STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505404	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany at Pacific	916 Pacific Avenue 3rd-5th Floors Everett, WA 98201

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33954 Based on observation, interview, and record review, the facility failed to maintain a homelike environment in resident rooms for 2 of 3 sampled residents (Resident 4, and 7) reviewed. The failure to have functioning lights over the sinks in resident rooms and to ensure the soap dispenser had soap placed residents at risk for diminished quality of life. Findings included . <RESIDENT 4> Resident 4 admitted to the facility on [DATE]. In a phone interview on 04/16/2024 at 2:43 PM, Resident 4 stated the room they had stayed in at the facility was not maintained in a clean condition and there were lights in the room that did not work. <RESIDENT 7> Resident 7 admitted to the facility on [DATE]. In an observation/interview on 04/17/2024 at 11:50 AM, Resident 7 stated the light over the sink was not working and they had notified staff who had not responded yet. Resident 7 stated the soap dispenser by the sink was empty and it had been like that, and they had notified staff, but they never refilled it. In an observation of the room, the light over the sink was inoperable and the soap dispenser was empty. In an interview on 04/17/2024 at 11:55 AM, Staff G, Nursing Assistant Certified, was unable to provide any information about Resident 7's soap dispenser being empty, or the inoperable light over the sink, they stated they would notify housekeeping and maintenance. In a joint observation on 04/17/2024 at 11:58 AM, with Staff G, the next room up from Resident 7's was observed, the light over the sink in that room was inoperable. In a phone interview on 04/18/2024 at 4:07 PM, Staff A, Administrator, stated maintenance had repaired the room lights they had been notified about. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505404	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany at Pacific	916 Pacific Avenue 3rd-5th Floors Everett, WA 98201

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Refer to WAC 388-97-0880(1)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505404	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany at Pacific	916 Pacific Avenue 3rd-5th Floors Everett, WA 98201

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 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** 33954 Based on observation, interview, and record review, the facility failed to resolve resident grievances for 1 of 2 sampled residents (Resident 2) reviewed for grievances. The failure to resolve resident grievances placed residents at risk for ongoing unmet care needs, missed activities, and unresolved missing property. Findings included . Review of the facility policy titled, Resident and Family Grievances, dated 07/01/2023, showed: -Prompt efforts to resolve include facility acknowledgement of a complaint/grievance and actively working toward resolution of that complaint/grievance. -A resident or family member may voice grievances with respect to care and treatment which has been furnished as well as that which has not been furnished . -Grievances may be voiced verbally, written, by telephone by the Ombudsman programs, and by verbal complaint of the resident. -The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form or assist the resident or family member to complete the form, and they will take any immediate actions needed to prevent further potential violations of any resident right. -The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form. All staff involved in the grievance investigation or resolution should make prompt efforts to resolve the grievance and return the grievance form to the Grievance Official. Prompt efforts include acknowledgement of complaint/grievances and actively working toward a resolution of that complaint/grievance. -The Grievance Official, or designee, will keep the resident appropriately apprised of progress towards resolution of the grievance. <RESIDENT 2> Resident 2 admitted to the facility on [DATE]. According to the Annual Minimum Data Set (an assessment tool) assessment, dated 03/11/2024, the resident had no cognitive impairment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505404	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany at Pacific	916 Pacific Avenue 3rd-5th Floors Everett, WA 98201

