STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505389	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Cascade Park	801 Southeast Park Crest Avenue Vancouver, WA 98683

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47518 Based on observation, interview and record review, the facility failed to ensure care and services were provided in a manner that promoted residents' dignity related to urinary catheter (a tube inserted into the bladder that drains urine into a bag outside of the body) care for 2 of 2 sampled residents (Residents 11 & 39) reviewed for urinary catheter. This failure placed residents at risk for embarrassment, diminished self-worth, and a decreased quality of life. Findings included . 1) Resident 11 was admitted to the facility on [DATE]. The modification of admission Minimum Data Set (MDS) assessment, dated 06/27/2024, documented Resident 11 was moderately cognitively impaired and had an indwelling catheter. Resident 11's Alteration in Elimination Care Plan, dated 06/26/2024, documented .Keep drainage bag covered for dignity. Resident 11's Indwelling Catheter Care Plan, dated 07/26/2024, revised 08/07/2024, documented .drainage bag to remain covered . On 08/05/2024 at 3:59 PM, Resident 11 was observed sleeping in bed with the foley catheter drainage bag hanging off the right side of the bed uncovered. On 08/06/2024 at 10:06 AM, Resident 11's foley catheter drainage bag was observed hanging off the right side of the bed uncovered. At 2:01 PM, Resident 11 was observed lying in bed awake on his back with the foley catheter drainage bag hanging on the right side of the bed uncovered, with urine visible in the drainage bag. On 08/07/2024, at 8:42 AM, Resident 11's foley catheter drainage bag was observed folded in thirds, lying on the floor to the right side of the bed without a hook present on the bag to hang off the bed and without a privacy bag present. At 8:44 AM, Staff G, Certified Nursing Assistant, said foley catheter drainage bags were supposed to hang off the side of the bed and were not supposed to be on floor. Staff G said foley catheter drainage bags were supposed to have a privacy bag over the drainage bag so you cannot see the urine. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 8:47 AM, Staff C, Resident Care Manager and Registered Nurse (RN), said foley catheter drainage bags should be covered and placed in a black bag secured to the bed frame and not on the floor. Staff C said the cover was over the bag, so you didn't see the urine, and stated, It's a dignity issue. After observing the placement of the foley catheter drainage bag folded into thirds on the floor, Staff C said the foley catheter drainage bag should not be on the floor and stated, That should definitely not be like that. It should be covered. It should have a bag. It doesn't even have a hook to hang it. 2) Resident 39 was admitted to the facility on [DATE]. The admission MDS assessment, dated 07/23/2024, documented Resident 39 was moderately cognitively impaired and had an indwelling catheter. Resident 39's Foley Catheter Care Plan, dated 08/06/2024, documented, .Drainage bag to remain covered . On 08/05/2024 at 3:58 PM, Resident 39 was observed sleeping in bed with the foley catheter drainage bag hanging off the right side of the bed uncovered with urine visible in the bag. On 08/06/2024 at 10:40 AM, Resident 39 was observed in the rehabilitation gym working with staff. Resident 39's foley catheter drainage bag was uncovered with urine visible in the bag. At 2:00 PM, Resident 39 was observed lying in bed with the foley catheter drainage bag hanging off the left side of bed uncovered with urine visible in the bag. On 08/07/2024 at 10:02 AM, Resident 39 was observed lying in bed with the foley catheter drainage bag hanging off the right side of the bed uncovered and visible from the hallway. On 08/08/2024 at 11:45 AM, Staff B, Director of Nursing Services and RN, said it was her expectation foley catheter drainage bags were covered and not placed on the floor. Refer F-880 Reference WAC 388-97-0180 (1)(2)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934 Based on interview and record review, the facility failed to ensure residents and/or their representatives were offered the opportunity to participate in care conferences for 1 of 6 sampled residents (53) reviewed for right to participate in planning care. This failure placed residents at risk of a diminished quality of life when not allowed to be involved in their long-term care needs. Findings included . Resident 53 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment, dated 06/18/2024, showed the resident was alert and oriented. The electronic health records (EHR) showed a care conference was conducted on 