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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>505409 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY COMPLETED<br><br>06/12/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Summitview Rehab and Health Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3801 Summitview Avenue<br>Yakima, WA 98902 |  |

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

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
| <p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922</b></p> <p>Based on interview and record review, the facility failed to address required documentation for Advanced Directives (AD), a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity) including incorporating ADs into the care planning process for 1 of 5 residents (Resident 10) reviewed for ADs. These failures placed the residents at risk of losing their right of having their preferences and/or decisions followed regarding their end-of-life care.</p> <p>Findings included .</p> <p>Review of a policy titled Advanced Directives, dated September 2022, showed when a resident admitted , the facility would inquire about any existing written ADs and if not, would provide the resident or the resident's legal representative assistance and written information with the resident's right to refuse, accept, or formulate an AD. The facility would then document in the resident's medical record the resident's decision.</p> <p>&lt;Resident 10&gt;</p> <p>Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include Rheumatoid Arthritis (a chronic inflammatory disorder that damages the joints and other body systems) and chronic kidney disease. The 04/24/2024 comprehensive assessment showed the resident was cognitively intact and could make their own decisions.</p> <p>During an interview on 06/04/2024 at 10:17 AM, Resident 10 stated they did not have an AD in place but felt they needed to have one. Resident 10 stated they had not been asked about an AD or assisted by the facility regarding formulating an AD since they admitted .</p> <p>During an interview on 06/06/2024 at 3:06 PM, Staff Z, Social Worker, stated they were responsible for addressing ADs with Residents. Staff Z stated they addressed ADs with residents on admission and then quarterly (every 3 months) during their Interdisciplinary Team (IDT) care conferences and they documented the outcome in the box provided on the IDT document.</p> <p>Review of the 02/08/2024 and 04/24/2024 IDT care conference documents showed ADs were not discussed or documented. The documents showed boxes regarding AD's, but they were blank, and the notes did not show ADs were discussed, offered, formulated, or refused.</p> <p>(continued on next page)</p> |

