assessment showed Resident 5 had active discharge planning already occurring for the resident to return to the community and a referral had not been made to the local contact agency (an organization that helps nursing home residents learn about community support options, including alternative living situations). (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/14/2024 at 1:55 PM, Staff A, Administrator, stated they were aware that Resident 5 was going to discharge home, but there had been issues with the discharge. They stated Staff B had been working with the Resident Representative (RR) and had been cleared by therapy to return home. Staff A stated Resident 5 was now staying in the facility long term, a decision made by the RR/Power of Attorney (POA - a person that can make decisions on your behalf in the event you no longer have the capacity to make decisions), despite Resident 5 stating they wanted to return home. Staff A stated Staff B had been working with the RR on discharge planning and the discharge planning should have been documented in the resident's medical record. Reference: WAC 388-97-0080(1)(2)(a)(b)(d)(e)(4)(5)(6)