03/25/2024, and no other care conferences were documented. The EHR showed Resident 53 had a quarterly MDS assessment, dated 06/18/2024. On 08/08/2024 at 10:27 AM, Staff K, Social Services Coordinator, said care conferences were done at the residents' request, significant change or quarterly. At 10:49 AM, Staff M, Social Services Director, said she expected care conferences to occur quarterly, as needed or for a significant change. Staff M said the MDS and care conference should be in coordination with one another. Staff M said she expected care conferences to be documented in the EHR under assessment or in a progress note. On 08/09/2024 at 8:37 AM, Staff B, Director of Nursing Services and Registered Nurse, said care conferences should be done quarterly. Reference WAC 388-97-1020 (2)(e)(f)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934 Based on interview and record review, the facility failed to provide and/or have procedures in place to assist with completing advance directives (AD), and obtaining and maintaining Durable Power of Attorney (DPOA) documentation for 1 of 6 sampled residents (53) reviewed for ADs. This failure place residents at risk for losing their right to have their healthcare preferences and/or decisions honored. Findings included . Resident 53 was admitted to the facility on [DATE]. The quarterly Minimum Data Set assessment, dated 06/18/2024, showed the resident was alert and oriented. Resident 53's electronic health record did not show an ADs or documentation that ADs were reviewed since March 2024, almost five months since the last review. Resident 53's care plan interventions, dated 03/19/2024, documented: Patient does not want to execute an Advance Directive at this time. On 08/08/2024 at 10:27 AM, Staff K, Social Services Coordinator, said Resident 53 did not want to generate an AD, but an AD should have been reviewed in June 2024. On 08/09/2024 at 8:37 AM, Staff B, Director of Nursing Services and Registered Nurse, said advanced directives should have been reviewed during the care conference in June for Resident 53. Reference WAC 388-97-0280 (3)(c)(i)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50416 Based on observation, interview and record review, the facility failed to ensure a timely response and/or resolution to resident concerns about lost items was completed for 2 of 7 sampled residents (50 & 286) reviewed for grievances. This failure placed residents at risk for not having their concerns addressed, increased frustration and a decreased quality of life. Findings included . Record review of the facility's Lost Item Policy documented, if an item was missing, the resident or responsible party was expected to inform a staff member and/or fill out a Lost, Misplaced, Damaged Item form, which was then forwarded to Social Services. Social Services would initiate a search for the item and if the item was not recovered in the initial search (within three business days), Social Services staff would note the action taken on the Lost Item form and forward this form to the Administrator to determine further action needed. The administrator would notify the resident within five business days once a determination was made. 1) Resident 50 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment, dated 06/05/2024, documented Resident 50 was alert and oriented, and required minimal assistance with activities of daily living. An Admission Note, dated 11/30/2023 at 9:42 PM, noted, [Resident's first name in all caps]arrived to facility in wheelchair from an acute hospital for post-acute care to 103-1 . On 08/08/2024 at 9:51 AM, Resident 50 said he was admitted to the facility with a manual wheelchair. The resident said he was later transferred to the hospital; but when he returned, he did not find his wheelchair. Resident 50 said he reported his missing wheelchair to Staff J, Certified Nursing Assistant. Resident 50 stated Staff J gave him a paper to fill out. Resident 50 stated, I spoke to some lady who takes care of that kind of stuff. She brought me the paper I had filled out because she could not read my writing, and I told her about the wheelchair. On 08/07/2024 at 9:16 AM, Staff K, Social Services Coordinator, said Resident 50 had a wheelchair when he came to the facility. Staff K said she had maintenance look for the wheelchair, but it was never found. Staff K said the matter was then forwarded to the Administrator. On 08/08/2024 at 8:29 AM, when asked about Resident 50's missing wheelchair, Staff A, Administrator, stated, I heard of it this morning for the first time. Staff A said if a resident reported a missing item, the facility staff would try to find it and replace it if they were unable to find the item. At 2:43 PM, Staff J said he had conversations with Resident 50 about his wheelchair late last year. Staff J said Resident 50 said the wheelchair had been missing and people had been looking for it. At 3:29 PM, Staff A said Resident 50 did have a wheelchair on admission that was given to him at the hospital prior to coming to the facility. Staff A stated, We are going to replace it. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Resident 258 was admitted to the facility on [DATE]. The MDS, dated [DATE], documented Resident 258 was alert and oriented and required minimal assistance with activities of daily living. On 08/05/2024 at 12:23 PM, Resident 286 said she lost personal laundry items which were yet to be returned. On 08/07/2024 at 9:14 AM, Resident 286 said her laundry was picked up a week and a half after her admission and she had missing items that were yet to be returned despite her asking staff members. Resident 286 said on the weekend of 08/03/2024, she wheeled herself to the laundry room and insisted to go through the pile of clothes on the table. Resident 286 was able to retrieve nine items from a pile of clean laundry. Resident 286 said as of 08/07/2024, she was still missing eight or nine of her personal items. On 08/08/2024 at 2:12 PM, Staff L, Resident Care Manager and Registered Nurse, said she was not aware of Resident 286's missing laundry. Staff L said she found out about it when she found a green slip in her mailbox that morning. Reference WAC 388-97-0460 (2)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47518 Based on observation, interview and record review, the facility failed to ensure an assessment, consent and/or physician order was obtained for beds being against the wall and bed rails for 4 of 5 sampled residents (5, 31, 61, & 189) reviewed for physical restraints. This failure placed residents at risk for injury, unmet needs, and a diminished quality of life. Findings included . Record review of the facility's policy entitled, Use of Restraints, revised April 2017, documented, 1. Physical Restraints' are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body . 9. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative . 1) Resident 5 was admitted to the facility on [DATE] with diagnoses including right leg below knee amputation. The Medicare-5 Day Minimum Data Set (MDS) assessment, dated 06/09/2024, documented Resident 5 was alert and oriented. Record review of Resident 5's Electronic Health Record (EHR) did not show physician orders for the bed being against the wall or half-length bed rails on the bed. Record review of Resident 5's EHR did not show an assessment and consent for Resident 5's bed being against the wall. On 08/05/2024 at 4:02 PM, Resident 5 was observed lying in bed sleeping. Resident 5's bed was observed with the left side of bed against the wall and half-length bed rails raised on both sides of the bed. On 08/06/2024 at 9:31 AM, Resident 5 was observed lying in bed awake with the left side of bed against the wall and half-length bed rails raised on both sides of the bed. At 1:57 PM, Resident 5's bed was observed with the left side of bed against the wall and half-length bed rails raised on both sides of the bed. On 08/07/2024 at 10:01 AM, Resident 5 was observed sleeping in bed on her right side, with the left side of bed against the wall and half-length bed rails raised on both sides of the bed. On 08/08/2024 at 3:40 PM, Resident 5's bed was observed with the left side of bed against the wall and half-length bed rails raised on both sides of the bed. 2) Resident 31 was admitted to the facility on [DATE]. The Medicare/5-day MDS assessment, dated 07/23/2024, documented Resident 31 was moderately cognitively impaired. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident 31's EHR did not show an assessment, consent, and physician orders for the bed being against the wall. On 08/05/2024 at 2:56 PM, Resident 31's bed was observed with the left side of bed against the wall. On 08/07/2024 at 9:58 AM, Resident 31's bed was observed with the left side of bed against the wall. On 08/08/2024 at 2:56 PM, Resident 31 was observed lying in bed on his right side with his wheelchair beside the bed. Resident 31's bed was observed with the left side of bed against the wall. 3) Resident 61 was admitted to the facility on [DATE]. The Modification of Admission MDS assessment, dated 06/30/2024, documented Resident 61 was alert and oriented. Record review of Resident 61's EHR did not show an assessment, consent, and physician orders for the bed being against the wall. On 08/05/2024 at 4:23 PM, Resident 61's bed was observed with the left side of bed against the wall. On 08/06/2024 at 9:12 AM, Resident 61's bed was observed with the left side of bed against the wall. When asked about