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

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Reference: WAC 388-97-0280(3)(c)(i-ii)</p>   |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48368</b></p> <p>Based on interview and record review, the facility failed to report allegations of abuse and/or neglect to the State Agency for 2 of 3 residents (Residents 27 and 13) reviewed for abuse/neglect. This failure placed the residents at risk for unidentified and ongoing abuse/neglect.</p> <p>Findings included .</p> <p>Review of the Nursing Home Guidelines, or The Purple Book, guidelines dated October 2015 showed facilities were required to report to the state agency immediately when there was a .reasonable cause to believe abuse, neglect .has occurred, or On the reporting log within 5 days of discovery.</p> <p>Review of facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 04/2021, showed, the facility would report of all alleged violations of abuse/neglect to the required agencies within specified timeframes required by Federal requirements.</p> <p>&lt;Resident 27&gt;</p> <p>Review of the resident's medical record showed the resident was admitted to the facility on [DATE] with diagnosis including right femur (thigh bone) fracture. The comprehensive assessment dated [DATE] showed the resident had an intact cognition.</p> <p>Review of the facility's reporting log for May 2024, showed Resident 27's allegation of abuse had not been logged.</p> <p>Review of a grievance, dated 05/29/2024, showed Resident 27 reported an allegation of abuse involving Staff J, Nursing Technician (NT). Resident 27 stated that Staff J placed their lymphedema wraps (Low-stretch compression wraps or bandages that can reduce swelling caused by lymphedema by putting firm, even pressure on affected areas) to their legs too tight and when they told Staff J they were too tight, Staff J was very rude and yelled at them loudly they are suppose to be tight and are you refusing to get your legs wrapped?</p> <p>During an interview on 06/07/2024 at 10:30 AM, Staff B, Director of Nursing Services (DNS), stated on 05/29/2024 they did not feel like the allegations involving resident 27 were abuse or neglect based on the verbal statements they received. Staff B further stated once they received the written statement from Staff L, Nursing Assistant, (seven days after the incident) they felt it was an allegation of abuse and should have been reported.</p> <p>During an interview on 06/10/2024 at 9:29 AM, Staff A, Administrator, stated the statements from Staff J, NT, and Staff L, should have been written on the same day as the incident and a report made for Resident 27's allegations of abuse. Staff A stated the correct process was not followed in the reporting of Resident 27's allegation of abuse to the state agency.</p> <p>43280</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>&lt;Resident 13&gt;</p> <p>Review of the medical record showed the resident was admitted on [DATE] with diagnosis of an infection of the lower spine region. The 04/09/2024 comprehensive assessment showed the resident was cognitively intact and able to make their needs known.</p> <p>During an interview on 06/05/2024 at 10:37 AM, Resident 13 stated that nursing staff were in their room to provide them care. While Resident 13 turned to their left side and grabbed at the left side rail on their bed to assist the staff with turning, one of the NAs forcefully grabbed the resident's hands off the side rail without stating anything to the resident, did not warn me. The resident stated they could not remember the staff members name but had talked with a nurse who had made the staff member leave Resident 13's room and then the NA was no longer allowed to take care of them. Additionally, the resident was unsure of when the incident had taken place.</p> <p>During an interview on 06/06/2024 at 11:50 AM, Staff K, NA, stated they remembered Resident 13 informing them of how one of the staff grabbed (Resident 13's) arm really rough and took (Resident 13's) hand off the side rail . Additionally, Staff K informed Staff H, Licensed Practical Nurse, about Resident 13's allegation.</p> <p>Review of the facility's reporting log from February through June 2024, showed Resident 13's allegation of abuse had not been logged.</p> <p>During an interview on 06/07/2024 at 11:51 AM, Staff B, DNS, stated the correct process had not been followed because they were not informed of Resident 13's allegation of abuse regarding the NA's rough handling during cares. Staff B stated that all allegations of abuse needed to be reported to the state agency, but they had missed Resident 13's.</p> <p>Reference: WAC 388-97-0640(6)(c)</p> |   |  |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48368</b></p> <p>Based on interview and record review, the facility failed to conduct a thorough investigation into an allegation of abuse for 2 of 3 residents (Resident 27 and 13), reviewed for abuse and neglect. This failure placed the residents at risk for unidentified abuse, unmet care needs, and the continued exposure to abuse and/or neglect.</p> <p>Findings included .</p> <p>&lt;Resident 27&gt;</p> <p>Review of the resident's medical record showed the resident was admitted to the facility on [DATE] with diagnosis including right femur (thigh bone) fracture, high blood pressure, atrial fibrillation (irregular heartbeat) and Lymphedema (swelling caused by a build up of fluids usually in the arms or legs). The comprehensive assessment dated [DATE] showed the resident had an intact cognition and required assistance of one to two staff members for activities of daily living (ADLs, daily actions like dressing, transferring and toileting).</p> <p>Review of the form titled, Quality concern form, dated 05/29/2024, showed Resident 27 went to Staff B, Director of Nursing Services (DNS), with an allegation of abuse involving Staff J, Nursing Technician (NT). Resident 27 stated that Staff J placed their lymphedema wraps (Low-stretch compression wraps or bandages that can reduce swelling caused by lymphedema by putting firm, even pressure on affected areas) to their legs too tight and when they told Staff J they were too tight, Staff J was very rude and yelled at them loudly they are suppose(d) to be tight and are you refusing to get your legs wrapped? While resident 27 was making the report to Staff B, Staff J entered Staff B's office to interject, and at that time Staff J was sent home. Further review of the form showed no follow up or resolution had been determined.</p> <p>Review of the facility's reporting log for May 2024, showed no allegations/incidents involving Resident 27 had been logged.</p> <p>During an interview on 06/07/2024 at 10:30 AM, Staff B stated when they took verbal statements on 05/29/2024 from Staff J and Staff L, Nursing Assistant (NA), they did not feel they were allegations of abuse. Staff B stated they received the actual written statements on 06/04/2024 from Staff J (six days after the allegation), and 06/05/2024 from Staff L (seven days after the allegation). Staff B stated when they received the written statement on 06/05/2024 from Staff L it was determined there was an actual allegation of abuse involving Resident 27 and they called the allegation into the state agency (seven days after the allegation). Staff B further stated they should have obtained written statements the same day and started an investigation for allegations of abuse.</p> <p>43280</p> <p>&lt;Resident 13&gt;</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Review of the medical record showed the resident was admitted on [DATE] with diagnose of an infection of the lower spine region. The 04/09/2024 comprehensive assessment showed the resident was cognitively intact and able to make their needs known.</p> <p>During an interview on 06/05/2024 at 10:37 AM, Resident 13 stated that a NA without stating a reason for doing so, forcefully grabbed the resident's hands off the side rail that they were using to help turn themselves in bed, The resident stated a nurse made the NA leave Resident 13's room and then the NA was no longer allowed to take care of them.</p> <p>During an interview on 06/06/2024 at 11:50 AM, Staff K, NA, stated they remembered talking to Resident 13 about how an NA was rough during cares and grabbed Resident 13's arm to take the residents hands off the side rail they were using to help turn in bed. Staff K stated they had informed Staff H, Licensed Practical Nurse (LPN) about what the resident had stated.</p> <p>Review of the facility's reporting log from February to June 2024, showed Resident 13's allegation of abuse had not been logged.</p> <p>During an interview on 06/07/2024 at 11:11 AM, Staff H stated there was an incident where Resident 13 had made allegations that Staff P, NA, was rude, rough, and fast with cares. Staff H stated they informed the charge nurse that day that Resident 13 was alleging rough handling by Staff P and the charge nurse told Staff H that they would make sure that it was reported. Staff H stated that Staff P continued to work but was not allowed to go back into Resident 13's room.</p> <p>During an interview on 06/07/2024 at 11:51 AM, Staff B, DNS, stated they were not aware of Resident 13s allegations of rough handling by Staff P and that no investigation was completed. Staff B stated the correct process had not been follow and Staff P should have been removed from the schedule so that an investigation into the resident's allegation could have been conducted.</p> <p>Reference: WAC 388-97-0640(6)(a)(b)</p> |   |  |

