STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505403	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany at Silver Lake	2235 Lake Heights Drive Everett, WA 98208

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51551 Based on observation, interview and record review the facility failed to accommodate resident preferences for 3 of 5 sampled residents (Resident 508, 35, and 92) regarding important daily routines and health care. The failure of the facility to honor resident choice placed residents at risk for a diminished quality of life. Findings included . <RESIDENT 508> Resident 508 admitted to the facility on [DATE]. In an interview on 12/16/2024 at 10:26 AM, Resident 508 stated they preferred not to be awakened at 6:00 AM. Resident 508 stated they had told the nurses not to come in and they did not want breakfast, but the staff kept coming in and waking them up. Review of Resident 508's choice assessment, dated 12/14/2024, showed Resident 508 preferred to get up at 8:00 AM. Review a progress note dated 12/16/2024 at 1:45 PM, showed Resident 508 was angry for being woken up in the morning, and they refused vitals (blood pressure and heart rate) checked, breakfast, blood sugar check (checks sugar level in blood) and weight. Review of a progress note dated 12/17/2024 at 12:06 PM showed Resident 508 refused blood sugar check at 7:00 AM and refused their breakfast. Review of a progress note dated 12/18/2024 at 7:22 AM, showed Resident 508 refused having their blood sugar checked. In an interview on 12/18/2024 at 10:56 AM, Staff J, Licensed Practical Nurse (LPN), stated Resident 508 had refused their blood sugar check and insulin at 7:00 AM on 12/16/2024-12/18/2024 because they did not want to be woke up before 8:00 AM. Staff J stated they reported this to the nurse practitioner on 12/17/2024. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility form, titled, Nurse Practitioner non urgent communication log, showed the provider had been notified of Resident 508's preference to not be woke up before 8:00 AM and had morning medications scheduled at 7:00 AM. The form showed the provider had responded on 12/16/2024 to change AM (morning) medications to be administered after 8 AM. Review of Resident 508's Medication Administration Record (MAR), dated December 2024, showed the morning medications were still ordered to be administered at 7:00 AM. In an interview on 12/18/2024 at 1:55 PM, Staff H, Registered Nurse (RN)/Nurse Manger, stated that they were not aware of Resident 508's preference because they had not done a care conference yet. Staff H stated the responses on the nurse practitioner non urgent communication log were supposed to be implemented within 24 hours. Staff H stated Resident 508's orders had not yet changed since the provider's 12/16/2024 response. <RESIDENT 35> Resident 35 admitted to the facility on [DATE]. According to the Minimum Data Set (MDS-assessment tool) assessment, dated 12/06/2024, the resident was cognitively intact. In an interview on 12/16/2024 at 2:32PM, Resident 35 stated they preferred more frequent showers or bed baths. Resident 35 stated they did not have a shower last week because they preferred female aides. There were only two young male aides working on their scheduled shower day. Review of Resident 35's shower task record, print date 12/17/2024, showed during the last 30 days the resident had received one shower on 12/14/2024. Staff documented not applicable for shower tasks on 11/19/2024, 12/05/2024 and 12/12/2024. Review of a facility form titled, Central Shower Schedule, copied on 12/18/2024, showed Resident 35 was scheduled for showers once a week on Thursday evenings. Review of a progress note dated 12/12/2024 at 03:44 PM, showed Resident 35 refused to take a shower with a male caregiver they preferred to shower with a female aide and the resident was scheduled to have a shower the next day. There was no documentation that Resident 35 was offered a shower with female caregivers on the following day. Reviewed of Resident 35's care plan, dated 12/16/2024, showed no documentation of Resident 35's preference for female caregiver with showers. In an interview on 12/18/2024 at 11:23 AM, Staff J, stated residents were assigned for showers once a week based on what room the resident was in, and staff do not ask residents about their shower preferences. In an interview on 12/18/2024 at 1:11 PM, Staff K, Social Service Director, stated nursing staff oversaw obtaining shower preferences. Social services would not ask for preferences unless the resident brought them up themselves during the care conferences. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/18/2024 at 1:45 PM, Staff H, stated nurses should chart resident refused instead of not applicable on the documentation of shower task records. Staff H stated nurses should offer the shower the next day if resident refused due to no female caregiver. Staff H stated they were not aware of Resident 35's preference to have more frequent showers. Staff H reviewed the shower documentation for the last 30 days for Resident 35 and agreed it showed Resident 35 had received one shower on 12/14/2024 and did not receive showers as scheduled. In an interview on 12/18/2024 at 2:09 PM, Staff B, Interim Director of Nursing (DNS), stated staff were to determine the reason why Resident 35 refused their shower and should offer a shower the following day to accommodate the residents shower needs. 51312 <RESIDENT 92> Resident 92 was admitted to the facility on [DATE]. In an interview on 12/16/2024 at 10:33 AM, Resident 92 stated scheduled showers are once a week. Resident 92 stated when they refuse to shower, they are not given a choice to have a shower at another time or with assistance from a female aide during the week. During an interview on 12/19/2024 at 2:15 PM, Staff H, RN/Nurse Manager, stated when residents are admitted , they are given a sheet of paper about their choices, and are able to document their preferences. If a resident refused to shower, the shower aid should ask why and tell the nurse manager and social worker. Record review of documentation on the 'Documented Survey Report V2 (documentation of care provided by staff), dated November 2024, showed that Resident 92 received one shower in November. Refer to WAC 388-97-0900(1)

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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** 51551 Based on interview and record review, the facility failed to promptly report and document resident grievances for 1 of 3 sampled residents (Resident 35) reviewed for grievance resolution. The failure of staff to initiate resident grievances resulted in delays in grievance resolution and an extended period where a resident went without their missing property and placed residents at risk for frustration and diminished quality of life. Findings included . Review of the facility policy, titled, Grievance Policy and Procedure for Residents, revised date of June 2022, showed any employee that is informed of a grievance by a resident will immediately initiate the procedures for resolution of a grievance. Resident 35 admitted to the facility on [DATE]. According to the Admission Minimum Data Set (MDS-an assessment tool) assessment, dated 12/06/2024, the resident was cognitively intact. In an interview on 12/16/2024 at 2:34 PM, Resident 35 stated they were missing a left-hand arthritis glove, and it had been missing for one week, and they had told everyone about it. Resident 35 stated the gloves provided comfort for their hands. Review of the facility grievance logs for 07/16/2024 through 12/16/2024 showed no grievances were logged for Resident 35. In an interview on 12/17/2024 at 2:00 PM, Staff L, Occupational Therapist, stated Resident 35 had arthritis gloves but one was missing since about one week ago. In an interview on 12/18/2024 at 1:11 PM, Staff K, Social Service Director, stated they had received the grievance form for Resident 35 on 12/17/2024 and they were not aware the arthritis glove had been missing for one week. Staff K stated everyone in the facility could complete the grievance form when the resident reported their missing items. In a follow up interview on 12/18/2024 at 2:24 PM, Staff L stated they had not completed a grievance form when Resident 35 reported missing the arthritis glove. Staff L stated Resident 35 had told a lot of people, including aides, they had lost their glove one week ago. In an interview on 12/18/2024 at 1:45 PM, Staff H, Registered Nurse/Nurse Manager, stated Resident 35 lost their arthritis glove one week ago. Staff H stated the person with knowledge of the missing glove should have completed the grievance form immediately. Refer to WAC 388-97-0460(2)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42927 Based on record review and interview, the facility failed to provide 4 of 5 residents (Resident 28, 86, 35, 508) with a summary of their baseline care plan. This failure placed residents at risk of not being informed of their initial plan for delivery of care and services and placed them at risk for unmet needs and possible complications. Findings included . Review of a facility policy, titled, Baseline Care Plan, dated 02/05/2020, showed the base line care plan: - Be developed within 48 hours of a resident's admission, - Admitting nurse shall gather information from hospital information, physician orders and discussion with the resident, - A written summary of the baseline care plan will be provided to the resident, - The written summary will be signed by the resident and included in the medical record. <RESIDENT 28> Resident 28 readmitted to the facility on [DATE]. Review of Resident 28's baseline care plan form showed which staff had completed the base line care plan. There was a signature by Staff N, Social Service Assistant and Staff O, Licensed Practical Nurse, dated 08/30/2024. The section that showed the baseline care plan had been reviewed with the resident and/or representative and the space where a copy had been provided to the resident were both blank. <RESIDENT 86> Resident 86 admitted to the facility on [DATE]. Review of Resident 86's Baseline Care plan form showed which staff had completed the base line care plan. There was a signature by Staff E, Registered Nurse (RN)/nurse manager (NM), on 10/23/2024. There was a signature by Staff N, dated 10/28/2024, five days after admission. The section showed the baseline care plan was reviewed with the resident and/or representative and the space where a copy had been provided to the resident was blank. 