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an email, dated 02/13/2024 at 2:04 PM, showed Collateral Contact 1 (CC1), a resident advocate, had emailed Staff A, Administrator, Staff B, Registered Nurse (RN)/Director of Nursing Services, and Staff H, Social Services, with concerns staff had not been listening to Resident 2 when they were asking to be changed, staff had told the resident they did not have time and that they would have to wait, and the day prior the resident had notified CC1 they had not been changed from 4:30 AM - 11:30 AM. CC1 notified those three staff that Resident 2 felt like they had no say when they were changed. CC1 had a concern and notified the facility that missing clothes may be an issue again, and the resident was missing a pair of pants. Review of an email, dated 02/13/2024 at 3:25 PM, showed Staff H had emailed CC1 they had looked into Resident 2's missing property concerns the facility had been notified about in the 02/13/2024 at 2:04 PM email. There was nothing at all listed about the resident's concerns staff had not been listening to Resident 2 when they were asking to be changed, that staff had told them they did not have time, that Resident 2 would have to wait, and nothing there was about the resident's allegation they had not been changed for seven hours, from 4:30 AM - 11:30 AM. Review of the February and March 2024 grievance logs showed none of the issues had been logged regarding Resident 2's concerns communicated to Staff A, Staff B, and Staff H in the email to them from CC1 on 02/13/2024. In an interview on 04/10/2024 at 11:27 AM, Resident 2 stated they would like to be up out of bed earlier in the day so they could attend the exercise class activity, but they frequently missed the activity because they needed two staff to get them out of bed, and they had to wait in bed until the facility had two staff to transfer them. Resident 2 stated they had to wait all morning to get out of bed because they had to wait for a second staff member, and they didn't want to come until they were done caring for their residents. The resident stated by the time they were able to get up out of bed, their day was over before it even got started. The resident stated the staff don't listen to them about how they wanted their sling on the Hoyer (a type of transfer/hoist equipment) to be positioned for transfers. Resident 2 stated there was an ongoing problem with their clothes because they didn't all come back from laundry. Resident 2 stated the facility had replaced some of their missing clothing, but not all, and it just continued to happen. In an interview on 04/10/2024 at 1:24 PM, Resident 2 stated they had issues with being left on the bedpan for a good hour before staff could help them off it, because they had to wait for the facility to get a second staff member to help them off the bedpan. The resident stated this had been happening at least three times a week. In an interview on 04/10/2024 at 2:10 PM, Staff A, and Staff B stated they had no knowledge of any toileting concerns Resident 2 may have. Staff B stated the resident tended to want to stay in bed until 11:00 AM. In a phone interview on 04/11/2024 at 8:56 AM, CC1 stated there had been care issues and communication issues regarding Resident 2, and they had a care conference on 03/08/2024. CC1 indicated they'd had multiple meetings with the facility and the issues just continued to keep happening without resolution. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505404	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany at Pacific	916 Pacific Avenue 3rd-5th Floors Everett, WA 98201

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/12/2024 at 8:35 AM, Resident 2 stated they had a care conference with CC1, Staff H, and Staff D, RN/Resident Care Manager (RCM), and they discussed the missing clothing, problems being left on the bedpan, waiting too long for toileting assistance, and other issues. In a review on 04/12/2024, no documentation could be found in Resident 2's clinical record of a care conference being done regarding the resident's multiple issues. In an interview on 04/12/2024 at 10:35 AM, Staff D stated they were in a care conference for Resident 2 on 03/08/2024. Staff D was asked about there being no documentation made in the resident's clinical record regarding the care conference and what had been discussed, Staff D stated it might have been because it was on a Friday, but usually they would have done a progress note after a care conference. Staff D denied any knowledge of Resident 2's toileting concerns. In an interview on 04/12/2024 at 12:11 PM, Staff I, Social Services Director, was asked for any documentation Staff H made regarding Resident 2's care conference held on 03/08/2024, Staff I stated Staff H was old school, and they did paper documentation, but they were supposed to have updated care conference documentation into the electronic health record. Staff I stated they assumed that Staff H had not updated the resident's electronic health records because they were no longer there. Staff I stated they could not find Staff H's paper documentation. In an interview on 04/17/2024 at 10:32 AM, Staff A was asked how they had resolved the issues they were notified about in the email on 02/13/2024 from CC1. Staff A was unable to provide any information, they stated they would talk to Staff B. Staff A stated they thought there should be some documentation somewhere. Staff A stated they thought the issue of no care in seven hours was an allegation that should have been logged on the incident reporting log. Refer to WAC 388-97-0460(1)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505404	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany at Pacific	916 Pacific Avenue 3rd-5th Floors Everett, WA 98201

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** 33954 Based on observation, interview, and record review, the facility failed to provide necessary care and services in accordance with professional standards of practice for 2 of 4 sampled residents (Residents 1 and 2) reviewed. The failure to obtain necessary physician progress notes and orders, and to revise the resident's medications accordingly, and to provide necessary transfer assistance placed residents at risk for unmet care needs, adverse medication-related outcomes, missed activities, and for diminished quality of life. Findings included . <RESIDENT 1> Resident 1 resided in the facility from [DATE] - 02/26/2024. The resident had diagnoses to include a stroke, heart failure, pneumonia, and breathing difficulties. Review of a nursing progress note, dated 02/21/2024, showed Resident 1 had an appointment with their physician that day. On 04/17/2024 a review of Resident 1's clinical record showed there were no physician progress notes found for their 02/21/2024 doctor appointment. In an interview on 04/17/2024 at 2:47 PM, Staff C, Licensed Practical Nurse (LPN)/Assistant Director of Nursing Services, and Staff J, Medical Records Director, stated they did not have the progress notes from Resident 1's doctor appointment on 02/21/2024. Staff J stated they would call and get those notes. In an interview on 04/17/2024 at 3:50 PM, Staff C stated they had just obtained the physician's notes from Resident 1's doctor appointment on 02/21/2024. A joint review of the progress notes showed there were medication orders that did not get implemented. Staff C contacted Staff F, LPN/Resident Care Manager, who stated they had never seen those doctor notes with the medication order changes. Neither Staff C nor Staff F could provide any information what had happened regarding the medication order changes. Staff C stated they thought the new orders may have needed to have been clarified. Review of Resident 1's physician After Visit Summary, dated 02/21/2024, showed: -An order for Mirabegron (medication to treat an overactive bladder) to be stopped, review of the February 2024 Medication Administration Records (MAR)/Treatment Administration Records (TAR), showed the medication was continued until 02/26/2024. -An order for Amlodipine (medication to treat high blood pressure) 10 milligrams (mg) to be taken once daily, review of the February 2024 MARs/TARs, showed the facility continued to administer the resident Amlodipine 5 mg twice daily, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505404	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany at Pacific	916 Pacific Avenue 3rd-5th Floors Everett, WA 98201

