

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505387	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024
NAME OF PROVIDER OR SUPPLIER Providence Mother Joseph Care		STREET ADDRESS, CITY, STATE, ZIP CODE 3333 Ensign Road Northeast Olympia, WA 98506	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793</p> <p>Based on observation, interview, and record review, the facility failed to ensure care was provided in a manner that promoted the resident's dignity and quality of life when personal grooming was not provided for 2 of 6 sampled residents (Resident 61 & 88) reviewed for dignity. This failure placed residents at risk for embarrassment, diminished self-worth, and a decreased quality of life.</p> <p>Findings included .</p> <p>1) Resident 61 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS, as assessment tool), dated 04/26/2024, documented Resident 61 was cognitively intact and needed supervision or touching assistance with activities of daily living (ADL's) including personal hygiene.</p> <p>On 05/21/2024 at 10:16 AM, Resident 61 said she had asked the facility staff multiple times for an emery board, to file her nails and for a razor, to address facial hair on her chin. Resident 61 was observed with multiple small hairs on her chin.</p> <p>2) Resident 88 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 34 was cognitively intact and was dependent on staff for showering and personal hygiene. Resident 88 said she tried to hide the chin hairs and wishes staff would help take care of them.</p> <p>On 05/29/2024 at 9:02 AM, when asked about addressing woman with facial hair, Staff C, Certified Nursing Assistant, said they do not ask about facial hair on women, because it is embarrassing.</p> <p>At 9:23 AM, when asked about facial hair on woman, Staff D, Registered Nurse, said asking about facial hair is rude, therefore they do not ask.</p> <p>At 10:04 AM, Staff E, Charge Nurse/Registered Nurse, said he expected staff to treat residents as if they were their own family by showing dignity and respect. Staff E said woman observed with facial hair must be approached gently to address the concern. Staff E said he expected the facility staff to address the issues with the residents when needed.</p> <p>At 2:10 PM, Staff B, Director of Nursing Services, said she expected staff to address the topic of facial hair on woman very gently and if a resident got mad, then do not bring it up again.</p> <p>Reference WAC 388-97-0180 (1-3)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793</p> <p>Based on observation, interview and record review, the facility failed to ensure visual impaired/legally blind residents received reasonable accommodations for 1 of 1 sampled residents (Resident 61) reviewed for accommodation of needs. This failure placed residents at risk of unmet care needs and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 61 was admitted to the facility on [DATE]. The admission Minimum Data Set (an assessment tool), dated 04/26/2024, documented Resident 61 was cognitively intact and was not able to walk or transfer independently.</p> <p>Resident 61's Vision Plan of Care, dated 04/20/2024, documented, Visual impairments secondary to blindness as evident by patient states she is legally blind. Plan of care included:</p> <ul style="list-style-type: none"> -Will move around room eat, and meet dressing and toileting needs with assistance recommended by therapy from staff. -Activities and social events that do not require visual acuity. -Ensure eyeglasses are worn, clean and in good repair. -Provide large print materials. <p>On 05/29/2024 at 10:04 AM, Staff E, Charge Nurse/Registered Nurse, said activities for the blind included contacting the Social Services department to assist with needs. Staff would read the daily menu to the residents, set up clock style formation for food on the plate, and provide large print documents for the residents. Activities staff would provide a magnifying glass to residents for small print reading.</p> <p>At 05/29/2024 at 11:34 AM, Staff G, Social Services Director, said for a visually impaired resident they had books on tape, large print materials (books, word searches, puzzles), radios and the daily newsletter. Staff G said they printed the monthly calendar and placed it on the bathroom doors in all rooms. Staff G was asked to observe Resident 61's room. At 11:40 AM, observation of the monthly calendar on Resident 61's bathroom door, displayed a normal standard size monthly calendar. Observation that bathroom door faces away from Resident 61's view area. When asked about the placement of the calendar for a visual impaired resident (with mobility concerns), Staff G said the calendar could be moved. Resident 61 was sitting on the bed and stated, I can't see that from over here. Resident 61 said they cannot read the daily newsletter, due to the paper being purple and the print black, it contrasts against each other and they cannot see their appointment list on the wall, due to small print. Staff G said they would enlarge all documents for Resident 61. When asked if, Resident should have had large print prior to today, Staff G said yes.</p> <p>At 2:10 PM, when asked what services were available for visual impaired residents, Staff B, Director of Nursing Services, said she did not know, but would follow up with an answer.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/30/2024 at 10:09 AM, Staff B, said the facility provided large print calendars, materials, and menus to the residents. Staff B said they also offered one on one activities. Resident 61 had been offered one on one visits but had declined.</p> <p>Reference WAC 388-97-0860 (1-2)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793</p> <p>.</p> <p>Based on interview and record review, the facility failed to obtain, provide, and/or assist with completing Advance Directives (ADs) for 1 of 4 sampled residents (Resident 42) reviewed for ADs. This failure placed residents at risk for losing their right to have their healthcare preferences and/or decisions honored.</p> <p>Findings included .</p> <p>Resident 42 admitted to the facility on [DATE]. The admission Minimum Data Set (an assessment tool), dated 03/20/2024, documented the resident was severely cognitively impaired.</p> <p>Review of Resident 42's hard chart or Electronic Health Record did not show documentation of an AD or a declination to formulate an AD.</p> <p>On 05/29/2024 at 12:24 PM, Staff F, Social Services Director (SSD), said AD's were obtained upon admission. Staff F said if the family did not have an AD, the facility would provide them with documentation and encourage the family to completed it and return it to the facility. Staff F said it was the responsibility of Social Services to provide and obtain AD's. When asked if the facility had obtained or offered an AD to Resident 42 or Resident 42's family, Staff F said Resident 42 could not have signed an AD in their current mental capacity.</p> <p>On 05/29/2024 at 2:10 PM, Staff B, Director of Nursing Services, said the social services department was responsible for obtaining AD or providing AD documentation. When asked if the facility should have asked or obtained an AD for Resident 42, Staff B, said an AD should have been obtained or offered to the resident or family.</p> <p>On 05/31/2024 at 12:29, Staff F, SSD, asked what was meant by obtaining an AD. After clarification, Staff F said, yes an AD should have been obtained or offered to the resident or resident representative.</p> <p>Reference WAC 388-97-0300 (1)(b), (3)(a-c)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793</p> <p>Based on observation, interview and record review, the facility failed to ensure a visually impaired/legally blind resident's room was maintained in a safe and accommodating manor for 1 of 7 sampled residents (Resident 61) reviewed for environment. This failure placed residents at risk of unmet care needs and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 61 was admitted to the facility on [DATE]. The admission Minimum Data Set (as assessment tool), dated 04/26/2024, documented Resident 61 was cognitively intact and was not able to walk or transfer independently.</p> <p>Resident 61's Vision Plan of Care, dated 04/20/2024 documented. Visual impairments secondary to blindness as evident by patient states she is legally blind. Plan of care includes:</p> <ul style="list-style-type: none"> -Will move around room eat, and meet dressing and toileting needs with assistance recommended by therapy from staff. -Arrange furniture in resident's room as desired and maintain clutter free environment to increase ability to move around room without injury. -Orientation to arrangement of furniture in room to increase awareness of environment. <p>On 05/21/2024 at 10:16 AM, Resident 61 was observed laying on the bed with a cast on the left foot. Resident 61 said they had asked the facility multiple times to bring the closet closer to the bed and been told it was not possible. Resident 61 said the closet was across the room, and they were not able to walk to the closet to obtain their belongings (clothes, blankets, accessories). Resident 61's closet was observed across the room. Resident 61's belongings were observed in a pile on the ground and in a chair next to the bed. No nightstand was observed next to the bed.</p> <p>On 05/23/2024 at 10:06 AM, Resident 61's closet was observed across the room, belongings were in a pile on the ground and in a chair next to the bed with no nightstand present next to the bed.</p> <p>On 05/24/2024 at 08:21 AM, Resident 61's closet was observed across the room, belongings were in a pile on the ground and in a chair next to the bed with no nightstand present next to the bed.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/29/2024 at 10:04 AM, Staff F, Charge Nurse/Registered Nurse, said he expected staff to accommodate a visually impaired/legally blind resident by completing more room checks, explaining to the resident where their belongings were, use the clock method when setting up resident for dining and offer music and TV for audible sensory. Staff F said he expected staff to anticipate resident's needs, making sure call light, bed control and TV remote were within reach and the bedside table was set up using the clock method. When asked about Resident 61's belongings observed in a pile on the chair next to the bed and on the floor, Staff F said that was not acceptable. Staff F said there should be a night stand next to the bed for the resident to place items in. Staff F said sometimes the nightstand got moved behind the curtain and was not visible unless you moved the divider curtain. When asked if it was acceptable to expect a visually impaired resident, who was not mobile, to move the curtain, Staff F said no.</p> <p>On 05/29/2024 at 2:10 PM, Staff B, Director of Nursing Services (DNS), said she expected staff to accommodate visually impaired residents by tailoring the room to fit their needs. When asked about Resident 61's belongings observed in a pile on the chair next to the bed and on the floor, Staff B said she would need to go check the room.</p> <p>On 05/30/2024 at 10:09, Staff B, DNS, said she had observed Resident 61's environment. Resident 61 had been provided a nightstand, but it was hidden behind the divider curtain. When asked if the nightstand behind the curtain was an appropriate location for a visually impaired resident, Staff B said no, it should be next to the resident.</p> <p>Reference WAC 388-97-0860 (2)</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>37044</p> <p>Based on interview and record review the facility failed to have a system in place that ensured grievances were initiated, logged, addressed, and timely resolved in response to residents' verbal conveyance of concerns during resident council for 5 of 9 months (June 2023, August 2023, September 2023, October 2023 and November 2023) of resident council minutes reviewed. The failure to identify the initiate, log, investigate and timely resolve reported complaints/concerns, and inform residents of the findings and actions taken to correct the issues, placed residents at risk of feelings of frustration, unimportance, diminished self-worth, and quality of life.</p> <p>Findings included .</p> <p>Review of the facility's Resident Council policy, revised 05/2024, showed Activity and/or Social Service representatives will assist the resident council chairperson by recording minutes and following up on resident reported concerns/issues. The council minutes will be routed to the appropriate department leaders to be followed up on within one week. The grievances are shared with the Administrator and department heads so potential patterns can be identified and quality improvement activities can be implemented.</p> <p>Review of the facility's Resident Grievance Policy, revised 10/2023, showed residents had the right to file grievance orally or in writing, and had the right to receive a written decision regarding the grievance. The facility would attempt to resolve grievances as timely as possible, but no later than 10 working days from receipt of the grievance by the Grievance Official. All grievance decisions must include: the date and time the grievance was received; a summary statement of the Resident's grievance; steps taken to investigate the grievance; a summary of the pertinent findings or conclusions, a statement whether the grievance was confirmed or not; any corrective action taken or to be taken; and the date the decision was issued.</p> <p><Resident Council></p> <p>June 2023</p> <p>Review of the Resident Council minutes for June 2023 showed 14 residents were present and the following concerns were conveyed by residents:</p> <p>Old Business (concerns brought forward in the previous Resident Council meeting):</p> <p>a) Late delivery of meals- Residents indicated there had been some improvement but dinner on Fridays remained a problem.