51551 <RESIDENT 35> (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 35 admitted to the facility on [DATE]. Review of the Baseline Care plan form showed a section for staff that had completed the base line care plan. There was a signature by Staff N, dated 10/16/2024, no other disciplines had completed the baseline care plan. The section showed the baseline care plan was reviewed with the resident and/or representative and the space where a copy had been provided to the resident was blank. Review of Resident 35's Electronic Health Record (EHR) showed no documentation that a written summary of the baseline care plan was provided to the resident or their representative. <RESIDENT 508> Resident 508 admitted to the facility on [DATE]. Review of the Baseline Care plan form showed a section for staff that had completed the base line care plan. There was a signature by Staff K, Social Service Director, dated 12/16/2024, no other disciplines had completed the baseline care plan. The section showed the baseline care plan was reviewed with the resident and/or representative and the space where a copy had been provided to the resident was blank. Review of Resident 508's EHR, showed no documentation that a written summary of the baseline care plan was provided to the resident or their representative. In an interview on 12/18/2024 at 1:55 PM, Staff H, RN/NM, stated the admission nurse initiated the baseline care plan and the baseline care plan should be done within 48 hours. Staff H stated it was social service's responsibility to set up a meeting with the family which also included nursing and therapy departments. In an interview on 12/18/2024 at 2:09 PM, Staff B, Interim Director of Nursing, stated whomever the nurse was that completed the admission should be the one to put the baseline care plan information together within 24 hours. The admission nurse should discuss with the resident their basic care, including pain, skin, Activity of daily living (ADL) .as much as possible. Staff B stated the baseline care plan should be printed and provided and have residents or representatives sign. The signed copy of the baseline care plan should be scanned into the EHR. Staff B stated a brief care conference should be held within 24 hours and should include social service, nursing and a therapist. Staff B replied they did not see documentation that Resident 28, 86, 35 or 508 had reviewed their baseline care plan with facility staff. Refer to WAC 388-97-1020(3)(4)(b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725 Based on observation, interview, and record review the facility failed to review and revise care plans for 1 of 2 sampled residents (Resident 69) reviewed for activities of daily living (ADLs), 1 of 1 sampled residents (Resident 75) reviewed for discharge planning, 1 of 2 sampled residents (Resident 9) reviewed for communication, 1 of 4 sampled residents (Resident 18) reviewed for dementia care, 1 of 1 sampled residents (Resident 40) reviewed for dental services, and 1 of 1 sampled residents (Resident 83) reviewed for urinary management. These failures placed the residents at risk for lack of consistent interventions, unmet care needs, adverse health effects, and a diminished quality of life. Findings include . Review of the facility policy titled, Comprehensive Care Plans, dated February 2023, showed that the facility will develop and implement a comprehensive person centered care plan for all residents, consistent with resident rights, that include measurable objectives and timeframes to meet the needs, comprehensive care plan will be revised and reviewed by the interdisciplinary team after each comprehensive and quarterly assessment, objectives will be used to monitor the residents progress, and alternate interventions will be documented as needed. <DEMENTIA CARE> Resident 18 admitted to the facility on [DATE] with diagnoses to include Alzheimer's Dementia (a progressive disease that destroys memory and other important mental functions). According to the quarterly Minimum Date Set (MDS- an assessment tool) assessment dated [DATE], Resident 18 had severely impaired cognition. In a record review on 12/17/2024, Resident 18's care plan under focus revised 09/09/2022, showed that Resident 