her bed being against the wall, Resident 61 said she did not know why it was against the wall. At 1:52 PM, Resident 61 was observed lying in bed watching TV with the left side of bed against the wall. On 08/07/2024 at 9:56 AM, Resident 61 was observed sleeping in bed with the left side of bed against the wall. On 08/08/2024 at 2:51 PM, Resident 61 was observed lying in bed looking at her phone with the left side of bed against the wall. 4) Resident 189 was admitted to the facility on [DATE]. The Admission/Medicare-5 day MDS assessment, dated 07/27/2024, documented Resident 189 was alert and oriented. Record review of Resident 189's EHR did not show an assessment, consent, and physician orders for the bed being against the wall. On 08/05/2024 at 4:20 PM, Resident 189 was observed lying in bed asleep with the left side of the bed against the wall. On 08/06/2024 at 10:00 AM, Resident 189's bed was observed with the left side of bed against the wall. When asked about the bed being against the wall, Resident 189 stated, It's always been like that. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/07/2024 at 8:38 AM, Resident 189 was observed lying in bed on her right side with the left side of bed against the wall. On 08/08/2024 at 2:59 PM, Resident 189 was observed lying in bed on her right side with the left side of bed against the wall. On 08/09/2024, at 8:40 AM, Staff C, Resident Care Manager and Registered Nurse (RN), said a safety device assessment and consent, and physician orders were needed for residents that had their bed against the wall and/or had side rails on the bed. When asked about Resident 5's bed being against the wall and with half side rails, Staff C said he could not find an assessment, consent, and orders for Resident 5's bed being against the wall. Staff C said he could not find physician orders for half side rails on Resident 5's bed, and stated, That needs to be done for sure . Why is her bed against the wall. When asked about the beds being against the wall for Resident 31, Resident 61, and Resident 189, Staff C said he could not find an assessment, consent, and physician orders for Resident 31's, Resident 61's, or Resident 189's bed being against the wall. At 8:48 AM, Staff B, Director of Nursing Service and RN, said it was her expectation assessments, consents, and physician orders were completed for residents with bed rails and/or beds against the wall. Reference WAC 388-97-0620 (1)(a)(b), (4)(a)(b)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934 Based on interview and record review, the facility failed to provide a written Bed-Hold notice to the resident or resident's representative at the time of transfer to the hospital for 2 of 6 sampled residents (36 & 31) reviewed for notices of bed holds. This failure placed residents at risk for lack of knowledge regarding their right to hold their bed while in the hospital. Findings included . 1) Resident 36 was admitted to the facility on [DATE]. The Annual Minimum Data Set (MDS) assessment, dated 06/13/2024, showed the resident was severely cognitively impaired. The electronic health records (EHR) documented Resident 36 transferred to an acute hospital on 05/04/2024. No documentation was noted showing contact was made to the resident or resident's family regarding a Bed-Hold. On 08/07/2024 at 2:18 PM, Staff F, Admissions Coordinator, said when a resident was admitted to the hospital, admissions contacted the resident or the resident representative and covered the bed-hold agreement with them. Staff F said the documentation would be put into the EHR. At 2:42 PM, Staff F said she was not able to find a bed-hold for Resident 36. 47518 2) Resident 31 was admitted to the facility on [DATE]. The Medicare/5-day MDS assessment, dated 07/23/2024, documented Resident 31 was moderately cognitively impaired. Resident 31 was hospitalized on [DATE] and returned on 07/17/2024. The Electronic Health Record did not show documentation of a written bed hold notice. On 08/08/2024 at 11:20 AM, Staff F, Admissions Coordinator, said the admissions department completes the bed hold form for residents that transfer to the hospital. Staff F said if they could not reach the resident or resident representative, they would make a progress note and try again. Staff F said she did not have a copy of the bed hold notice for Resident 31. At 11:45 AM, Staff B, Director of Nursing Services and Registered Nurse, said they should have followed up again with Resident 31's representative and offered a bed hold notice. Staff B stated, We are not in compliance. Reference WAC 388-97-0120 (4)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47518 Based on observation, interview and record review, the facility failed to ensure a comprehensive