</p> <p>New Resident Concerns/Comments:</p> <p>a) The kitchen was not accommodating residents' special orders. One unidentified resident reported they asked for a grilled cheese sandwich but was told by kitchen staff they could not make one.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b) Friday night meals continue to be delivered late.</p> <p>c) Some staff members are not knocking before entering resident rooms, and don't introduce themselves or inform the resident of their intent.</p> <p>d) Residents reported there were not enough mechanical lift slings.</p> <p>Staff H, Supervisor of Food Services, informed the residents that the kitchen had been falling behind secondary to being short staffed. Therefore, kitchen staff had a difficult time accommodating resident special requests. A proposed solution was for residents to place their special orders a day in advance.</p> <p>The council minutes did not include the identity or number of residents who were involved with each complaint or the specifics of each complaint (e.g. how late were the meals being delivered) or what affect the issues had, if any, on the residents.</p> <p>July 2023</p> <p>Review of the July 2023 Grievance Log showed no grievances were logged related to late meals, staff not knocking before entering residents' rooms, a shortage of mechanical lift slings, or the kitchen not honoring resident meal requests.</p> <p>July 2023- No Resident Council meeting was held.</p> <p>August 2023</p> <p>Review of the Resident Council minutes for August 2023 showed six residents were present and they conveyed the following concerns:</p> <p>Old Business:</p> <p>a) The kitchen was not accommodating residents' special orders This has been resolved.</p> <p>b) Friday night meals continue to be delivered late- This has been resolved.</p> <p>c) Some staff members are not knocking before entering resident rooms, and don't introduce themselves or inform the resident of their intent- This has been a continued problem, nursing to bring up in huddles (short in-services/education for staff.)</p> <p>d) Residents reported there were not enough mechanical lift slings- Not resolve but the facility plans to purchase an individual sling for all long-term care residents.</p> <p>New Resident Concerns/Comments:</p> <p>a) The facility only has one Hoyer lift available die to other Hoyer lifts being repaired.</p> <p>b) Staff members not knocking before entering resident rooms, and introducing themselves and stating their intent, continues to be a problem.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The council minutes did not include the identity and/or number of residents who reported each concern and the affect it had on them (e.g., Unable to attend activities or be toileted due to unavailability of Hoyer lifts), if any, was not recorded.</p> <p>Review of the August 2023 Grievance Log showed there were no entries related the recurrent concern of staff not respecting resident privacy. As staff continued to enter residents' rooms without knocking. Nor were there any entries related to the shortage of functional Hoyer lifts.</p> <p>September 2023</p> <p>Review of the Resident Council minutes for September 2023 showed five residents were present and conveyed the following concerns:</p> <p>Old Business:</p> <p>a) The kitchen is not honoring residents' identified dislikes- This is an ongoing issue. Staff H will address.</p> <p>b) Some staff members are not knocking before entering resident rooms, and don't introduce themselves or inform the resident of their intent- This continues to be ongoing. Ombudsman educated that this was a resident right. Nursing assured the issue would be address.</p> <p>c) Residents reported there were not enough mechanical lift slings- This has been resolved.</p> <p>d) The facility only has one Hoyer lift- This has been resolved.</p> <p>New Resident Concerns/Comments:</p> <p>a) Nursing aides are entering resident rooms and then standing around not doing anything.</p> <p>The council minutes did not indicate the number or identity of the residents who had concerns about food dislikes not being honored, continued to have staff enter their rooms without knocking and announcing themselves or that had concerns about nurse aides standing around in their rooms.</p> <p>This was the third consecutive Resident Council in which residents reported concerns about staffs' failure to respect their right to privacy without resolution. Residents report staff continue to enter resident rooms without knocking, introducing themselves or stating their purpose or intent. There is no documentation that nurses performed Huddles with staff as stated in the August 2023 Resident Council Minutes.</p> <p>October 2023</p> <p>Review of the Resident Council minutes for October 2023 showed five residents were present and conveyed the following concerns:</p> <p>Old Business:</p> <p>a) No further complaints about nurse aides standing in resident room not doing anything.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>New Resident Concerns/Comments:</p> <p>a) Shower chairs are missing.</p> <p>b) Shower slings are a concern again. Residents personal labeled shower slings are being borrowed. Residents were informed the shortage of shower slings was due to an increased census.</p> <p>c) The time between lunch meal service and dinner service is too long due to late delivery of the dinner meal. Staff H would follow up on this repeated concern. Staff H discussed the concerns about lunch being served at noon and dinner not being served until greater than five hours later, and entertained suggestions that a snack pass for residents be implemented.</p> <p>The council minutes did not indicate the number or identity of the residents who had concerns about shower slings being borrowed, late delivery of dinner meals or the shortage of shower chair. Nor did it address if the shortage of shower chairs resulted in residents not being bathed. Late delivery of dinner meals was a concern that residents had reported in three of the past four Resident Council meetings without resolution.</p> <p>Review of the October 2023 Grievance Log showed no entries related to the residents' reported complaints about dinner being served greater than five hours after lunch, staff borrowing residents' shower slings to use with another resident or the missing shower chairs.</p> <p>November 2023</p> <p>Review of the Resident Council minutes for November 2023 showed five residents were present and conveyed the following concerns:</p> <p>Old Business:</p> <p>a) Shower chairs are missing. Resolved.</p> <p>b) Shower slings are a concern again. Residents personal labeled shower slings are being borrowed. Residents were informed the shortage of shower slings was due to an increased census. More slings were purchased.</p> <p>c) The time between lunch meal service and dinner service is too long due to late delivery of the dinner meal- continues to be an issue. Staff H informed the residents that she was in the thinking stage and was considering changes to the meal pass.</p> <p>New Resident Concerns/Comments:</p> <p>a) Residents continue to express concerns about meal pass times.</p> <p>The council minutes did not address whether Staff H implemented a resident snack pass as discussed in the October Resident Council, or what, if anything, had been done to address the issue. The issue of meal pass times has been brought forward by residents at five of the past six Resident Council meetings without resolution.</p> <p>(continued on next page)</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the November 2023 Grievance Log showed no grievances were logged related the ongoing issue of mealtimes and/or late delivery of meals.</p> <p>On 05/31/2024 at 9:18 AM, Staff A, Administrator, was asked about the recurrent complaint/concern(s) expressed by residents during four consecutive Resident Council meetings, alleging staff demonstrate a lack of concern for residents' privacy, by continuing to enter resident rooms without knocking, and what the facility had done to address these concerns. Staff A said for the August 2023 Resident Council minutes, huddles (staff education) were supposed to be performed. Documentation show ther staff education occurred was requested, but not provided.</p> <p>On 05/31/2024 at 9:51 AM, when asked what was done each month to address the residents' recurrent concerns about delayed delivery of meals and the five hours between lunch and dinner meal service being too long, a concern that was brought forward in five of the last six Resident Councils meeting from July - November 2023, Staff A said that Staff H tried to address the issue each time it came up. When asked if the snack pass that was discussed in resident council was ever implemented, Staff A indicated she was unsure. When asked if the facility investigated and identified why meals were late, how late they were, and what danger, if any, the situation posed to residents, Staff A indicated this was not investigated but agreed that staff should have investigated how the issue affected each individual resident. Staff A said grievances should have been initiated on each resident's behalf.</p> <p>Reference WAC 388-97-0460 (1)(2)</p>

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793</p> <p>Based on observation, interview, and record review, the facility failed to complete an assessment for 1 of 2 sampled residents (Resident 42) reviewed for physical restraints. This failure placed residents at risk for injury, unmet needs, and a diminished quality of life.</p> <p>Findings included .</p> <p>The facility's policy entitled Physical Restraint, reviewed 06/2021, documented 2. If the nursing or therapy assessment indicates that the device or restraint can help meet one of the goals above, potential risks and benefits of use of the device or restraint are discussed with the resident/responsible party. The resident/responsible party signs a form stating s/he has been informed of the results of the assessment, the risks and benefits of the restraint, and consent for its use. The assessment and consent form are filed in the restraint section of the resident record.</p> <p>Resident 42 admitted to the facility on [DATE]. The admission Minimum Data Set (an assessment tool), dated 03/20/2024, documented the resident was severely cognitively impaired.</p> <p>On 05/21/2024 at 1:42 PM, Resident 42's bed was observed placed against the wall, preventing exit from one side of the bed.</p> <p>On 05/23/2024 at 9:40 AM, Resident 42 was laying in bed with multiple staff members in the room cleaning. Resident 42's bed was observed placed against the wall, preventing exit from one side of the bed.</p> <p>Record review of Resident 42's Electronic Health Record showed no indication that a physical restraint assessment was completed.</p> <p>On 05/29/2024 at 10:04 AM, Staff F, Charge Nurse/Registered Nurse, said the facility did not use physical restraints, but if a physical restraint was used, Physical Therapy or Occupational Therapy would complete the assessment. Staff F said using a bed against the wall as way to prevent a resident from exiting that side of the bed, would require consent and an assessment. Staff F said he did not know if an assessment completed for Resident 42.</p> <p>At 11:57AM, Staff M, Rehabilitation Director, said when using a physical restraint, the facility must have an order from the physician, consent, an assessment and it must be care planned. When asked for Resident 42's physical restraint assessment, Staff M said that was not therapy's responsibility, it was a nursing responsibility.</p> <p>On 05/30/2024 at 11:55 AM, when asked whose responsibility it is for completing the bed against the wall physical restraint assessment, Staff A, Administrator, said it was both nursing and activities responsibility. Staff A said she would look for the assessment.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 12:58 PM, Staff A, said there was no assessment completed for the bed against the wall physical restraint. When asked if there should have been an assessment completed, Staff A, said the bed against the wall was used to prevent movement on the injured side of Resident 42's body, it prevented Resident 42 from getting off that side of the bed. Staff A said yes, an assessment should have been completed.</p> <p>Reference WAC 388-97-0620</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044</p> <p>Based on interview and record review, the facility failed to ensure Minimum Data Sets (MDS- an assessment tool) accurately reflected residents' health status and/or care needs for 3 of 29 sample residents (Residents 62, 76 and 88) reviewed for assessments. The failure to accurately assess whether residents' had a terminal diagnosis, were on a physician ordered planned weight loss program, and accurately code dental issues, placed residents at risk for unidentified and/or unmet care needs.</p> <p>Findings included .</p> <p>1) Resident 62 admitted to the facility on [DATE]. Review of the Admission MDS, dated [DATE], showed the resident was cognitively intact and had no obvious or likely cavities or broken natural teeth.</p> <p>On 05/22/2024 at 10:53 AM, Resident 62 complained she had teeth that were sensitive to hot and cold and stated, I have cracked upper and lower molars on the left side and my cap fell off my bottom right molar. Resident 62 said her dental issues were present prior to admission to the facility.</p> <p>On 05/24/2024 at 11:03 AM, Resident 62 said no staff member had inspected their oral cavity or even asked to inspect it.