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	05/16/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 40998 Based on interview, and record review, the facility failed to provide a written notice to the resident, resident's representative(s), and representative of the Office of the State Long-Term Care Ombudsman of an emergency transfer for 3 of 5 residents' (Resident's1, 2, and 3) reviewed for hospitalization s. This failure did not afford residents and/or their representatives to make informed decisions about transfers and prohibited access to an advocate who could inform the resident/representative of their options and rights. Findings included . Review of facility policy titled, Transfer and Discharge, revised on 05/01/2024, showed It is the policy of this facility to permit each resident to remain in the facility, and not initiated transfer or discharge for the resident from the facility, except in limited circumstances. The policy showed Emergency Transfers/Discharges are initiated by the facility for medical reasons to an acute care setting such as hospital, for the immediate safety and welfare of a resident. Provide a notice of transfer and the facility's bed hold policy to the resident and representative as indicated. Social services or designee, will provide copies of notices for emergency transfers to Ombudsman, but may send when practicable. The resident will be permitted to return to the facility upon discharge from the acute care setting. In situations where the facility decides to discharge the resident while the resident is still hospitalized , the facility will send a notice of discharge to the resident and representative before the discharge and must also send a copy of the discharge notice to the Ombudsman at the same time. <RESIDENT 1> Resident 1 was transferred to the hospital on 04/20/2024. A review of the resident's clinical records showed no evidence of documentation regarding completion of a transfer/discharge form or any notification to the resident and/or the resident's representative or the Office of the State Long-Term Care Ombudsman for the facility-initiated discharge/hospitalization . <RESIDENT 2> (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 2 was transferred to the hospital on 04/15/2024. A review of the resident's clinical records showed no evidence of documentation regarding completion of a transfer/discharge form or any notification to the resident and/or the resident's representative or the Office of the State Long-Term Care Ombudsman for the facility-initiated discharge/hospitalization . <RESIDENT 3> Resident 3 was transferred to the hospital on 02/22/2024. A review of the resident's clinical records showed no evidence of documentation regarding completion of a transfer/discharge form or any notification to the resident and/or their representative or the Office of the State Long-Term Care Ombudsman for the facility-initiated discharge/hospitalization . During a joint interview/record review on 05/16/2024 at 1:50 PM, Staff A, Administrator, stated Resident 1 had not been activated into the system and there were no transfer/discharge notices completed for Resident 1, 2 or 3, when they went out to the hospital after a facility-initiate discharge. Refer to WAC 388-97-0120 (2)(a-d)

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 40998 Based on interview, and record review, the facility failed to provide a bed hold notice in writing at the time of a resident transfer to the hospital or within 24 hours of transfer to the hospital for 3 of 5 residents (Residents 1, 2, and 3) reviewed for hospitalization s. This failed practice placed residents or their representative at risk for lack of knowledge regarding the right to hold their bed while they were at the hospital. Findings included . Review of the facility's policy titled, Bed Hold Policy, dated 05/01/2024, stated the facility will provide written information to the resident and/or representative regarding bed hold policies prior to transferring a resident to the hospital or the resident goes on therapeutic leave. <RESIDENT 1> A review of Resident 1's hospital admission information showed the resident discharged from facility to the hospital on 04/20/2024. <RESIDENT 2> A review of Resident 2's current nursing progress notes and admission/discharge history, showed the resident discharged from facility to the hospital with a return anticipated on 04/15/2024. <RESIDENT 3> A review of Resident 3's current nursing progress notes and admission/discharge history, showed the resident discharged from facility to the hospital with a return anticipated on 02/22/2024. Review of the medical records for Resident's 1, 2 and 3, showed no documentation the residents' or the resident's representative had been provided with a written bed hold notification at time of their discharge or within 24 hours of discharge. During a joint interview/record review on 05/16/2024 at 1:50 PM, Staff A, Administrator, was unable to provide any information regarding bed holds for Resident 1, 2 or 3. Refer to WAC 388-97-0120 (4)(a-c)

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40998 Based on record review, and interview, the facility failed to complete and transmit resident assessment data to the Centers for Medicare & Medicaid Services (CMS) within the required timeframes for 1 of 5 residents (Resident 1) whose Minimum Data Set (MDS - an assessment tool) assessments were reviewed for timeliness in transmission/submission. The facility's lack of an effective system in ensuring the MDS assessments and tracking records are completed and transmitted timely as required placed all residents of the facility at risk for unmet care needs and diminished quality of life. Findings included . Resident 1 admitted to the facility on [DATE] with diagnoses that included altered mental status, dementia, anxiety, and Chronic Obstructive Pulmonary Disease (lung disease). Review of the MDS tracking record on 05/15/2024 at 12:45 PM, showed an Entry or Discharge MDS assessment had not been completed for Resident 1. In an interview on 05/15/2024 at 2:35 PM, Staff D, Licensed Practical Nurse (LPN)/Admission Nurse, stated the day Resident 1 was transferred to the facility Was an awful day, if I am being honest. Staff D stated they would have never accepted this resident for admission after receiving report from the hospital that the resident had an altered mental status. Staff D stated after a few hours of being in the facility, having provided care to the resident and food, He was too out of it, try to escape, trying to pull out catheter. Staff D stated they spoke with Staff A, Administrator, and the decision was made to send the resident back to the emergency room . In a joint interview and record review on 05/16/2024 at 1:50 PM, Staff A stated Resident 1 was not activated into the computer system, so an entry or discharge MDS were not completed. Refer to WAC 388-97-1000 (5)(a)(e)(iii)