person-centered care plan was developed and implemented for focused areas of care for 1 of 2 sampled residents (61) reviewed for care plans related to skin conditions. This failure placed residents at risk for unmet care needs and a diminished quality of life. Findings included . Resident 61 was admitted to the facility on [DATE]. The Modification of Admission Minimum Data Set assessment, dated 06/30/2024, documented Resident 61 was alert and oriented and had an open lesion(s) on the foot. Record review of Resident 61's physician orders, dated 07/12/2024, documented: 1) Left lateral ankle abrasion: Cleanse with wound cleanser, skin prep periwound [tissue surrounding a wound], apply foam dressing. Change 3 times per week and as needed. every evening shift every other day for Wound care. 2) Right great toe abrasion: Cleanse with wound cleanser, skin prep periwound, apply hydrofera blue [an antibacterial wound dressing] and cover with border foam dressing, change 3 times per week and as needed. every evening shift every other day for Wound care. 3) Right medial ankle abrasion: Cleanse with wound cleanser, skin prep periwound, apply hydrofera blue and cover with border foam dressing, change 3 times per week and as needed. every evening shift every other day for Wound care. 4) Right plantar foot abrasion: Cleanse with wound cleanser, skin prep periwound, apply foam dressing. Change 3 times per week and as needed. every evening shift every other day for Wound care. Record review of Resident 61's physician orders, dated 07/18/2024, documented: 1) blister to top of R [right] foot: clean with NS [normal saline]. cover with foam every evening shift. Record review of Resident 61's comprehensive care plan did not document a focus area, goal, and/or interventions related to abrasions and/or blisters to the right or left foot. On 08/08/2024 at 12:24 PM, Resident 61 was observed with a foam dressings on her right foot covering the great toe and bottom middle inner area of foot. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:31 PM, Staff C, Resident Care Manager and Registered Nurse (RN), said the Admission Nurses would develop resident care plans upon admission and the Resident Care Managers would review the care plan and update them throughout the resident's stay. Staff C said if a resident had a skin condition, there would be a care plan to reflect it. Staff C was unable to locate a skin condition care plan for Resident 61. Staff C stated, She doesn't have one. Why would she not have one. We will have to create one for her . At 3:12 PM, Staff B, Director of Nursing Services and RN, said it was her expectation skin care plans were in place for residents with skin conditions. Reference WAC 388-97-1020 (1)(2)(a)(b)(c)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51254 Based on observations, interviews and record review, the facility failed to ensure necessary care and services were provided for positioning in a wheelchair for 1 of 1 sampled resident (#21) reviewed for quality of care related to positioning. This failure placed residents at risk for unmet care needs, discomfort, a diminished quality of life and being unable to attain or maintain their highest practicable level of well-being. Findings included . Resident 21 was admitted to the facility on [DATE] with diagnoses including Inclusion Body Myositis (IBM). The quarterly Minimum Data Set assessment, dated 07/18/2024, showed Resident 21 was alert and oriented, had functional impairment on both sides, and required a motorized wheelchair for mobility once he is out of bed. The care plan, dated 12/16/2022, showed the resident has impaired physical mobility due to weakness requiring two person assist with a hoyer lift. The use of adaptive equipment to include power wheelchair for mobility. On 08/05/2024 at 11:28 AM, Resident 21 was observed sitting in a tall back motorized wheelchair, leaning to his left side, with the head rest to right of his neck and a self-releasing seatbelt across his upper abdomen. The left arm rest was tilted down toward the ground appearing not in alignment with his right arm rest. On 08/06/2024 at 11:03 AM, Resident 21 was observed leaning to his left in his motorized wheelchair with the left armrest hanging below his abdomen and the wheelchair appeared tilted to the left side. Resident 21 said his specialty wheelchair was new as of the first of this year (2024). Resident 21 said he was fitted for the wheelchair but the wheelchair did not fit him correctly. Resident 21 said no one ever checked to see if the new wheelchair was appropriately fitted. Resident 21 stated the chair caused him extreme discomfort and I am unable to get help to fix the wheelchair. Resident 21 said he was so upset about the wheelchair, and