</p> <p>On 05/31/2024 at 9:36 AM, Staff V, MDS Registered Nurse (RN), acknowledged that they did not physically assess Resident 62's oral cavity/dentition. Staff V proceeded to Resident 62's room and spoke with/assessed the resident's oral cavity and confirmed the resident had a cracked upper and lower molar on the left side and was missing a cap from a right lower molar. When asked if the MDS was correctly coded Staff V stated, No.</p> <p>2) Resident 76 admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], showed staff coded the resident was on Hospice services but did not have physician documented condition or chronic disease that may result in a life expectancy of less than six months.</p> <p>On 05/31/2024 at 9:41 AM, Staff V, MDS RN, said the MDS was inaccurately coded and needed to be corrected.</p> <p>46793</p> <p>3) Resident 88 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 88 was cognitively intact. Resident 88's MDS, Section K documented Resident 88 had no swallowing disorder, had a loss of 5% or more weight loss and was on a physician prescribed weight loss program.</p> <p>Review of Resident 88's weight record showed on 04/30/2024, the resident weighed 202 lbs. On 05/30/2024, the resident weighed 169 pounds which was a -16.34 % Loss.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/30/2024 at 2:07 PM, when asked if Resident 88 was on a physician prescribed weight loss program, Staff A, Administrator, stated, No, I think they meant that the weight loss was anticipated due to diuresing (an increased amount of urine passed from the body). Yeah, that's what the RD [Registered Dietitian] said in her note .but no, she's not on a physician's ordered planned weight loss program. When asked if Resident 88's MDS was correct, Staff A said no.</p> <p>Reference WAC 388-97-1000 (1) (b)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793</p> <p>Based on interview and record review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASARR) [an assessment completed prior to admission into a skilled nursing facility to determine whether a resident with a diagnosis of a serious mental illness needed specialized mental health services] was completed accurately for 1 of 5 sampled residents (Resident 42), reviewed for unnecessary medication review. This failure placed residents at risk for inappropriate placement and/or not receiving timely and necessary services to meet mental health care needs.</p> <p>Findings included .</p> <p>The facility's policy entitled Pre-Admission Screening and Resident Review, revised 05/2024, documents, It is the policy of Providence Mother [NAME] Care Center to ensure the receipt of a complete and accurate Pre-Admission Screening and Resident Review (PASRR) Level I from the referring hospital, physician or other referral source for all individuals who are seeking admission to the ministry.</p> <p>Resident 42 admitted to the facility on [DATE]. The admission Minimum Data Set (an assessment tool), dated 03/20/2024, documented the resident was severely cognitively impaired.</p> <p>Review of Resident' 42's Electronic Health Record and hard chart showed a PASARR Level I, dated 03/07/2024, indicated a Level II PASARR was required. No PASARR Level II documentation was included.</p> <p>On 05/29/2024 at 2:10 PM, Staff B, Director of Nursing Services, said PASARR's were typically completed before admission and would indicate if a Level II assessment was required. Staff B said she would look for the PASARR Level II.</p> <p>At 3:03 PM, Staff B provided a new PASARR Level I, completed 05/24/2024 by the Social Services Director, documenting Resident 42 did not require a Level II evaluation and the original PASARR Level I was incorrect. When asked if the correction should have been addressed at the time of admission, Staff B, said yes.</p> <p>Reference WAC 388-97- 1915 (1-2)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044</p> <p>Based on interview and record review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASRR) assessment accurately reflected the resident's mental health diagnoses for 1 of 5 sampled residents (Resident 20) reviewed for unnecessary medications. This failure placed residents at risk for inappropriate placement and/or not receiving timely and necessary mental health services to meet their mental health needs.</p> <p>Findings included .</p> <p>Resident 20 admitted to the facility on [DATE]. Review of the Admission Minimum Data Set (MDS, an assessment tool), dated 11/24/2023, showed the resident was cognitively intact, had a diagnoses of anxiety and depressive disorders, and received antidepressant and antianxiety medication during the assessment period.</p> <p>Resident 20's physician orders showed the following psychotropic medication (medications that exert an effect on the chemical makeup of the brain and nervous system) orders: mirtazapine (an antidepressant medication) daily for depression; escitalopram (an antidepressant medication) daily for anxiety and depression; buspirone (an anxiolytic medication) three times a day for anxiety.</p> <p>Review of Resident 20's Level I PASRR, dated 11/16/2023, showed the resident was assessed to have no indicators of serious mental illness (SMI), to include depressive and anxiety disorders, which the resident was actively being treated for.</p> <p>On 05/31/2024 at 12:00 PM, Staff F, Social Services Director, said Resident 20's Level I PASRR was inaccurate and should have included depressive and anxiety disorders.</p> <p>Reference: WAC 388-97-1915 (1)(2) (a-c)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044</p> <p>Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of practice for 5 of 26 sampled residents (Residents 90, 88, 62, 34 and 427) of 20 reviewed for medication management. The failure to follow, obtain, and/or clarify incomplete physician's orders when indicated, to sign for medication(s) that were administered, to document the reason and notify the provider when medications were held, placed residents at risk for medication errors, adverse side effects, delayed review of their medication regimen and unmet care needs.</p> <p>Findings included .</p> <p>1) Resident 90 admitted to the facility on [DATE].</p> <p>Review of Resident 90's electronic health record (EHR) showed orders for:</p> <p>a) Propranolol (a blood pressure medication) twice daily, with direction to hold the medication for a systolic blood pressure (SBP) less than 100 or Pulse (P) less than 55.</p> <p>b) Furosemide (a diuretic) daily, hold for a SBP less than 100 or P less than 55.</p> <p>c) Spironolactone (a diuretic) daily, hold for a SBP less than 100 or P less than 55.</p> <p>Review of the May 2024 Medication Administration Record (MAR), showed on the following dates Resident 90's SBP and P were within the physician ordered parameters for administration of their medications, but facility nurses held the resident's propranolol, furosemide and/or spironolactone, instead of administering them as ordered.</p> <p>-05/04/2024 SBP= 100, P= 76; Held</p> <p>-05/17/2024 SBP= 100, P= 67; Held</p> <p>-05/18/2024 SBP= 100, P= 68; Held</p> <p>-10/23/2024 SBP=105, P= 72; Held</p> <p>-05/27/2024 SBP= 100, P=74; Held</p> <p>Review of Resident 90's EHR showed no documentation or assessment was present indicating the resident was symptomatic, to justify holding the medications, despite the resident's SBP and P being within the physician's ordered parameters.</p> <p>On 05/28/2204 at 1:35 PM, when asked if facility nurses administered Resident 90's furosemide, propranolol, and spironolactone in accordance with the physician's orders Staff B, Director of Nursing (DNS), stated, No. Staff B explained that in the absence of documentation to show the resident was symptomatic, the medications should have been administered as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2) Resident 88 admitted to the facility on [DATE].</p> <p><Medications Parameters></p> <p>Review of Resident 88's EHR showed orders for:</p> <p>a) Metoprolol (a blood pressure medication) daily, hold for a SBP less than 100 or P less than 55.</p> <p>b) Lotensin (a blood pressure medication), hold for a SBP less than 100 or P less than 55.</p> <p>c) Torsemide (a diuretic), hold for a SBP less than 100 or P less than 55.</p> <p>Review of the April 2024 and May 2024 MARs showed on the following dates the resident's P was less than 55, but facility nurses administered the metoprolol, Lotensin and/or torsemide instead of holding them as ordered.</p> <p>04/29/2024- P= 52; Administered.</p> <p>05/08/2024- P= 53; Administered.</p> <p>On 05/30/2024 at 1:54 PM, Staff A, Administrator, said on the above referenced dates, facility nurses administered Resident 88's metoprolol, Lotensin and/or torsemide outside of the physician ordered parameters, when the medications should have been held.</p> <p><Intravenous Access></p> <p>Review of provider order, dated 05/18/2024, showed Resident 88 had an order to infuse two liters of normal saline intravenously (IV) at 75 milliliter per hour.</p> <p>Review of the May 2024 MAR and Treatment Administration Record (TAR) showed the infusion was completed on 05/19/2024. The MAR/TAR showed no orders were in place to monitor the IV insertion site for signs or to perform maintenance flushes to maintain the patency of the IV access.</p> <p>Observation on 05/22/2024 at 1:23 PM, showed Resident 88 still had a peripheral IV in place to the left lower arm.</p> <p>On 05/31/2024 at 10:19 AM, Staff A, Administrator, said Resident 88's IV orders were incomplete and they expected facility nurses to have identified that and obtained maintenance and monitoring orders to include routine flushes of the peripheral line.</p> <p>3) Resident 62 admitted to the facility on [DATE].</p> <p>Review of provider order, dated 03/21/2024, showed an order for hydrocodone 1/2 tablet every four hours as needed for a pain level of 4-6 and an order for hydrocodone one tab every four hours for a pain level of 7-10.</p> <p>Review of the May 2024 MAR showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-On 05/01/2024 at 9:51 AM, the Resident 62 reported a pain level of 7 and was medicated with hydrocodone 1/2 tab instead of a full tab as ordered.</p> <p>-On 05/05/2024 at 12:06 AM, Resident 62 reported a pain level of 5 and was medicated with hydrocodone one tab, instead of a half tab as ordered.</p> <p>-05/05/2024 at 9:54 AM, Resident 62 reported a pain level of 7 and was medicated with hydrocodone 1/2 tab instead of a full tab as ordered.</p> <p>-On 05/06/2024 at 11:43 PM, Resident 62 reported a pain level of 6 and was medicated with hydrocodone one tab, instead of 1/2 tab as ordered.</p> <p>-On 05/07/2024 at 9:10 PM, Resident 62 reported a pain level of 5 and was medicated with hydrocodone one tab, instead of 1/2 tab as ordered.</p> <p>-On 05/08/2024 at 7:03 AM, Resident 62 reported a pain level of 5 and was medicated with hydrocodone one tab, instead of 1/2 tab as ordered.</p> <p>On 05/28/2024 at 9:13 AM, when asked if, on the above referenced occasions, a facility nurse administered Resident 62's hydrocodone in accordance with the physician's order Staff A, Administrator, stated, No.</p> <p>42960</p> <p>4) Resident 34 was admitted to the facility on [DATE] with diagnosis of anxiety (a feeling of fear, dread or uneasiness), hypertension (high blood pressure), diabetes(a disease that can lead to excess sugar in the blood), and chronic kidney disease(loss of kidney function). The Quarterly Assessment MDS (Minimum Date Set), an assessment, dated 05/01/2024, showed the resident was moderately cognitively impaired and needed supervision to maximal assistance with ADL (Activities of Daily Living).</p> <p>Review of the May 2024 MAR showed Busperone (a medication used to treat anxiety) was documented as Held due to Medication not available (Pharmacy Notified) on 05/11/2024 the 7AM to 9AM dose.</p> <p>On 05/30/2024 at 10:10 AM Staff L, Charge Nurse and Licensed Practical Nurse(LPN), said Resident 34's Busperone doses for 7AM to 9AM was held because it was not available from the pharmacy. When asked what her expectations would be, Staff L said when a nurse holds a resident's medication they should write a progress note about contacting the pharmacy and the physician. Staff L looked for a progress note and said I am not seeing any notes in the chart for that day.</p> <p>On 05/30/2024 at 3:19 PM Staff B, DNS, said the Busperone was held on that day and her expectation is for the nurse to contact and notify the physician they cannot give the medication because it is not available and find out if the physician has any additional orders such as monitoring the resident.</p> <p>Review of the May 2024 MAR for Resident 34 showed Tylenol was documented as given on 05/20/2024 at 10:46 AM as c/o headache; Site: Head; Pn Int: rest/repo; PAIN:4. The results documented on 05/28/2024 at 3:02 PM showed as effective.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/30/2024 at 10:10 AM Staff L, Charge Nurse and Licensed Practical Nurse(LPN) said Resident 34's nurse should have reassessed their pain within 30 minutes to an hour.</p> <p>On 05/30/2024 at 3:19 PM Staff B, DNS, said the nurse should have reassessed the resident's pain sooner.</p> <p>50392</p> <p>5) Review of Resident 427's Electronic Medical Administration Record (EMAR) showed Clonazepam (a psychotropic medication) 0.5 milligrams (mg) was given on 05/24/2024 at 9:15 AM.</p> <p>On 05/24/2024 at 12:16 PM, Staff K, Licensed Practical Nurse (LPN) was asked to take one medication from the controlled medication drawer (a locked drawer that stores high risk medications). A medication card (a card that stores medications) for Clonazepam 0.5 mg was taken out the controlled medication drawer by Staff K. A review of the corresponding signature page in the controlled medication book (a book where controlled medication use is documented by signature) showed that the medication given on 05/24/24 at 9:15 AM had not been signed for. Staff K states she had not signed off for this medication in the controlled substance book yet.