18 and Power of Attorney (POA) wished the resident to remain on the memory care unit at the facility and only be asked about returning to the community on comprehensive assessments. The facility no longer has a memory care unit. In a record review on 12/17/2024, Resident 18's care plan under focus stated resident was high risk for falls related to history of recurrent falls and unaware of safety needs, revised on 06/05/2024. Under the intervention it showed Resident 18 required a fall mat to the left side of the bed (door side), this was revised 09/05/2023, a four Wheeled [NAME] (4WW) at bedside and in common areas to remind resident to use it, this was revised on 1/01/2023. In an observation on 12/17/2024 at 1:30 PM, Resident 18 was in bed with eyes closed, no floor mat on the floor and did not see a 4WW in the room. In an interview on 12/18/2024 at 1:58 PM, Staff F, Nursing Assistant Certified (NAC), stated that Resident 18 was total assist with all their care needs. Staff F stated that resident had not walked since they started working at the facility and had not used floor mat on the floor when resident was in bed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/19/2024 at 9:55 AM with Staff G, NAC, stated that Resident 18 required total assist with their care needs. Staff G stated resident no longer walked and does not use 4WW. They also stated that they don't place the floor mat on the floor when resident was in bed. In an interview on 12/19/2024 at 2:00 PM Staff E, Registered Nurse (RN)/ Nurse Manager (NM) stated that when there were changes or updates on resident's care, they were required to update the care plan as soon as possible. Otherwise, they review care plans quarterly and yearly. They were unsure why Resident 18's care plan was not updated. In an observation on 12/19/2024 at 2:15 PM, Resident 18 was in bed asleep, no floor mat and did not see a 4WW in the room. <ACTIVITIES DAILY LIVING> Resident 69 admitted to the facility on [DATE]. According to the quarterly MDS assessment dated [DATE], resident was cognitively intact. In an interview on 12/16/2024 at 10:12 AM, Resident 69 stated that the staff brings their dinner and place it on their table and leave without waking resident up. In a record review with a print date 12/17/2024, Resident 69's care plan under intervention for Restorative showed, NAC Restorative Aide (RA) Program: Eating/Swallowing Program; set up, assure upright for meals, remains upright 20-30 minutes after meals, cues/assist to eat/drink slowly, to take small bites/sips, to swallow before taking another bite/sip, to alternate liquids, solids, temps, textures, to take on bite/sip at a time. Monitor for food pocketing and safe swallow. Notify LN if frequently coughs, monitor intake, provide meal replace for poor intake per protocol. Document total # minutes with eating program throughout shift. Date initiated was 08/18/2023. In an observation on 12/17/2024 at 12:42 PM, Resident 69 was observed lying on their bed with their lunch tray on their table with half drank milk and an empty bowl. In interview on 12/18/2024 at 10:45 AM, Staff I, Restorative Assistant (RA) stated that they had not assisted Resident 69 with meals and resident was not on Eating/Swallowing Program. In an interview on 12/18/2024 at 1:30 PM, Staff E stated that Resident 69 was no longer on Restorative Feeding Program and that they would update the care plan. 51312 <DISCHARGE PLANNING> Resident 75 admitted to the facility on [DATE] with diagnoses to include bilateral (both) below the knee amputation. According to the quarterly MDS assessment dated [DATE], resident was cognitively intact. In an interview on 12/16/2024 at 2:12 PM, Resident 75 stated their goal was to return to the community. They stated no one at the facility had discussed their discharge plan with them. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a review of Resident 75's care plan on 12/19/2024 showed no focus area for discharge planning. In a joint interview on 12/19/2024 at 1:49 PM, Staff N, Social Services Assistant and Staff S, Social Services, Staff S reported they had not discussed discharge planning with Resident 75. Staff N reported they spoke with DSHS (Department of Social and Human Services) case manager in April 2024 when they admitted to the facility and had not followed-up on a plan since then. During an interview on 12/19/2024 at 2:45 PM, Staff B, Interim Director of Nursing Services (DNS), stated social services were responsible for resident discharge planning. 