stated, I went to therapy and threatened a lawsuit. Resident 21 said the vendor for the wheelchair came out about a month or so ago and told him the [NAME] was broken and he would have to find out if there was a warranty. Resident 21 said the wheelchair vendor had not been back nor had he heard anything about the status. On 08/07/2024 at 10:29 AM, Staff C, Resident Care Manager (RCM) and Registered Nurse (RN), said someone was supposed to come look at the wheelchair for a wobbly wheel. When asked about the incidents of Resident 21 running into the bed and the wall, Staff C stated at first we just took it out of auto mode, so it became a manual wheelchair and staff had to maneuver it. We then turned it back on so [Resident 21] could operate it, but [the resident] was supposed to keep the chair in off status when not moving. At 10:55 AM, Staff E, Speech Language Pathologist and Therapy Director, said an assessment was done for the wheelchair on 11/02/2023 to have a new custom motorized wheelchair ordered. Staff E said she would look for the documentation related to; vendor notes about the wheelchair as no in house assessment appears to have been done. (continued on next page)

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	505389	A. Building B. Wing	08/09/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 1:05 PM, Resident 21 stated, Sitting in this wheelchair is like being a cork inside a bottle, referencing the wheelchair fit for his body habitus (shape and size of a person's body or body parts). Resident 21 stated, I have run into my bed and the wall several times. Resident 21 said because the controller was positioned under his stomach. The resident said his stomach leaned into the controller propelling the wheelchair into the wall and bed. Resident 21 said he had to yell for help to get staffs' attention for assistance to stop the wheelchair. On 08/08/24 at 11:58 AM, when asked about injuries to Resident 21 caused by accidental controller activation due to the wheelchair's fit, Staff D, RCM and Licensed Practical Nurse, stated, We padded the bed frame. Staff D said she removed back support pieces from the specialty wheelchair because they were not placed right and causing pressure to [the resident's] skin. Staff D stated, the seatbelt helps to hold his stomach up from touching the lever. At 11:58 AM, Staff B, Director of Nursing Services and RN, said the motorized wheelchair was newer. Staff B was not aware of the plan for the wheelchair repair. When asked if Resident 21's positioning in the wheelchair had ever been assessed for proper fit, Staff B stated PT [physical therapy] should have. They know about the incidents because they attend the morning meetings. On 08/09/2024 at 9:45 AM, Staff E said she was not aware of the chair pieces being removed from the back rest of the wheelchair. Staff E said the records reflected the wheelchair [NAME] was documented in June 2024, when the wheelchair vendor assessed the wheelchair. Staff E said the broken armrest was new to her as of this week. Staff E stated she thinks PT was present for the wheelchair delivery. Staff E said she was unable to find an assessment for the wheelchair fit upon receipt of new motorized wheelchair. Staff E stated, Usually, we would do an assessment, but he was outside of his skilled window, (meaning he was not on services). Reference WAC 388-97-1060 (1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51254 Based on observation, interview and record review, the facility failed to ensure pressure ulcers were thoroughly assessed, consistently monitored, and skin care and treatment were provided timely to promote healing of an existing pressure ulcer and prevent development of a new pressure ulcer for 1 of 6 sample residents (51) reviewed for pressure ulcers. Resident 51 experienced harm when an existing pressure ulcer on the coccyx worsened and a new pressure ulcer developed to the right buttock and upper thigh area that became infected and required hospital treatment. This failure placed residents at risk for deterioration in skin conditions, discomfort and a diminished quality of life. Finding included . The (corporation) Wound Management Guidelines, dated 08/25/2020, noted the following: --Skin checks are completed by Licensed nurse weekly. CAN/NAC/Shower aides (nursing assistants) will report any alterations in skin identified during routine care. --If a Resident is identified to have a new skin alteration the Licensed Nurse will: Initiate Risk Management and investigate the potential cause, development, and implement interventions. --If a Resident is identified to have a new skin alteration the Licensed Nurse will: Initiate a referral to the Registered Dietitian [RD] if indicated. Follow up on any