</p> <p>On 05/28/2024 at 2:45 PM, Staff B, Director of Nursing Services, said their expectation was staff would sign for a controlled medication when administering the medication. Staff B said it should have been signed as staff was giving the medication.</p> <p>Reference WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960</p> <p>Based on interview and record review the facility failed to provide assistance with bathing for 4 of 7 sampled residents (Residents 22, 161, 93 & 61) reviewed for activities of daily living and choices related to bathing. These failures placed residents at risk for diminished self worth, poor hygiene and decreased quality of life.</p> <p>Findings included .</p> <p>1) Resident 22 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS), an assessment tool, dated 02/15/2024, indicated the resident had mild cognitive impairment and needed assistance with ADL (Activities of Daily Living).</p> <p>Resident 22's shower record dated 04/23/204 - 05/22/2024 documented resident received a shower on 05/01/2024, 05/08/2024, 05/11/2024, 05/22/2024 and declined a shower on 04/30/2024.</p> <p>On 05/24/2024 at 9:24 AM, Staff L, Charge Nurse and Licensed Practical Nurse (LPN) said Resident 22 should receive a shower during the evening shift on Wednesdays and Saturdays. Staff L confirmed there was no documentation of Resident 22 receiving a shower between 05/01/2024 and 05/08/2024 and between 05/11/2024 - 05/22/2024. Staff L's expectation was for there to be documentation by the staff of the resident's refusals of showers and attempts by the nurse to reapproach.</p> <p>On 05/24/2024 at 12:34 PM, Staff B, Director of Nursing (DNS), confirmed Resident 22 did not receive 2 showers a week according to the documentation in the shower record.</p> <p>37044</p> <p>2) Resident 161 admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], showed Resident 161 was dependent on staff for bathing and decisions about bathing were Very important.</p> <p>On 05/21/2024 at 1:20 PM, Resident 161 said staff did not come on the days they were supposed to provide showers. The resident reported the previous Friday staff informed her they couldn't provide their shower because a nursing assistant called off.</p> <p>An ADL care plan (CP), dated 05/07/2024, showed Resident 161 was to be showered twice weekly.</p> <p>Review of Resident 161's March 2024 bathing record showed from 05/07/2024 - 05/29/2024 (23 days), no bathing was offered/provided.</p> <p>On 05/29/2024 at 12:11 PM, when asked how many baths/showers had been offered/provided to Resident 161 from 05/07/2024 - 05/29/2024, Staff B, stated, I don't see any.</p> <p>3) Resident 93 admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], showed Resident 93 was dependent on staff for bathing and decisions about bathing were Very important.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/21/2024 at 10:38 AM, Resident 93 said he was supposed to be provided two showers a week, but indicated he was only receiving one a week. The resident denied refusing any care. Resident 93 stated, They [staff] just don't show up.</p> <p>An ADL CP, dated 3/28/2024, showed the resident was to be showered twice a week on Tuesdays and Friday evening shift.</p> <p>Review of Resident 93's March 2024 bathing record showed from 05/01/2024 - 05/23/2024 (23 days), showed the resident was showered on 05/11/2024 and 05/22/2024. On the following date(s), staff made the following entries:</p> <p>On 05/23/2024 Day shift- Sink and washcloth clean up; PM shift- Peri care only</p> <p>On 05/22/2024 PM shift-Sink and washcloth clean up.</p> <p>On 05/20/2024 Day shift- Peri care only.</p> <p>On 05/19/2024 Day shift- Sink and washcloth clean up.</p> <p>On 05/18/2024 Day shift- Sink and washcloth clean up.</p> <p>On 05/16/2024 Day shift- Sink and washcloth clean up.</p> <p>On 05/14/2024 PM shift- Peri care only.</p> <p>On 05/13/2024 Day shift-Resident declined; PM shift-Sink and washcloth clean up.</p> <p>On 05/12/2024 PM shift-Resident declined.</p> <p>On 05/11/2024 Day shift- Sink and washcloth clean up.</p> <p>On 05/10/2024 Day shift-Sink and washcloth clean up.</p> <p>On 05/08/2024 PM shift- Resident declined.</p> <p>On 05/03/2024 Day shift-Peri care only; PM shift- Resident declined.</p> <p>On 05/02/2024 Day shift-Peri care only; PM shift- Resident declined.</p> <p>On 05/01/2024 Day shift-Peri care onl; Resident declined. Day shift.</p> <p>On 5/23/2024 at 12:13 PM, Resident 93 said the bathing entries were inaccurate, they were not offered bathing daily and certainly not twice a day, they were never bathed at the sink and did not decline any bathing. Resident 93 said the documented showers on 05/11/2024 and 05/22/2024 seemed correct and he believed staff had provided one more shower during the timeframe (05/01/2024 - 05/22/2024). Resident 93 reiterated that he had received one shower a week, just not the two showers he was told would be provided. The resident's report of being bathed weekly was consistent with staffs' documentation of bathing provided.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/29/2024 at 12:16 PM, when asked about the bathing documentation Staff B, DNS, said she was unsure why staff documented they offered bathing almost daily and sometimes twice a day.</p> <p>On 05/29/2024 at 1:43 PM, Staff A, Administrator, said they had identified the cause of the daily bathing entries, Staff A explained that bathing was showing up as a task for nurse aides to complete daily, for days and evening shifts. To resolve the task or make it go away, staff had to pick one of the set responses of: Resident declined; Peri care only; Sink and washcloth clean up; Shower; or Bed bath. Staff A acknowledged this led to inaccurate bathing documentation, resulting in an inability to determine if bathing was offered or not.</p> <p>46793</p> <p>4) Resident 61 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 61 was cognitively intact and was not able to walk or transfer independently.</p> <p>On 05/21/2024 at 10:16 AM, Resident 61 said she has not had a shower in two weeks due to being COVID positive, only bed baths. Resident 61 said they have not had their hair washed in over two weeks and it was causing their head to itch. Resident 61 was observed scratching their scalp multiple times during the interview.</p> <p>Review of Resident 61's Plan of Care Shower days were identified as Tuesdays and Fridays with a preference for showers.</p> <p>A Physician's order, dated 04/19/2024, documented use of Ketoconazole (treatment for fungal infections on skin or scalp) 2% shampoo (apply to hair while in shower, typically during day shift [Frequency: weekly on Tuesday, Friday] for scalp management.</p> <p>Resident 61's bathing record documents:</p> <p>On 05/21/2024 Day shift: Sink and washcloth clean up, PM shift: Shower (Ketoconazole held).</p> <p>On 05/17/2024 Day shift: No documentation, PM shift: Peri care only (Ketoconazole applied).</p> <p>On 05/14/2024 Day shift: Bed Bath, PM shift: Peri care only (Ketoconazole held).</p> <p>On 05/10/2024 Day shift: Bed bath, PM shift: Res declined (Ketoconazole applied). (No documentation in Electronic Health Record showing refusal of bathing episode.)</p> <p>On 05/07/2024 Day: Sink and Washcloth clean up, PM shift: Peri care only (Ketoconazole applied).</p> <p>On 05/03/2024 Day shift: Bed Bath/Res declined, PM shift: Peri care only (Ketoconazole applied). (No documentation in Electronic Health Record showing refusal of bathing episode.)</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/29/2024 at 10:04 AM, Staff F, Charge Nurse/Registered Nurse, said during COVID outbreaks residents are only allowed to get bed baths. Staff F said if a resident refused a bathing episode, they would be asked by the CNA three times during the shift. If it was a continual refusal, then the CNA would inform the Charge Nurse of the refusals. Staff F said then they will go and clarify with the resident about the reason for the refusals. Staff F said medicated shampoos were kept on the medication cart and were given to the resident when showering. When asked about refusals of bathing episodes and how medicated shampoos were being provided, Staff F said he had never seen a situation where a resident refused the bathing episode but still received the medicated shampoo, because the resident would have to have a shower in order to receive the treatment. When shown the bathing dates for Resident 61 and when the hair treatment was provided, Staff F said he did not know how that was possible if the Resident did not take the shower. Staff F said it must have been miss clicks in the system.</p> <p>On 05/29/2024 at 2:10 PM, Staff B said the process for bathing during COVID outbreaks was bed baths only, due to water moisture absorbing into the N95 (filtration mask), causing aerosol issues. Staff B, said medication or treatment services for hair should be completed when showering, but could be completed with a bed bath too. When shown dates for bathing episodes and medicated hair treatment, Staff B said she did not know why a refusal would be documented with a treatment applied or why the medication would be held on a shower day. Staff B could not provide an answer.</p> <p>Refer to F-842</p> <p>Reference WAC 388-97 -1060 (2)(c)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044</p> <p>Based on observation, interview and record review, the facility failed to provide the necessary care and services to maintain residents' highest practicable level of well-being for 9 of 11 residents (Residents 49, 62, 20, 76, 93, 90, 23, 34, and 50) reviewed for bowel management and 1 of 2 residents (Resident 88) reviewed for positioning. The failure to initiate bowel care in accordance with physician's orders, address changes in bowel habits and to reposition residents at the frequency they were assessed to require, placed residents at risk for pain/discomfort, skin breakdown and unmet bowel care needs.</p> <p>Findings included .</p> <p><Bowel Management></p> <p>Review of the facility's Bowel Protocol policy, revised 08/2022, showed licensed staff would monitor residents' bowel movement (BM) report daily at the start of each shift. If a resident had no BM after nine shifts, nurses would administer:</p> <p>a) Miralax on the 10th shift.</p> <p>b) If no results from Miralax by the end of the 10th shift, Miralax would be administered again on the 11th shift.</p> <p>c) If no results from Miralax by the end of the 11th shift, lactulose would be administered during the 12th shift.</p> <p>d) If no results from Miralax by the end of the 12th shift, bisacodyl would be administered orally on the 13th shift.</p> <p>e) If no results from Miralax by the end of the 13th shift, a bisacodyl suppository would be administered.</p> <p>f) If the resident did not have a BM after the bowel protocol medications were administered. the nurse would call the provider for further orders.</p> <p>1) Resident 20 admitted to the facility on [DATE].</p> <p>Review of their April 2024 bowel record showed they had no BM from 04/18/2024 - 04/25/2024 (24 shifts).</p> <p>Review of Resident 20's April 2024 Medication Administration Record (MAR) showed no 'as needed' bowel medication was administered after 9 shifts without a BM as ordered.</p> <p>On 05/28/2024 at 10:02 AM, when asked if facility nurses administered as needed bowel medication after nine shifts without a BM as ordered Staff A, Administrator stated, No.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2) Resident 90 admitted to the facility on [DATE].</p> <p>Review of their May 2024 bowel record showed they had no BM from 05/01/2024 - 05/04/2024 (12 shifts).</p> <p>Review of the May 2024 MAR showed no as needed bowel medication was administered after nine shifts without a BM as ordered.</p> <p>On 05/28/2024 at 09:23 AM, when asked if facility nurses administered as needed bowel medication after nine shifts without a BM as ordered Staff A, Administrator stated, No.</p> <p>3) Resident 49 admitted to the facility on [DATE].</p> <p>Review of their May 2024 bowel record showed they had no BM from 05/09/2024 - 05/12/2024 (12 shifts).</p> <p>Review of the May 2024 MAR showed no as needed bowel medication was administered after nine shifts without a BM as ordered.</p> <p>On 05/28/2024 at 09:01 AM, when asked if facility nurses administered as needed bowel medication after nine shifts without a BM as ordered Staff A, Administrator stated, No.</p> <p>4) Resident 93 was admitted to the facility on [DATE].</p> <p>On 05/21/24 at 11:01 AM, Resident 93 complained of suffering from constipation and stated, When I first got here, I was taking pain pills and that did it.</p> <p>Review of Resident 93's April 2024 bowel record showed they had no BM from 04/21/2024 - 04/25/2024 (15 shifts).</p> <p>Review of the April 2024 MAR showed facility nurses did not initiate the bowel protocol and administer as needed bowel medication on the 10 shift as ordered.</p> <p>On 05/31/2024 at 10:33 AM, Director of Nursing (DNS), confirmed on the above referenced dates Resident 93 went 5 days with no BM. When asked if facility nurses initiated the bowel protocol on the 10th shift as ordered Staff B, stated, No.</p> <p>5) Resident 23 admitted to the facility on [DATE].</p> <p>Review of their April and May 2024 bowel record showed they went the following periods without a BM: 04/28/2024 - 05/01/2024 (11 shifts) and 05/20/2024 - 05/23/2024 (12 shifts).</p> <p>Review of Resident 23's April and May 2024 MARs showed no as needed bowel medications were administered after nine shifts without a BM as ordered.