47047 <DENTAL> Resident 40 admitted to the facility on [DATE] with diagnoses that included heart failure and chronic obstructive pulmonary disease (COPD-progressive lung disease that limits airflow and makes it difficult to breath). In an observation and interview on 12/16/2024 at 1:32 PM Resident 40 stated they needed to get their teeth pulled so they could get dentures. Resident 40 was observed to have several missing teeth, two lower teeth and no upper teeth. In a review of Resident 40's care plan dated 11/28/2022 showed resident did not want to have dentures and did not want their diet changed. In a review of Resident 40's Admission Minimum Data Set, dated dated dated [DATE] showed the resident had mouth or facial pain, discomfort or difficulty with chewing. In a review of Resident 40's Annual MDS dated [DATE] showed resident had no mouth or facial pain, discomfort or difficulty with chewing. In an interview on 12/19/2024 at 1:19 PM Staff C, RN/NM stated residents are offered dental services at admission and as needed. Staff C stated residents are re-offered services when it was determined they had any dental problems or pain. Staff C stated they did not know the last time dental services were discussed with Resident 40. <COMMUNICATION> Resident 9 admitted to the facility on [DATE] with diagnoses that included stoke, hearing loss, and diabetes mellitus 2 (disease characterized by elevated levels of blood glucose (or blood sugar), which leads over time to serious damage to the heart, blood vessels, eyes, kidneys and nerves). In an interview and observation on 12/16/2024 at 2:37 PM, Resident 9 was in their room laying in their bed. When attempted to speak with Resident 9, they pointed to a white board/dry erase board, sitting on their bed side table and stated the pen did not work. A new dry erase pen was provided from Staff C, RN/Nurse Manager. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 9's progress notes from 12/01/2024 through 12/18/2024 showed they frequently refused use of their hearing aids. No other information was provided about the reason for the refusals. Review of Resident 9's care plan dated 07/29/2024 showed they had a communication problem related to a hearing deficit and just obtained hearing aids. The goals for Resident 9 included they would be able to make their needs and wants known by verbal communication and tolerate wearing their hearing aids throughout the day. Resident 9 would be assisted daily with placement of their hearing aids in the morning and removal at the night. There was no intervention in Resident 9's care plan regarding the use of a dry erase board for communication. In an interview on 12/19/2024 at 9:27 AM, Staff P NAC stated they know how to care for a resident by reviewing the care plan, information provided to them from the nurse or other aides. In an interview on 12/19/24 01:23 PM, Staff C stated Resident 9 was able to communicate if speaking directly in front of them. Staff C stated the resident used the dry erase board infrequently, did not know how the dry erase board was implemented. Staff C stated the resident had hearing aids and heard just fine with them, but often declined to wear them because they heard more than what they wanted. <URINARY> Resident 83 admitted to the facility on [DATE] with diagnoses that included stroke and heart failure. Review of Resident 83's care plan dated 12/05/2024 showed the resident had bladder incontinence related to their disease process and was at risk for infections, skin breakdown and was being treated for a urinary tract infection. The goals on Resident 83's care plan included no skin breakdown and resolution of a urinary tract infection. Interventions included changing the resident every two hours and as needed in addition to establishing a voiding pattern. Review of Resident 83's electronic medical record showed no information about establishing a voiding pattern. In an interview on 12/19/2024 at 1:25 PM Staff C stated updating care plans was a process that includes the interdisciplinary team. Staff C stated the care plan for Resident 83 needed to be updated as they were beyond finding a pattern to voiding given Resident 83 was incontinent of urine. In a joint interview on 12/20/2024 at 10:48 AM, Staff A, Administrator and Staff B, Interim DNS both stated they were unaware of the concerns with implementation and revision of resident's comprehensive care plans. Refer to WAC 388-97-1020(5)(b)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51312 Based on observation, interview, and record review, the facility failed to ensure 1 of 1 resident (Resident 82) reviewed for blood sugar (BS) monitoring received BS checks per standards of practice/care. This failure exposed residents to an increased risk of inaccurate insulin administration and the potential for decreased blood sugar. Finding Included . A review of the facility policy, titled Timely Administration of Insulin, dated June 2020, stated that insulin administration will be coordinated with mealtimes and snacks. Resident 82 admitted to the facility on [DATE] with diagnoses to include diabetes type 2 (a chronic disease that occurs when the sugar level in the blood stream was too high.) In an observation and interview on 12/19/2024 at 12:56 PM, Staff Q, Licensed Practical Nurse (LPN) assessed Resident 82's BS after they had eaten their lunch. Staff Q