RD recommendations. --Residents/and or representatives are informed/educated regarding risk factors for skin breakdown and the importance of following the interventions on the care plan. --Braden Risk Assessment is completed on admission, weekly x 3 weeks and then quarterly, annually, and with a significant change of condition. Resident 51 was admitted to the facility on [DATE] with diagnoses including healing Stage 2 pressure ulcer to the coccyx. The 5-day admission Minimum Data Set (MDS) assessment, dated 11/29/2023, showed Resident 51 was alert and oriented, and required one person assist with bed mobility. The MDS showed the resident was assessed to be at risk of developing pressure ulcers and had a healing Stage 2 pressure ulcer on the coccyx. The Admission Nursing skin assessment, dated 11/23/2023, noted healing pressure wound to coccyx. Nearly healed upon admission, protective Mepilex (foam absorbent dressing for treatment of chronic and acute wounds) in place. No weekly skin audits were documented from the initial assessment date of 11/23/2023 until 12/14/2023 (three weeks without documented weekly skin audits). Record review of Resident 51's medical record showed the admission Braden assessment, dated 11/23/2023; the weekly (x 3 weeks) Braden assessments on 11/30/2023, 12/07/2024 and 12/14/2024; and then no Braden assessments from 12/14/2023 until 06/20/2024. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The skin audit, dated 12/21/2023, noted open area to pt [resident's] coccyx [same wound the resident was admitted with] treatment applied. New open area to pt skin fold between R (right) buttock and upper thigh pictures taken. The audit showed the wound measurements were 2.67 cm (centimeter) x 0.76 cm. Depth was not documented. The photo image of the wound showed red/pink open wound to the area described. Review of the care plan showed the skin at risk care plan and/or a skin impairment care plan were not initiated on admission. The alteration in skin integrity care plan and the nutrition care plan were initiated on 12/21/2023 when the pressure ulcers were documented on the skin audit. A wound assessment, dated 01/22/2024, showed the right buttock/upper thigh wound measured 3.43 cm x 2. 03 cm. No depth measurement was documented. The photo image showed the wound with a yellow base and a faint pink color in the outer wound areas. Resident 51's December 2023 and January 2024 Treatment Administration Record showed treatment was not initiated, for the new right buttock/upper thigh wound, until 01/24/2024 (34 days after the wounds were documented on the skin audit, dated 12/21/2023). Interventions included cleaning right ischial with normal saline/wound cleanser, apply skin prep to peri-wound and allow to dry, apply santyl (wound debrider) and cover it with a sheet of inter-dry twice daily and PRN (as needed). The quarterly MDS assessment, dated 02/29/2024, did not show a Braden Risk Assessment was completed. Record review of Resident 51's medical record showed the resident was admitted to the hospital for suspected osteomyelitis (bone infection) on 03/12/2024 and surgical debridement of the right ischial wound (right buttock/upper thigh). The medical record showed when Resident 51 was readmitted to the facility on [DATE], a Braden Risk Assessment was not completed until 06/20/2024. On 08/06/2024 at 9:29 AM, Resident 51 said they developed multiple pressure ulcers in the facility since being admitted . Resident 51 said they even had to have one surgically treated. Resident 51 stated they did not have a special wheelchair cushion or pressure relieving mattress for quite some time after being admitted . On 08/08/24 at 9:46 AM, Staff H, RD stated, We will find out about admission pressure ulcers by chart audit, review of nursing admission assessment, or find physician orders. When asked how she would be notified if a resident developed a pressure ulcer in house, Staff H stated, The Resident Care Manager [RCM] will email me or tell me. If a pressure ulcer is identified in house, then the resident will be placed on a weekly monitoring under nutrition at risk and documented interventions. After reviewing Resident 51's medical record, Staff H stated, Resident 51 was placed on nutrition at risk on [03/22/2024]. Staff H stated, Resident 51 was not placed on nutrition at risk on admission despite having an identified pressure ulcer, as the wound was nearly healed. At 10:36 AM, Staff D, RCM and Licensed Practical Nurse, was observed performing a dressing change for Resident 51's right ischial (buttock/upper thigh) pressure ulcer. The wound had moderate drainage and had an unpleasant odor. The wound base was pink. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	At 11:58 AM, Staff D said Resident 51 was originally on a regular mattress until the facility got a foam mattress. Staff D stated, We got the specialty air mattress sometime toward the end of December [2023]. Staff D stated, We got a waffle seat cushion about the same time. Staff D said no interventions were added to the care plan. At 11:58 AM, Staff B, Director of Nursing Services and Registered Nurse, said any in-house Stage 2 pressure ulcer or higher would be investigated as an incident. After reviewing the incident report log, Staff B said she was unable to provide an investigation for the right buttock/thigh pressure ulcer documented on 12/21/2023. Staff B stated, [Resident 51] was admitted with that wound, but Staff B was unable to find supporting documentation in the medical record. Staff B said she would expect a baseline care plan to be completed by day five after admission. Reference WAC 388-97-1060 (3)(b)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51254 Based on observation, interview and record review, the facility failed to ensure infection control and prevention practices were implemented for hand hygiene during a clean technique dressing change and during care of catheter bags for 2 of 8 sampled residents (Residents 51 & 11) reviewed for infection prevention and control. This failure placed residents at risk for wound infection, health complications and a diminished quality of life. Findings included . 1) Resident 51 was admitted on [DATE]. The 5-day admission Minimum Data Set (MDS) assessment, dated 11/29/2023, showed Resident 51 was alert and oriented, required one person assist with bed mobility, was assessed to be at risk of developing pressure ulcers, and had a healing Stage 2 pressure ulcer to the coccyx. The quarterly MDS, dated [DATE], indicated Resident 51 had one Stage 4 pressure ulcer to the right ischium (buttock and upper thigh). Resident 51's medical record showed the wound was first documented on 12/21/2023 measuring 2.67 cm (centimeter) x 0.76 cm. Most recent measurements on 07/29/2024 documented the Stage 4 wound measured 2.12 cm x 1.66 cm with deepest depth 7.2 cm. On 08/08/2024 at 10:36 AM, Staff D, Licensed Practical Nurse (LPN), was observed during Resident 51's wound care for the right ischial pressure ulcer. After Staff D removed and discarded the old dressing and dirty gloves, Staff D did not wash her hands before putting on clean gloves and continuing with wound care. On 08/08/2024 at 11:19 AM, Staff I, Infection Control Nurse and LPN, stated, I would expect a nurse to gather supplies for wound care, enter the room, undress wound with clean gloves, sanitize hands, allow to dry, then place on a new pair of clean gloves to apply new dressing to wound. On 08/09/2024 9:45 AM, Staff B, Director of Nursing Services and Registered Nurse (RN), stated, I would expect a nurse to change gloves and wash hands, between removal of a dirty dressing, and placement of a clean wound dressing. 47518 2) Record review of the facility's policy entitled, Catheter Care, Urinary, revised August 2022, documented Infection Control . 2. Be sure the catheter tubing and drainage bag are kept off the floor. Resident 11 was admitted to the facility on [DATE] with diagnoses including a urinary tract infection. The Modification of Admission MDS assessment, dated 06/27/2024, documented Resident 11 was moderately cognitively impaired and had an indwelling catheter (a tube inserted into the bladder that drains urine into a bag outside of the body). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 11's Indwelling Catheter Care Plan, dated 07/26/2024, revised 08/07/2024, documented .drainage bag to remain covered, off the ground . On 08/07/2024 at 8:42 AM, Resident 11's foley catheter drainage bag was observed folded in thirds, lying on the floor to the right side of the bed with no hook present on bag to hang off the bed, and no privacy bag present. At 8:44 AM, Staff G, Certified Nursing Assistant, said foley catheter drainage bags were supposed to hang off the side of the bed and were not supposed to be on floor. At 8:47 AM, Staff C, Resident Care Manager (RCM) and RN, said foley catheter drainage bags should be in a black bag secured to the bed frame and not placed on the floor. After observing Resident 11's foley catheter drainage bag folded into thirds on the floor, Staff C said the foley catheter drainage bag should not be on the floor and stated, That should definitely not be like that. It should be covered. It should have a bag. It doesn't even have a hook to hang it. On 08/08/2024, at 11:45 AM, Staff B, Director of Nursing Services and RN, said it was her expectation foley catheter drainage bags were covered and not placed on the floor. Refer to F-550 Reference WAC 388-97-1060 (3)(c)