</p> <p>On 05/28/2024 at 09:01 AM, when asked if facility nurses administered as needed bowel medication after nine shifts without a BM as ordered Staff A, Administrator stated, No.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6) Resident 62 admitted to the facility on [DATE].</p> <p>Review of their April and May 2024 bowel record showed they went without a BM from 04/04/2024 - 04/07/2024 (12 shifts)</p> <p>Review of Resident 62's April 2024 MAR showed no 'as needed' bowel medications were administered after nine shifts without a BM as ordered.</p> <p>On 05/28/2024 at 09:01 AM, when asked if facility nurses administered as needed bowel medication after nine shifts without a BM as ordered Staff A, Administrator stated, No.</p> <p>7) Resident 76 admitted to the facility on [DATE].</p> <p>Review of their May 2024 bowel record showed they had no BM from 05/13/2024 - 05/17/2024 (15 shifts) and 05/19/2024 - 05/23/2024 (15 shifts).</p> <p>Review of the May 2024 MAR showed no as needed bowel medication was administered after nine shifts without a BM as ordered.</p> <p>On 05/28/2024 at 09:57 AM, when asked if facility nurses administered as needed bowel medication after nine shifts without a BM as ordered Staff A, Administrator stated, No.</p> <p>42960</p> <p>8) Resident 34 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS), an assessment tool, dated 05/01/2024, indicated the resident was moderately cognitively impaired and needed supervision to maximal assistance with ADL (Activities of Daily Living).</p> <p>The Bowel Record for 04/23/2024 - 05/13/2024 documented Resident 34 did not have a Bowel Movement (BM) on 04/25/2024, 04/26/2024, 04/27/2024, 04/28/2024, 04/29/2024, 04/30/2024, 05/02/2024, 05/04/2024, 05/05/2024, 05/08/2024, 05/09/2024, 05/10/2024, and 05/11/2024.</p> <p>On 05/28/24 at 9:53 AM Staff B, Director of Nursing and Registered Nurse indicated the bowel record did not have documentation of a BM from 04/25/024 - 04/30/2024 and 05/08/2024 - 05/11/2024 and her expectation would be for the Certified Nursing Assistants (CNA) to be thorough in their documentation and for the nurse to start the Bowel Protocol if the resident has not had a BM after 3 days.</p> <p>50392</p> <p>9) Resident 50 was admitted to the facility on [DATE]. The admission MDS showed Resident 50 was cognitively intact.</p> <p>On 05/21/2024 at 12:45 PM, Resident 50 stated, Sometimes I get diarrhea; they don't treat it. This has been going on for a long time, it comes and goes. It is not being addressed.</p> <p>Record review of bowel record showed the following:</p> <p>5/12/24 - Fluffy, not well-formed DAY shift</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5/12/24 - Watery/liquid NIGHT shift</p> <p>5/12/24 - Fluffy, not well-formed PM shift</p> <p>5/13/24 - Watery/liquid PM shift</p> <p>5/13/24 - Smooth, snake/sausage shaped NIGHT shift</p> <p>5/13/24 - Fluffy, not well-formed DAY shift</p> <p>5/14/24 - Fluffy not well-formed DAY shift</p> <p>5/15/24 - Watery/liquid NIGHT shift</p> <p>5/16/24 - Fluffy, not well-formed DAY shift</p> <p>5/16/24 - Watery/liquid PM shift</p> <p>5/17/24 - Watery/liquid PM shift</p> <p>On 05/30/2024 at 9:36 AM, when asked about the process when resident has diarrhea, Staff K, Licensed Practical Nurse, said I would ask how many times it has happened, if all night I would see if they had orders for MiraLAX (a stool softener) or stool softeners and we would hold those. Staff K said she would let the charge nurse know and notify Certified Nursing Assistant's to alert me so I can look at the stool. Sometimes patients have watery stools and they do not describe them accurately. Staff K said if more than 3 times we would let physician know and see if they want to order a treatment.</p> <p>At 9:46 AM, Staff J, Charge Nurse, Licensed Practical Nurse, said if a resident had watery/liquid or fluffy not well-formed stools then hold bowel medications and notify doctor to see if there is clinical indication for a Clostridium difficile test (a test for infectious bacteria in the colon that causes loose stools.) Staff J said if there were three loose stools we intervene and the facility would complete a bowel assessment to make sure the resident was not having an impaction (blockage of stool.) Staff J said the doctor should have been notified.</p> <p>Review of Progress notes from 05/01/2024 through 05/30/2024 showed no entries regarding physician notification or bowel assessments for watery/liquid or fluffy not well-formed stools.</p> <p>Review of Physician's orders, dated 04/01/2024 through 05/24/2024, showed no orders for stool softeners.</p> <p><Medication></p> <p>Resident 6 was admitted to the facility on [DATE]. The quarterly MDS, dated [DATE], indicated Resident 6 was cognitively intact.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/21/2024 at 3:24 PM, Resident 6, said they had yeast in their folds of skin. Resident 6 said they used an Over the Counter (OTC) personal cream. A cream was observed on the bedside table with no prescription label on it.</p> <p>On 05/23/2024 at 9:58 AM, Resident 6 stated I apply my cream to my skin folds myself. I have tried every cream on the market, and this is the only one that works. I use OHEALS manuka honey and eczema cream, it works (OHEALS).</p> <p>Observation of OHEALS cream container showed ingredients include Clotrimazole (a medication used to treat fungal infections and skin conditions.)</p> <p>Review of Physician's orders since admission did not include an order for OHEALS.</p> <p>Review of Nursing progress notes from 04/01/2024-05/30/2024 showed no documentation of OHEALS use.</p> <p>On 05/29/2024 at 1:00 PM, Resident 6, said they had been using OHEALS at bedside since admission.</p> <p>On 05/28/2024 at 10:32 AM, Staff I, Licensed Practical Nurse, said Resident 6 had pretty good skin and sometimes had redness under skin folds. Staff I said Resident 6 lets his wife know about his redness and she usually brought in OTC medications. When asked what was the process for OTC medications brought into the facility for treatment, Staff I said the facility would let the physician know, and they would decide if the resident can use it. Staff I said the physician would let us know and it would be documented in the PRN (as needed) section on the Medication Administration Record (MAR) or the progress notes from the physician.</p> <p>On 05/29/2024 at 11:50 AM, Staff B, Director of Nursing Services, said they would ask the resident to bring in the OTC product sealed, and the facility would ask the provider or physician if the product can be used by the resident. The decision would be in a Progress note or an order on the MAR from the physician/provider.</p> <p>46793</p> <p><Positioning/Skin></p> <p>Resident 88 was admitted to the facility on [DATE]. The admission MDS, dated [DATE] documented the Resident 88 was cognitively intact.</p> <p>On 05/22/2024 at 10:06 AM, Resident 88 said they were only repositioned when they asked to be repositioned. Resident 88 said they had pain in the right arm and their butt was sore to from not being repositioned frequently.</p> <p>Resident 88's Positioning Plan of Care documented, monitor for need of padding to siderails and wheelchairs. Special attention when moving resident. Turn and reposition with devices every 2 hours.</p> <p>On 05/23/2024 at 9:44 AM, Resident 88 was sitting up in bed at a 45-55 percent angle, right hand sitting on top of the blanket and left hand under the blanket.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>At 1:21 PM, Resident was sitting in the same position, but leaning towards the right. Resident said they were tired of sitting in the same position, staff did not reposition Resident 88 when staff [NAME] in her lunch tray.</p> <p>On 05/28/2024 at 9:12 AM, Resident 88 was laying supine (on back) in bed, sloughing to the left side of the bed. Resident 88 reported she had been repositioned in the early morning, but not since then. Resident 88 said she is supposed to be repositioned every two hours, but it was not happening.</p> <p>Resident 88's Pressure ulcers Plan of Care documented, At risk for pressure ulcers r/t impaired mobility d/t increased weakness, severe deconditioning or poor activity endurance status post hospitalization for diagnosis</p> <p>Resident will be free of pressure ulcers,</p> <p>Interventions for decreased sensory perception: Frequent turning and repositioning, heel protection.</p> <p>Interventions for Moisture: Barrier cream when indicated, Frequent checks for dryness, frequent toileting.</p> <p>Interventions for Low Activity Level: Frequent turning and repositioning.</p> <p>Interventions for Impaired Mobility: Encourage Independent turning and repositioning, evaluate turning and repositioning. Increase frequency of turning and repositioning.</p> <p>Interventions for Friction and Shear: Use pads or sheet to move resident.</p> <p>A Skin Assessment, dated 05/10/2024, documented Under breast (left) MASD (Moisture Associated Skin Damage), BUE (bilateral upper extremities) left elbow bend -bruise, Coccyx (tail bone)-MASD. Braden scale (assessment tool rating pressure ulcers) 15. High risk for Pressure Ulcers. Care plan reviewed no changes. Nutrition adequate.</p> <p>A Skin Assessment, dated 05/17/2024, documented Under breast (left) MASD, BUE left elbow bend -bruise, Coccyx MASD. Braden scale 10. High risk for Pressure Ulcers. Care plan reviewed no changes. Nutrition very poor.</p> <p>A Skin Assessment, dated 05/24/2024, documented Under breast (left) MASD, BUE left elbow bend -bruise, Coccyx MASD. Braden scale 10. High risk for Pressure Ulcers. Caer plan reviewed no changes. Nutrition very poor.</p> <p>On 05/29/2024 at 10:04 AM Staff F, Charge Nurse/Registered Nurse said staff should be repositioning residents every two hours at a minimal, some residents require even more repositioning. When explained that residents have reported not being repositioned within the two hours timeframe, Staff F, said all residents should be repositioned every two hours.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/29/2029 at 2:10 PM, Staff B, Director of Nursing Services, said all residents should be repositioned every two hours with or without assistance. When explained that residents have reported not being repositioned within the two hours timeframe, Staff B, said it was not acceptable and resident required repositioning every two hours, more if needed.</p> <p>Reference WAC 388-97- 1060 (1)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50392</p> <p>Based on observation, record review, and interview the facility failed to provide pressure ulcer treatment and services in accordance with professional standards for 1 of 6 sampled residents (Resident 45) reviewed for pressure ulcers. This failure placed residents at risk for untreated pressure ulcers, pain, and a decreased quality of life.</p> <p>Findings include .</p> <p>Resident 45 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS, an assessment tool), dated 02/29/2024, indicated Resident 45 was moderately cognitively impaired.</p> <p>Review of the Medication Administration Record (MAR), dated 05/16/2024, showed an order to .apply Skin Prep [a protective substance applied to area surrounding wound to prepare and protect skin] to peri wound [area surrounding wound].</p> <p>On 5/28/2024 at 11:44 AM, an observation of pressure ulcer treatment provided by Staff I, Licensed Practical Nurse (LPN) and Staff J, Charge Nurse, LPN, demonstrated that the step of applying Skin Prep to peri wound was not done.</p> <p>At 12:23 PM, Staff J confirmed Skin Prep was to be applied to peri wound during the dressing change but was not applied as ordered.</p> <p>At 12:28 PM, Staff I confirmed Skin Prep was ordered to be applied to the peri wound during wound care but was not applied as ordered.</p> <p>Reference WAC 388-97-1060 (3)(b)</p>