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	-An order for Tamsulosin (medication to treat an enlarged prostate/urinary retention) to be stopped, review of the February 2024 MARs/TARs showed the facility continued to administer the resident Tamsulosin until 02/23/2024. <RESIDENT 2> Resident 2 admitted to the facility on [DATE]. According to the Annual Minimum Data Set (an assessment tool) assessment, dated 03/11/2024, the resident had no cognitive impairment. In an observation on 04/10/2024 at 11:27 AM, Resident 2 was observed being transferred out of bed into their wheelchair by Staff K, Nursing Assistant Certified (NAC), and Staff L, NAC/Shower Aide. During the transfer, Resident 2 stated they had to miss the morning activity because they were not able to get out of bed because they had to wait for two staff to get them out of bed. Staff K stated they place the resident on the bedpan at 10:00 AM, and then they get the resident up at 11:00 AM, Staff K stated they were not this resident's usual staff. Staff L stated they mostly do showers, so they weren't this resident's usual staff either. The resident stated they need two staff to transfer them, so they had to wait all morning because other staff have their own work to do, and they only come later to be the second person for them, and they have their own work to do. The resident stated by the time staff get them up, their day was over before it even started. Refer to WAC 388-97-1060 (1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505404	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany at Pacific	916 Pacific Avenue 3rd-5th Floors Everett, WA 98201

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 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33954 Based on interview, and record review, the facility failed to obtain and file clinical laboratory reports for 1 of 1 sampled resident (Resident 1) reviewed for lab results. The failure to ensure resident's laboratory results were filed in the resident's clinical record placed them at risk for unmet care needs. Findings included . Resident 1 resided in the facility from [DATE] - 02/26/2024. Review of Resident 1's nursing progress note, dated 02/21/2024 at 7:29 PM, showed Staff F, Licensed Practical Nurse (LPN)/Resident Care Manager, authored a note that indicated the resident had a doctor appointment that day and two lab tests were done. On 04/17/2024, Resident 1's clinical record was reviewed. There were no laboratory results filed in the resident's clinical record from their doctor appointment on 02/21/2024. In an interview on 04/17/2024 at 3:50 PM, Staff F and Staff C, LPN/Assistant Director of Nursing Services, were unable to provide any information about the lack of documentation in Resident 1's clinical record from their 02/21/2024 doctor appointment. In a phone interview on 04/18/2024 at 2:04 PM, Staff A, Administrator, was unable to provide any information why the facility had not obtained and filed the lab results from Resident 1's doctor appointment on 02/21/2024. Refer to WAC 388-97-1720 (1)(a)(i)(iii)(2)(l)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505404	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany at Pacific	916 Pacific Avenue 3rd-5th Floors Everett, WA 98201

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 0779 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep signed and dated reports of x-rays and other diagnostic services in the residents record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33954 Based on interview, and record review, the facility failed to obtain and file a radiology report for 1 of 1 sampled resident (Resident 1) reviewed for radiology results. The failure to ensure residents radiology results were filed in their clinical record placed them at risk for unmet care needs. Findings included . Resident 1 resided in the facility from [DATE] - 02/26/2024. Review of Resident 1's nursing progress note, dated 02/21/2024 at 7:29 PM, showed Staff F, Licensed Practical Nurse (LPN)/Resident Care Manager, authored a note that indicated the resident had a doctor appointment that day and a chest X-Ray was done. A review of Resident 1's clinical record on 04/17/2024, showed no chest X-Ray report was filed in the resident's clinical record from their doctor appointment on 02/21/2024. In an interview on 04/17/2024 at 3:50 PM, Staff F and Staff C, LPN/Assistant Director of Nursing Services, were unable to provide any information about the lack of the results of the chest X-ray in the resident's clinical record from their 02/21/2024 doctor appointment. In a phone interview on 04/18/2024 at 2:04 PM, Staff A, Administrator, was unable to provide any information why the facility had not obtained and filed the chest X-Ray results from Resident 1's doctor appointment on 02/21/2024. Refer to WAC 388-97-1720 (1)(a)(2)(l)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505404	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany at Pacific	916 Pacific Avenue 3rd-5th Floors Everett, WA 98201