then administered sliding-scale (an insulin prescription that adjusts the amount of insulin a person receives based on their blood sugar level) insulin (medication injected into the skin to help regulate blood sugar levels) to the resident. Staff Q stated they needed to administer Resident 82's insulin and nothing more. Record review of Resident 82's Medication Administration Record (MAR) for December 2024 showed six units (measurement for insulin) of insulin was administered on 12/19/2024, based on their sliding scale BS level of 292. In an interview on 12/19/2024 at 2:10 PM Staff R, LPN, stated Resident 82's sliding scale insulin needed to be administered even after they had eaten, and the provider would not need to be notified. In an interview on 12/19/2024 at 2:20 PM, Staff E, Registered Nurse (RN)/Nurse Manager, stated when a resident had their BS taken after they had eaten, the nurse was to notify and obtain guidance from the provider. In an Interview on 12/19/2024 at 2:45 PM, Staff B, Director of Nursing Services (DNS), stated the provider should be notified and asked for guidance if a BS was checked after a meal. In an interview on 12/19/2024 at 3:00 PM, Staff C, RN/Nurse Manager, stated when a BS was taken after a resident had eaten, then the sliding scale insulin would be administered, and a note placed in the resident record to show the BS was taken after the meal. Refer to WAC 388-97-1620(2)(b)(ii)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505403	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany at Silver Lake	2235 Lake Heights Drive Everett, WA 98208

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on observation, interview, and record review the facility failed to provide respiratory care consistent with professional standards of practice for 1 of 2 sampled residents (Resident 40) reviewed for respiratory care. Failure to follow provider's orders for oxygen (O2) therapy placed the resident at risk for unmet needs, potential negative outcomes and a diminished quality of life. Findings included . Review of the facility policy titled, Oxygen Administration, undated, showed oxygen would be administered to resident's who needed it, consistent with professional standards of practice, the comprehensive care plan and the resident's goals and preferences. The explanation and guidelines outlined in the policy showed oxygen was administered under orders of a physician. Resident 40 admitted to the facility on [DATE] with diagnoses that included heart failure and chronic obstructive pulmonary disease (COPD-progressive lung disease that limits airflow and makes it difficult to breath). On 12/16/2024 at 1:51 PM, Resident 40 was observed lying in their bed. Resident 40 was wearing a nasal cannula (a thin flexible tube that goes around the head and into the nose that administers oxygen) which was attached to the oxygen concentrator. The concentrator was set to administer 4 liters per minute of oxygen (lpm). On 12/17/2024 at 2:38 PM, Resident 40 was observed lying in their bed on their back, the head of the bed slightly elevated. Observed the oxygen concentrator setting at 4 lpm. Review of Resident 40's Medication Administration Record (MAR) for December 2024, showed they had a physician order to apply oxygen, per nasal cannula, at 2 lpm to keep oxygen saturations (a measurement of the amount of oxygen in the blood) greater than or equal to 88-92 percent as needed. Review of Resident 40's care plan revised on 08/11/2023, showed oxygen settings included O2 by use of nasal prongs at 2 lpm as needed to keep O2 saturations above 88-92 percent. In an interview on 12/17/ 2024 at 3:15 PM, Staff D, Licensed Practical Nurse (LPN) stated the process for residents on O2 included checking their O2 saturations and changing the tubing every Monday. When asked how the settings on the concentrator are determined, Staff D stated they follow the physician orders. Staff D stated the concentrator settings are checked every time they go into the room. Staff D stated Resident 40 had a physician order for O2 as needed at 2 lpm. Staff D stated Resident 40 always wore their oxygen, they always wanted to use it and it was usuaslly set at 2 lpm. Staff D stated they could not find an order for Resident 40's oxygen use. On 12/17/2024 at 3:20 PM, Staff D entered Resident 40's room and checked the setting on the concentrato, stated the concentrator was set at 4 lpm. Staff D adjusted the concentrator settings from 4 lpm to 2 lpm . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505403	A. Building B. Wing	12/20/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/17/2024 at 3:24 PM Staff C, Registered Nurse/Nurse Manager, stated O2 settings should be checked each time a nurse enters a resident's room, but at minimum each shift. Staff C stated Resident 40 has a physician order for O2 use at 2 lpm as needed, but the resident wanted to use it all the time. Refer to WAC 388-97-1060(3)(j)(vi)