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044</p> <p>Based on observation, interview and record review, the facility failed to ensure Intravenous (IV) access devices were assessed, and maintained/monitored in accordance with professional standards of practice for 2 of 2 residents (Residents 90 & 88) reviewed for IV therapy. The facility failed to provide Peripherally Inserted Central Catheter (PICC/ a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near the heart) care as ordered, to include changing needleless injection caps, weekly dressing changes and measuring of arm circumference and PICC external length. Additionally, the facility failed to ensure maintenance flushes and ongoing monitoring of a peripheral IV access sites. These failures placed residents at risk for loss of vascular access, infection, and other complications and negative outcomes.</p> <p>Findings included .</p> <p>Review of the facility's Peripherally inserted central catheter dressing change policy, revised 08/20/2023, showed PICC dressings, measurements of external length, and changing of the needleless injection cap would be done a minimum of weekly. When measuring the PICC external length, if a significant amount of the PICC is inadvertently withdrawn, notify the practitioner and prepare for a chest x-ray or other diagnostic test to determine the position of the PICC tip.</p> <p>Review of the facility's IV dressing change policy, dated 08/20/2023, showed routine maintenance of a short peripheral IV catheter insertion site included regular assessment of the site. Typically, at least every four hours or every one to two hours for a resident who was critically ill, sedated or cognitively impaired. The need for continued use of a short peripheral IV catheter should be reassessed daily. A catheter should be removed as soon as it's no longer included in a resident's plan of care or if it is not used for 24 hours.</p> <p>1) Resident 90 admitted to the facility on [DATE]. Review of the admission Minimum Data Set (MDS, an assessment tool), dated 05/08/2024, showed the resident was cognitively intact and received IV medication during the assessment period.</p> <p>On 05/22/2024 at 10:07 AM, Resident 90 was observed lying in bed with an IV antibiotic infusing at 25 milliliters per hour (ml/hr) via pump through a single lumen valved PICC to the right upper arm.</p> <p>Review of Resident 90's physician's orders showed the following 05/01/2024 PICC maintenance and monitoring orders:</p> <p>a) Assess insertion site for signs and symptoms of phlebitis, infection, or catheter malfunction each shift.</p> <p>b) Flush catheter before and after medication administration and at least once daily with normal saline (NS). The amount of NS to be used was not identified.</p> <p>c) Change needleless injection caps when visibly soiled, if removed for blood draws, disconnected and with weekly dressing changes.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>d) When performing PICC dressing changes document the external catheter length, arm circumference, type of dressing applied and condition of insertion site.</p> <p>The March 2024 Treatment Administration Record (TAR) showed Resident 90 was scheduled to have their PICC dressing and needleless injection caps changed, as well as their arm circumference and PICC external length measured on 05/01/2024, 05/07/2024, 05/14/2024 and 05/21/2024. Review of the TAR showed on 05/01/2024, 05/07/2024 and 05/21/2024, facility nurses documented an H (held). On each occasion the reason provided was Held due to medication not available (pharmacy notified).</p> <p>On 05/14/2024 facility staff signed that they completed the weekly dressing change, changing of the needleless injection caps, and recorded the PICC external length as five centimeter (cm).</p> <p>A 05/01/2024 admission nurses note documented the PICC external length upon admission as one cm.</p> <p>Review of the electronic health record (EHR) showed no documentation or indication that staff compared the 05/14/2024 external length with the admission external length and identified the catheter had backed out four centimeters since admission. Nor was there any documentation that facility nurses notified the practitioner of the variance.</p> <p>On 05/28/2024 at 2:33 PM, Staff A, Administrator, confirmed facility nurses failed to perform Resident 90's weekly PICC line dressing changes, needleless injection cap changes, and to obtain the resident's arm circumference and external length measurements as ordered. Staff A stated, Held due to medication not available from the pharmacy. That doesn't make sense.</p> <p>2) Resident 88 admitted to the facility on [DATE].</p> <p>Review of provider order, dated 05/18/2024, showed nursing was to infuse two liters of NS intravenously at 75 ml/hr.</p> <p>Review of Resident 88s May 2024 Medication Administration record (MAR) showed the second liter of NS was completed on 05/19/2024.</p> <p>On 05/22/2024 at 1:23 PM, Resident 88 still had a peripheral IV in place to the left lower arm.</p> <p>Review of the EHR and May 2024 MAR/TARs, showed facility nurses failed to obtain peripheral IV maintenance and monitoring orders for the peripheral IV after the completion of the continuous infusion. There was no direction or documentation to indicate nursing provided maintenance flushes to the peripheral IV at least daily or that the insertion site was monitored for signs and symptoms of infection/infiltration at least every four hours as directed in their policy. Additionally, the peripheral IV was not discontinued after 24 hours of non-use as directed.</p> <p>On 05/31/2024 at 10:19 AM, Staff A, Administrator, said Resident 88's orders were incomplete. Maintenance orders for routine flushes and monitoring of the insertion site for signs and symptoms of infection/infiltration should have been in place and implemented until the peripheral IV was discontinued. When asked if the peripheral IV was discontinued after 24 hours of non-use as directed in the policy Staff A stated, No.</p> <p>Reference WAC 388-97-1060 (3)(j)(ii)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044</p> <p>Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure timely acquiring, receiving, and administering of all drugs) to meet the needs of each resident for 2 of 2 sampled residents (Residents 90 & 76) reviewed for pharmacy services. Failure to ensure timely receipt and administration of ordered medications, resulted in residents missing several doses of ordered medications and placed them at risk for inadequate and/or ineffective treatment of underlying medical conditions, and other negative health outcomes.</p> <p>Findings included .</p> <p>Review of the facility's undated pharmacy services agreement showed facility staff were to re-order medications three to five days before the supply runs out. For new orders and admissions if the medication(s) were ordered by noon the medications would be delivered in the 4:00 -5:00 PM delivery window except for Saturdays and Sundays. If ordered after noon, but before 8:00 PM, the medication(s) would be delivered in the 1:00 AM - 3:00 AM delivery window. Medications ordered after 8:00 PM would be delivered the next day. If the pharmacy does not make the delivery. The facility may obtain delivery from a third-party pharmacy.</p> <p>1) Resident 90 admitted to the facility on [DATE].</p> <p>Review of the May 2024 Medication Administration Record (MAR) showed an order for xifaxan (an antibiotic) every 12 hours for liver cirrhosisfrom. On 05/01/2024 - 05/05/2024, staff held nine doses and documented the reason as medication not available (pharmacy notified).</p> <p>Review of the May 2024 MAR showed an order for spironolactone (a diuretic) daily. On 05/02/2024 the spironolactone was held. Staff documented the reason as Medication not available.</p> <p>2) Resident 76 admitted to the facility on [DATE].</p> <p>Review of the physician's orders showed a 05/22/2024 order for hydrocodone every eight hours for pain.</p> <p>Review of the May 2024 MAR showed the hydrocodone was held once on 05/22/2024 and twice on 05/23/2024. Facility nurses documented the reason the medication was held as Medication not available (Pharmacy notified).</p> <p>On 05/29/2023 at 1:23 PM, Staff A, Administrator, explained that the facility prior used their own pharmacy, but in February/March 2024 switched to an outside pharmacy. Staff A acknowledged facility staff were still learning the new system for ordering/re-ordering medications, as well as the process for obtaining prior authorization for medications that required it. Staff A provided documentation to show the facility had ordered Resident 76's hydrocodone before the pharmacy's delivery deadline but said the pharmacy did not process the order and send it on the next delivery run as outlined in their contract.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reference WAC 388-97-1300(1)(a)(ii)</p>

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>46793</p> <p>Based on observation and interview, the facility failed to maintain a kitchen environment which allowed each resident to receive nourishing, palatable, and well-balanced meals without cross contamination when reviewed for kitchen. This failure placed residents at risk of lack of nutritional intake, avoidable weight loss, foodborne illness, and a diminished quality of life.</p> <p>Findings included .</p> <p>Tray line assembly started on 05/24/2024 at 11:55 AM.</p> <p>At 12:00 PM, Staff N, Cook, took the fish off the plate, and set it on the long 6 foot white cutting board on the steam table and cut it up into small pieces. Staff N then placed the fish back on plate. Staff N then changed her gloves.</p> <p>At 12:15 PM, Staff N opened door to small metal storage container (next to ice box, where fish was being held at temperature) with gloves on, shut the door and then grabbed a lemon with gloves on out of a container filled with more lemons and placed it on the plate. Staff N did not change gloves after touching environmental surfaces and before moving to next plate.</p> <p>At 12:16 PM, Staff N opened door to small metal storage container (next to ice box, where fish was being held at temperature) with gloves on, shut the door and then grabbed a lemon with gloves on out of a container filled with more lemons and placed it on the plate. Staff N did not change gloves after touching environmental surfaces and before moving to next plate.</p> <p>At 12:18 PM, Staff N opened a door to a small metal storage (heating storage, across from small ovens) with gloves on, grabbed food item and returned to plating. Staff N did change gloves after touching environmental surfaces.</p> <p>At 12:25 PM, Staff N started cutting chicken on a small cutting board with a newly obtained knife, touched chicken with gloves on. Staff N did not change gloves, even with visible chicken residue on gloves.</p> <p>At 12:30 PM, Staff N opened door to small metal storage container (next to ice box, where fish was being held at temperature) with gloves on, shut the door and then grabbed a lemon with gloves on out of a container filled with more lemons and placed it on the plate. Staff N did not change gloves after touching environmental surfaces and before moving to next plate.</p> <p>At 12:34 PM, Staff N changed gloves but did not wash hands.</p> <p>At 12:38 PM, Staff O, Cook, entered the kitchen, completed hand hygiene at sink and put on new gloves.</p> <p>At 12:42 PM, Staff O pulled a stack of plates off the rack and placed them directly on top of fish cutting area. Bottom of plate observed with fish residue on it.</p> <p>(continued on next page)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>At 12:47 PM, Staff O opened door to small metal storage container (next to ice box, where fish was being held at temperature) with gloves on, shut the door and then grabbed a lemon with gloves on out of a container filled with lemons and placed it on the plate. Staff O did not change gloves after touching environmental surfaces and before moving to next plate. Staff O grabbed a single use paper towel, wiped their gloves and the edge of the plate with the paper towel, then set the paper towel back on the counter, where fish was cut.</p> <p>At 12:52 PM, Staff O picked up ground hamburger with gloves on, then changed gloves.</p> <p>At 12:54 PM, Staff O opened door to small metal storage container (next to ice box, where fish was being held at temperature) with gloves on, shut the door and then grabbed a lemon with gloves on out of a container filled with lemons and placed it on the plate. Staff O did not change gloves after touching environmental surfaces and before moving to next plate. Staff O grabbed a single use paper towel, wiped their gloves and the edge of the plate with the paper towel, then set the paper towel back on the counter, where fish was cut.</p> <p>At 12:55 PM, Staff O pushed rice noodle back on to plate and did not change gloves. Staff O grabbed the single use paper towel sitting in fish residue, wiped gloves off and the edge of the plate with paper towel, then set the paper towel back on the counter, where fish was cut.</p> <p>At 12:56 PM, Staff O was cutting up chicken on cutting board, touching chicken with hands, gloves on. Staff O did not change gloves before moving to the next plate. Staff O using paper towel to wipe gloves and setting it back on counter, where fish was cut.</p> <p>At 12:58 PM, Staff O pushed Rice noodle back on to plate with gloves on. Staff O did not change gloves.</p> <p>At 1:12 PM, Staff O mashed tater tots with fingers, gloves on. Staff O did not change gloves.</p> <p>At 1:14 PM, Staff O opened door to small metal storage container (next to ice box, where fish was being held at temperature) with gloves on, shut the door and then grabbed a lemon with gloves on out of a container filled with lemons and placed it on the plate. Staff O did not change gloves after touching environmental surfaces and before moving to next plate. Staff O grabbed a single use paper towel, wiped their gloves and the edge of the plate with the paper towel, then set the paper towel back on the counter, where fish was cut.</p> <p>At 1:17 PM, Staff O was cutting up chicken on cutting board, touching chicken with hands, gloves on. Staff O did not change gloves before moving to the next plate. Staff O using paper towel to wipe gloves and setting it back on counter, where fish was cut.</p> <p>At 1:19 PM, Staff O was cutting up chicken on cutting board, touching chicken with hands, gloves on. Staff O did not change gloves before moving to the next plate. Staff O using paper towel to wipe gloves and setting it back on counter, where fish was cut.</p> <p>At 1:20 PM, Staff O was cutting up chicken on cutting board, touching chicken with hands, gloves on. Staff O did not change gloves before moving to the next plate. Staff O using paper towel to wipe gloves and setting it back on counter, where fish was cut.</p> <p>(continued on next page)</p>