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33954 Based on interview, and record review, the facility failed to maintain complete, accurate, and accessible clinical records for 3 of 4 sampled residents (Resident 1, 2, and 4) reviewed for care and services. The failure to maintain clinical records in accordance with professional standards of practice placed residents at risk for unmet care needs and diminished quality of life. Findings included . <RESIDENT 1> Resident 1 resided in the facility from [DATE] - 02/26/2024. The resident had diagnoses to include a stroke, heart failure, pneumonia, and breathing difficulties. A review of Resident 1's clinical record on 04/17/2024, showed there were no physician progress notes found for their doctor appointment on 02/21/2024. In an interview on 04/17/2024 at 2:47 PM, Staff C, Licensed Practical Nurse (LPN)/Assistant Director of Nursing Services (ADNS), and Staff J, Medical Records Director, stated they did not have the progress notes from Resident 1's doctor appointment on 02/21/2024. Staff J stated they would call and get those notes. In a joint interview/record review on 04/17/2024 at 3:50 PM, Staff C stated they had just obtained the physician's notes from the resident's doctor appointment on 02/21/2024. A joint review of the progress notes showed there were medication orders that did not get implemented. <RESIDENT 2> Resident 2 admitted to the facility on [DATE]. According to the Annual Minimum Data Set (an assessment tool) assessment, dated 03/11/2024, the resident had no cognitive impairment. In a phone interview on 04/11/2024 at 8:56 AM, Collateral Contact 1 (CC1), a resident advocate, stated there had been care and communication issues regarding Resident 2. CC1 stated there was a care conference regarding these concerns with facility staff on 03/08/2024. In an interview on 04/12/2024 at 8:35 AM, Resident 2 stated they had a care conference with CC1, Staff H, Social Services, and Staff D, Registered Nurse (RN)/Resident Care Manager (RCM), and they discussed the missing clothing, problems being left on the bedpan, waiting too long for toileting assistance, and other issues. A review on 04/12/2024, no documentation could be found in Resident 2's clinical record regarding the care conference done on 03/08/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505404	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany at Pacific	916 Pacific Avenue 3rd-5th Floors Everett, WA 98201

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/12/2024 at 10:35 AM, Staff D stated they were in a care conference for Resident 2 on 03/08/2024. Staff D was asked about there being no documentation made in the resident's clinical record regarding the care conference and what had been discussed, Staff D stated usually they would have done a progress note after a care conference. Staff D denied any knowledge regarding the resident's toileting concerns. In an interview on 04/12/2024 at 12:11 PM, Staff I, Social Services Director, was asked for any documentation Staff H, Social Services, made regarding Resident 2's 03/08/2024 care conference. Staff I stated Staff H did paper documentation, but they were supposed to have updated care conference documentation into the electronic health record. Staff I stated they could not find Staff H's paper documentation of the care conference. In an interview on 04/17/2024 at 10:32 AM, Staff A, Administrator, was unable to provide any information why there was no documentation done by Staff D, or Staff H for the care conference held on 03/08/2024 with Resident 2 and CC1. <RESIDENT 4> The resident resided in the facility from [DATE] - 04/06/2024. Review of Resident 4's Medication Administration Records/Treatment Administration Records, dated 04/01/2024 through 04/06/2024, showed when Resident 4 discharged from the facility, they had current orders for four different topical (medication relating to being applied directly to the body) treatment medications. Review of Resident 4's discharge instructions, dated 04/06/2024, showed a form titled Medications discharged With Resident, the form did not include any of the resident's four topical treatment medications. In a phone interview on 04/16/2024 at 2:43 PM, Resident 4 stated they did not discharge with all their necessary treatment medications. In an interview on 04/17/2024 at 12:29 PM, Staff C stated they normally send resident medications home with them, and they document how many medications they send, but they don't document treatment medications sent on the form, but they still send them home with the resident. Staff C stated for Resident 4 they couldn't say for sure which medications were sent home with them. Staff C stated treatment medications were individualized, not house stock, and they were labeled with the resident's name. In a phone interview on 04/18/2024 at 9:56 AM, Resident 4 stated they did not discharge with all their necessary treatment medications. Refer to WAC 388-97-1720 (1)(a)(i)(ii)(iii)(iv)(b)(2)(c)(h)