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>At 1:21PM, Staff O opened door to small metal storage container (next to ice box, where fish was being held at temperature) with gloves on, shut the door and then grabbed a lemon with gloves on out of a container filled with lemons and placed it on the plate. Staff O did not change gloves after touching environmental surfaces and before moving to next plate. Staff O grabbed a single use paper towel, wiped their gloves and the edge of the plate with the paper towel, then set the paper towel back on the counter, where fish was cut.</p> <p>At 1:22PM, Staff O pulled a wrapped package of cheese out of cold storage. Placed the cheese on a plate, then opened both metal storages to grab items. Staff O then went back to touching cheese without changing gloves, putting the cheeseburger into the microwave and then removed cheeseburger and placed on the plate. Staff O did not change gloves.</p> <p>At 1:25 PM, Staff O wiped the rim of the plate with the same paper towel, that has been used multiple times and placed back on cutting board in fish residue.</p> <p>At 1:27 PM, Staff O opened door to small metal storage container (next to ice box, where fish was being held at temperature) with gloves on, shut the door and then grabbed a lemon with gloves on out of a container filled with lemons and placed it on the plate. Staff O did not change gloves after touching environmental surfaces and before moving to next plate. Staff O grabbed a single use paper towel, wiped their gloves and the edge of the plate with the paper towel, then set the paper towel back on the counter, where fish was cut.</p> <p>At 1:29 PM, Staff O wiped the rim of the plate with the same paper towel, that has been used multiple times and placed back on cutting board in fish residue.</p> <p>At 1:30 PM, Staff O was cutting up chicken on cutting board, touching chicken with hands, gloves on. Staff O did not change gloves before moving to the next plate. Staff O using paper towel to wipe gloves and setting it back on counter, where fish was cut.</p> <p>At 1:33 PM Staff O pulled a stack of plates off the rack and placed them directly on top of fish cutting area. Bottom of plate observed with fish residue on it.</p> <p>At 1:35 PM, Staff O was cutting up chicken on cutting board, touching chicken with hands, gloves on. Staff O did not change gloves before moving to the next plate. Staff O using paper towel to wipe gloves and setting it back on counter, where fish was cut.</p> <p>At 1:36 PM, Staff O grabbed cheese and hamburger bun with gloves on, then touched lettuce and tomato at salad bar. Staff then microwaved the hamburger bun and cheeses, touching environmental surfaces. Staff O then placed lettuce and tomato on hamburger bun. Staff O did not change gloves.</p> <p>On 05/24/2024 at 2:53 PM, Staff H, Supervisor Food Services, said the expectation for hand hygiene at tray line included changing gloves and hand hygiene. After reviewing all incidents of touching environmental surfaces, Staff H said touching multiple environmental surfaces and not changing gloves or washing hands was not acceptable. After reviewing multiple uses with a single use paper towel, Staff H said the paper towels are single use and should not have been used repeatedly. After reviewing multiple time of plates being set in cut up fish residue, Staff H said that was not acceptable. After reviewing multiple time of staff grabbing lemons out of the container and not changing gloves, Staff H said that was not acceptable.</p> <p>(continued on next page)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/29/2024 at 2:40 PM, Staff A, Administrator, said her expectation for kitchen to prevent cross contamination was hand washing, changing gloves, and to have communication in the prep areas. After reviewing multiple touching of multiple environmental surfaces, touching other different kinds of food (fish, chicken, citrus), and multiple observations of cross contamination, Staff A, said none of that was acceptable.</p> <p>Reference WAS 388-97-1100</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793</p> <p>Based on observation, interviews, and record review, the facility failed to obtain dishwasher temperatures logs and maintain the temperature in required range, failed to discard expired or no Use By Date (UBD) food and beverages items, and failed to maintain and document refrigerator temperature logs for 8 of 8 facility refrigerators reviewed for food service. These failures placed residents at risk of food-borne illness, unsanitary conditions, and a diminished quality of life.</p> <p>Findings included .</p> <p><Refrigerator temperature logs></p> <p>Review of the facility's refrigerator temperature logs, from [DATE] through [DATE], documented the Cooler/Freezer, Reach In refrigerator, Dairy refrigerator, Salad Bar, Montreal refrigerator, Bistro refrigerator, B wing refrigerator and C wing refrigerator had multiple missing entries and documented temperatures outside the acceptable parameters for cold food holding:</p> <p>Cooler/Freezer:</p> <p>Missing recorded temperatures on [DATE], [DATE] & [DATE].</p> <p>Temperatures over cold holding requirements on [DATE]-42 degrees Fahrenheit and [DATE]-45 degrees Fahrenheit.</p> <p>Reach In:</p> <p>Missing recorded temperatures on [DATE] PM shift, [DATE] AM shift, [DATE] PM shift & [DATE] AM shift.</p> <p>Dairy refrigerator:</p> <p>Missing recorded temperatures on [DATE] PM shift, [DATE] AM shift, [DATE] PM shift, [DATE] AM shift & [DATE] PM shift.</p> <p>Temperatures over cold holding requirements on [DATE] 43 degrees Fahrenheit, [DATE] 43 degrees Fahrenheit, [DATE] 48 degrees Fahrenheit, [DATE] 42 degrees Fahrenheit, [DATE] 44 degrees Fahrenheit, [DATE] 44 degrees Fahrenheit, [DATE] 43 degrees Fahrenheit, [DATE] 42 degrees Fahrenheit, [DATE] 42 degrees Fahrenheit, [DATE] 42 degrees Fahrenheit, [DATE] 47 degrees Fahrenheit, [DATE] 42 degrees, [DATE] 45 degrees Fahrenheit, [DATE] 46 degrees Fahrenheit & [DATE] 58 degrees Fahrenheit.</p> <p>Salad Bar:</p> <p>Missing recorded temperatures on [DATE] AM shift, [DATE] AM shift, [DATE] PM shift, [DATE] PM shift, [DATE] AM shift & [DATE] AM shift.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Montreal refrigerator:</p> <p>Missing recorded temperatures on [DATE] AM & PM shift, [DATE] PM shift, [DATE] PM shift, [DATE] PM shift, [DATE] PM shift, [DATE] AM & PM shift, [DATE] AM & PM shift, [DATE] AM & PM shift, [DATE] AM & PM shift, [DATE] AM & PM shift, & [DATE] AM & PM shift.</p> <p>Bistro Refrigerator:</p> <p>Missing recorded temperatures on [DATE] PM shift.</p> <p>B Wing refrigerator:</p> <p>Missing recorded temperatures on [DATE] AM & PM shift, [DATE] PM shift [DATE] PM shift & [DATE] AM & PM shift.</p> <p>C Wing refrigerator:</p> <p>Missing recorded temperatures on [DATE] PM shift, [DATE] PM shift, [DATE] PM shift, [DATE] AM shift, [DATE] AM shift, [DATE] AM & PM shift.</p> <p>On [DATE] at 2:53 PM, Staff H, Supervisor Food Services, said it is the expectation of staff to complete the refrigerator logs daily and Kitchen staff was responsible for all dining room refrigerators. Staff H said if they see a missing date on the temperature log sheet she will highlight and discuss it with the Kitchen staff during huddle the next day. When shown the multiple missing dates, Staff H said the missing dates were not acceptable and should have been filled in.</p> <p>On [DATE] at 2:40 PM, Staff A, Administrator, said if temperatures logs were missing or out of required range, staff should be informing their supervisor and maintenance, under required temperatures and missing temperatures logs were not acceptable.</p> <p><Dishwasher temperatures></p> <p>[DATE] under 150 degrees Fahrenheit records-Lunch Wash cycle: 6th, 12th, 14th, 15th, 16th, 17th, 18th, 19th, 20th, 21st, 22nd.</p> <p>[DATE] under 165 degrees Fahrenheit records-Lunch Rinse cycle: 3rd, 6th, 7th, 13th, 14th, 15th, 16th, 17th, 18th, 19th, 20th, 21st, 22nd.</p> <p>[DATE] under 165 degrees Fahrenheit records-Dinner Rinse cycle: 1st, 2nd, 3rd, 4th, 5th, 18th, 19th.</p> <p>On dishwasher temperature log, under Corrective Actions Notify manager whenever temperature does not meet standards section of the form, no corrective actions documented for temperatures below regulation requirement.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 2:53 PM, Staff H said it was the expectation that staff completed the dishwasher logs daily. Staff H said if they saw an out of compliance temperature on the temperature log sheet staff should be contacting their supervisor or maintenance to address the problem. When shown the multiple out of compliance dates, Staff H said the missing dates were not acceptable and action should have been taken.</p> <p>On [DATE] at 2:40 PM, Staff A, Administrator, said if temperatures were not within the required ranges, staff should be informing the supervisor and maintenance, under required temperatures were not acceptable.</p> <p><Expired food/No UBD></p> <p>On [DATE] at 9:45 AM, during Initial Brief Tour of Kitchen the following foods were found with no expiration date, no UBD or improperly stored:</p> <p>5 cans Caramel with no expiration date.</p> <p>Beans dry no open dates or UBD.</p> <p>Lea & [NAME] Worcestershire sauce no expiration date, only sticker dated ,d+[DATE] (no year).</p> <p>Light Molsulphures Molasses, no expiration date, only sticker dated ,d+[DATE].</p> <p>Open ,d+[DATE] bag of shrimp in freezer, with no expiration date or UBD. Bag of shrimp top was open and exposed to freezer elements.</p> <p>Open ,d+[DATE] bag of Feta cheese with no expiration date/UBD date in walk in cooler.</p> <p>Uncovered tater tots sitting on sheet pan in refrigerator.</p> <p>At 10:02 AM, Staff H said their process for cycling food was about every 2 months, everything was rotated within the 2 months. Staff H said they were on a 4 week cycle for menus and ordered as needed to fit the menu. When shown the cans without expiration dates, Staff H said she did not know what the expiration dated was. Staff H said they put a sticker on all the food items when they receive the items.</p> <p>At 10:14 AM, when shown the uncovered foods in the walker in cooler, Staff H said the food should be covered.</p> <p>On [DATE] at 10:02 AM, return visit to the Kitchen, the following foods were found with no expiration date, no UBD or improperly stored:</p> <p>8 50 ounce cans of Chicken Ready- One Whole Chicken without giblets packed in broth expiration date [DATE].</p> <p>No open date or UBD on large container of Black beans.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2 large containers Rice Vinegar expiration dates [DATE] and [DATE]. One of these Rice Vinegar containers was opened with a sticker dated ,d+[DATE].</p> <p>Large tub of vegetable gravy dated ,d+[DATE], UBD ,d+[DATE].</p> <p>At 10:24 AM, when asked what the date on the container was, Staff H said the 28th. (Date on inspection was the 24th).</p> <p>Open container of mushrooms, exposed to refrigerator elements. Sticker dated prepared on ,d+[DATE].</p> <p>Uncovered sausage gravy in shallow pan.</p> <p>Open ,d+[DATE] bag of shrimp in freezer, with no expiration date or UBD. The bag of shrimp was open and exposed to freezer elements.</p> <p>Large Styrofoam container with watery/gravy substance, labeled [NAME] in cooler, not covered, not dated, and exposed to refrigerator elements.</p> <p>At 10:32 AM, when asked about food storage, Staff H said everything should have had an expiration date, been labeled with open date and UBD date, and covered as required.</p> <p>On [DATE] at 11:50 AM, in Bistro Dining room, multiple drinks containers in refrigerator: two containers orange and brown liquid substance use by date ,d+[DATE], one orange liquid substance UBD ,d+[DATE] and one yellow liquid substance UBD ,d+[DATE].</p> <p>On [DATE] at 2:40 PM, Staff A, Administrator, said all food over expiration dates should have been thrown out, all food should have been labeled and dated properly. Staff H said this was not acceptable.</p> <p>Reference WAC [DATE] (3)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044</p> <p>Based on interview and record review, the facility failed to maintain complete and accurate records for 7 of 7 sampled residents (Residents 93, 61, 161, 90, 22, 81 & 50) reviewed for activities of daily living and choices. The failure to identify and correct a system issue with the facility's Point of Care (a computer program) charting, caused staff to falsely document bathing and/or resident refusal of bathing that did not occur. These failures resulted resident medical records containing inaccurate documentation of bathing that was not provided and/or refusal of care that did not occur. This detracted from staffs' ability to investigate resident complaints about not receiving showers and placed residents at risk for unmet care needs.</p> <p>Findings included .</p> <p>Resident 93 admitted to the facility on [DATE]. Review of the admission Minimum Data Set (MDS), an assessment tool, dated 04/04/2024, showed Resident 93 was cognitively intact and dependent on staff for the provision of bathing.</p> <p>An activity of daily living care plan, dated 3/28/2024, showed the resident was to be showered twice a week on Tuesdays and Friday evening shift.</p> <p>Review of Resident 93's March 2024 bathing record showed from 05/01/2024 - 05/23/2024 (23 days), the resident was showered on 05/11/2024 and 05/22/2024. However, on the following date(s), staff documented the following:</p> <p>On 05/23/2024 Day shift- Sink and washcloth clean up; PM shift- Peri care only.</p> <p>On 05/22/2024 PM shift-Sink and washcloth clean up.</p> <p>On 05/20/2024 Day shift- Peri care only.</p> <p>On 05/19/2024 Day shift- Sink and washcloth clean up.</p> <p>On 05/18/2024 Day shift- Sink and washcloth clean up.</p> <p>On 05/16/2024 Day shift- Sink and washcloth clean up.</p> <p>On 05/14/2024 PM shift- Peri care only.</p> <p>On 05/13/2024 Day shift-Resident declined; PM shift-Sink and washcloth clean up.</p> <p>On 05/12/2024 PM shift-Resident declined.</p> <p>On 05/11/2024 Day shift- Sink and washcloth clean up.</p> <p>On 05/10/2024 Day shift-Sink and washcloth clean up.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/08/2024 PM shift- Resident declined.</p> <p>On 05/03/2024 Day shift-Peri care only; PM shift- Resident declined.</p> <p>On 05/02/2024 Day shift-Peri care only; PM shift- Resident declined.</p> <p>On 05/01/2024 Day shift-Peri care onl; Resident declined. Day shift.</p> <p>On 5/23/2024 at 12:13 PM, Resident 93 said the bathing entries were inaccurate, they were not offered bathing daily and certainly not twice a day, they were never bathed at the sink and did not decline any bathing. Resident 93 said the documented showers on 05/11/2024 and 05/22/2024 seemed correct and he believed staff had provided one more shower during the timeframe (05/01/2024 - 05/22/2024). Resident 93 laughed at the six entires that staff provided Peri care only and said no staff member had ever provided them pericare because they don't need it; they were continent of bowel and bladder.</p> <p>On 05/29/2024 at 12:16 PM, when asked about the bathing documentation Staff B, Director of Nursing Services, said she was unsure why staff were documenting to bathing one to two times a day, or why they documented they provided peri-care on a resident who was always continent of bowel and bladder.</p> <p>Review of Residents 61, 161, 90, 22, 81 and 50's bathing records revealed similar findings.</p> <p>On 05/29/2024 at 1:43 PM, Staff A, Administrator, said she identified the cause of the daily bathing entries, and why there were inaccurate entries about care that was not provided (as above). Staff A said the bathing task was showing up on day and evening shift as a task the Certified Nursing Assistants had to complete, even though it was not a resident's scheduled shower day. Staff A explained the only way to resolve the task (make it go away), was for staff to select one of the available responses. The responses included: Resident declined; Peri care only; Sink and washcloth clean up; Shower; and Bed bath. Not applicable or activity did not occur were not available options for facility staff to choose. Staff A said it was widespread system issue that needed to be corrected. Staff A acknowledged the issue resulted in multiple inaccurate entries in residents' records related to care that was not actually provided.</p> <p>Refer to F-677</p> <p>Reference WAC 388-97-97-1060(1)(a)(i)(ii)(iii)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044</p> <p>Based on interview and record review, the facility failed to have a system in place that ensured effective communication, collaboration, and coordination of care occurred between the facility and the hospice provider for 1 of 2 sampled residents (Resident 76) reviewed for hospice services. The facility failed to designate a member of their inter-disciplinary team (IDT) to be the liaison with hospice staff, to obtain and maintain a current copy of the coordinated hospice plan of care, and to have a system/ documentation of what hospice staff had visited (e.g., registered nurse, chaplain, certified nursing assistant, massage therapist), when they visited, and what care they provided. These failures detracted from staffs' ability to effectively collaborate, communicate and coordinate care with the Hospice provider, and placed residents at risk for not receiving necessary care and services and/or unmet care needs.</p> <p>Findings included .</p> <p>Review of the facility's Hospice Coordination policy, revised 04/2023, showed Hospice would establish a regular communication schedule and determine the appropriate method(s) for communication (e.g., phone, email, in-person) in addition to electronic information exchange. Facility staff and the Hospice provider would collaborate on the development of the coordinated Hospice plan of care, and each would ensure residents received the necessary care and services. Hospice would provide, as needed, a sign in/out log and documentation regarding services provided during visits.</p> <p>1) Resident 76 admitted to the facility on [DATE]. Review of the admission Minimum Data Set, dated dated [DATE], showed the resident received Hospice services.</p> <p>Review of Resident 76's electronic health record (EHR) and hard (paper) medical record showed no current copy of the coordinated hospice plan of care was present. The most recent hospice plan of care in the resident's record was outdated. It was for the period of 05/01/2024 - 05/14/2024. According to the document the resident would receive: one chaplain visit every 15 days for 60 days and as needed (PRN) to provide support; a hospice aide visit every week and PRN, for nine weeks to provide bathing and personal care; a social work visit every 30 days for two months and PRN for counseling; and a skilled nursing visit every week for nine weeks and PRN, for symptom management, support and education.</p> <p>Review of the electronic health record (EHR) showed no documentation of what hospice disciplines had visited the resident, when, what care was provided and/or what occurred during the visit. Additionally, there was no documentation or indication what staff member was designated the hospice liaison.</p> <p>On 05/29/2024 at 3:02 PM, when asked who the facility's hospice liaison was, Staff W, Manager Long Term Care, indicated the facility did not have one. Staff W explained that if a hospice resident needed something any nurse could call. When asked what services Hospice was providing for Resident 76, at what frequency, when they last visited and what care was provided Staff W indicated they were new to the position and referred writer to Staff J, Licensed Practical Nurse (LPN), and the former Manager of Long-Term Care.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/29/2024 at 3:17 PM, Staff J, LPN, explained that sometimes when visiting the Hospice nurse would come talk to them if there was a change or concern. Otherwise, if a Hospice resident needed something they would just call hospice. Staff J said there were no set meetings with Hospice. The facility did not have a point person or liaison that was responsible for communication with Hospice. When asked what services Hospice was providing to Resident 76 Staff J said I have done this a long time, so I just know what Hospice provides, its usually a nurse one-two times per week and a hospice aide two times per week. When asked if Resident 76 had services from a chaplain, social work, massage, aroma, or music therapy Staff J stated, I don't know.</p> <p>On 05/29/2024 at 3:32 PM, Staff B, Director of Nursing, confirmed the facility did not have a person identified as the Hospice liaison or point person identified. When asked what services/disciplines hospice was providing Resident 76, the anticipated frequency of those visits, if the visits had occurred and whether the facility had documentation of them Staff B, said they did not know if Resident 76 had received visits from the hospice Chaplain, Medical Social Worker, or hospice aide as outlined in the coordinated hospice plan of care. Staff B indicated she was unsure. When asked if there was a current hospice plan of care or documentation (e.g., hospice sign-in log, visit notes etc.) from the hospice disciplines, other than skilled nursing, in Resident 76's EHR, Staff B said they could not find any.</p> <p>Review of the facility's contract with the Hospice provider showed it was missing the following requirements:</p> <ul style="list-style-type: none"> a) Contract was not signed by an authorized Hospice representative. b) A communication process, including how the communication would be documented between the facility and the hospice provider. c) A designated member of the facility's interdisciplinary team (IDT) was not identified who would be responsible for working with hospice representatives to coordinate care provided by the facility staff and hospice staff. d) The facility did not have a copy of the most recent hospice plan of care specific. Which was the responsibility of the facility's designated IDT member to obtain, but no IDT member had been designated. <p>On 05/30/2024 at 10:16 AM, Staff A, Administrator, acknowledged the facility had not designated an IDT member who would be responsible for collaboration with Hospice representatives and coordinate care. When asked if the facility had a copy of Resident 76's most recent plan of care Staff A stated, No,</p> <p>No Associated WAC</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff compliance with current infection control guidelines and standards of practice for correctly donning/doffing (to put on/to take off) personal protective equipment (PPE) for 2 of 2 dining observations reviewed for infection control. These failures placed residents at an increased risk for exposure to cross contamination (harmful spread of illness), transmission of diseases and a diminished quality of life.</p> <p>Findings included .</p> <p>Facility policy titled PMJCC Isolation for Transmission Based Precautions revised 05/2024, documented In addition to Standard Precautions, use contact Precautions for patients/resident known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact with the patient/resident (hand or skin-to-skin contact that occurs when performing patient-care activities that require touching the patient's/resident's dry skin) or indirect contact (touching) with contaminated environmental surfaces or patient care items, in the patient's environment.</p> <p>Washington State Hospital Association and Washington Stated Department of Health Aerosol Contact Precautions sign revised 10/09/2020, documents, Everyone must: including visitors doctors and staff clean hands when entering and leaving room. Respirator Use a NIOSH-approved N95 or equivalent of higher-level respirator especially during aerosolizing procedures. Mask Face mask is acceptable if respirator is not available and for visitors. Wear eye protection (face shield or goggles) Gown and glove at door.</p> <p>Put ON in this order:</p> <ol style="list-style-type: none"> 1. Wash or gel hands (even if gloves used) 2. Gown 3. Mask and eye cover 4. Gloves <p>Take OFF & dispose in this order:</p> <ol style="list-style-type: none"> 1. Gloves 2. Gown 3. Wash and gel hands 4. Mask and eye cover: Remove from earpiece or ties to discard-do not grab from front of mask. 5. Wash or gel hands (even if gloves used) <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/20/2024 at 12:11 PM, Staff Q, Certified Nursing Assistant (CNA), donned gown, gloves, and was already wearing N95 and eye protection. Staff Q entered room [ROOM NUMBER] on Enhanced Barrier Precautions to delivery meal tray. Before exiting the room Staff Q, doffed by removing gown, gloves and completed hand hygiene. Staff Q did not discard mask or clean/discard eye protection.</p> <p>At 12:27 PM, Staff R, CNA, donned gown, gloves, and was already wearing N95 and eye protection. Staff R could not locate addition PPE's and went looking for additional masks. A moment later Staff R returned with more masks and replaced the current mask. Staff R entered room [ROOM NUMBER] on Aerosol Contact Precautions to deliver meal tray. Before exiting the room Staff R, doffed by removing gown, gloves, mask and completed hand hygiene. Staff R did not clean/discard eye protection.</p> <p>At 12:36 PM, Staff S, CNA, donned gown, gloves, and was already wearing N95 and eye protection. Observations of Staff S wearing N95 mask under the nose with both straps under ears and chin to the nape of neck and wearing face shield at a 45-degree angle of the top of the head, instead of positioned against forehead. Staff S entered room [ROOM NUMBER] on Aerosol Contact Precautions to deliver meal tray. Before exiting the room Staff S, doffed by removing gown, gloves and completed hand hygiene. Staff S did not discard mask or clean/discard eye protection.</p> <p>At 12:36 PM, Staff T, CNA, donned gown, gloves, and was already wearing N95 and eye protection. Staff T entered room [ROOM NUMBER] on Aerosol Contact Precautions to deliver meal tray. Before exiting the room Staff T, doffed by removing gown, gloves and completed hand hygiene. Staff T did not discard mask or clean/discard eye protection.</p> <p>On 05/24/2024 at 12:33 PM, Staff U, CNA, donned gown, gloves, and was already wearing N95 and eye protection. Staff U entered room with Aerosol Contact Precautions to deliver meal tray. Before exiting the room Staff U, doffed by removing gown, gloves and completed hand hygiene. Staff U did not discard mask or clean/discard eye protection. Staff U was observed touching her face shield and hair with bare hands before picking up another meal tray to deliver.</p> <p>At 12:36 PM, Staff U, CNA, donned gown, gloves, and was already wearing N95 and eye protection. Staff U entered room on Aerosol Contact Precautions to deliver meal tray. Before exiting the room Staff U, doffed by removing gown, gloves and completed hand hygiene. Staff U did not discard mask or clean/discard eye protection.</p> <p>On 05/29/2024 at 1:46 PM, when explained multiple incidents of staff using PPE's incorrectly and asked if this was appropriate PPE usage, Staff V, Infection Preventionist, stated, No, absolutely not.</p> <p>On 05/29/2029 at 2:10 PM, Staff B, Director of Nursing Services, said proper doffing order is shield, mask, gown and then gloves. Staff B said they complete audits on staff a couple times a week on different shifts to ensure proper PPE usage. When explained observations of multiple staff using PPE's incorrectly and inappropriate doffing procedures, Staff B said staff should be changing all PPE's.</p> <p>At 2:40 PM, when asked proper doffing procedure, Staff A, Administrator, said she did not remember the order but knew that the gloves came off last. When explained observations of multiple staff using PPE's incorrectly and inappropriate doffing procedures, Staff A said improper PPE usage and doffing was not acceptable.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505387	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024
NAME OF PROVIDER OR SUPPLIER Providence Mother Joseph Care		STREET ADDRESS, CITY, STATE, ZIP CODE 3333 Ensign Road Northeast Olympia, WA 98506	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reference: WAC 388-97-1320 (1)(a)(c)</p>		