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| <p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44922</p> <p>Based on observation, interview and record review, the facility failed to recognize a significant change in status assessment needed to be completed for 1 of 2 residents (Resident 18) reviewed for comprehensive assessments who experienced a decline in skin integrity, weight loss, and swallowing and eating abilities. Failure to complete significant change of status care assessment placed the resident at risk for not receiving the care and services they required.</p> <p>Findings included .</p> <p>Review of the Resident Assessment Instrument ([RAI], provides guidance on assessing a residents' health and functional status) manual, dated August 22, 2023, showed a significant change is identified by a decline or improvement in a resident's health that will not resolve itself without staff or clinical interventions, impacts more than one area of the resident's health, and requires a new Minimum Data Set ([MDS], a standardized comprehensive assessment of each resident's functional capabilities and helps nursing home and staff identify health problems and needs) and care plan revisions. The manual further showed the MDS should have been completed within 14 days of the determination of the change.</p> <p>&lt;Resident 18&gt;</p> <p>Review of resident 18's medical records showed the resident admitted to the facility on [DATE] with diagnoses to include right sided weakness due to a stroke (when a blood vessel in the brain ruptures and bleeds or when there's a blockage in the blood supply to the brain) and obesity (excessive body fat). Review of the 05/30/2024 quarterly comprehensive assessment, showed the resident had severe cognitive impairment, required one to two staff assistance for eating, bed mobility, transfers, and repositioning.</p> <p>A concurrent observation and interview on 06/04/2024 at 8:41 AM, showed Resident 18 lying in bed, unable to speak, unable to feed themselves, and would follow movement in the room with their eyes. Staff K, Nursing Assistant, was assisting the resident with eating their breakfast but the resident ate and drank but a few bites and sips of their meal. Staff K stated the resident had declined over the past few months and recently in the past few weeks had become non-verbal. Staff K further stated the resident used to be able to feed themselves, had weight loss, and a huge open pressure injury on their bottom.</p> <p>Review of the Resident's medical records showed, in February 2024, Resident 18 began to show significant weight loss of 22.66 % within the previous six months, then in the same month acquired an unstageable pressure injury (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough [dead tissue within a wound] or eschar [dark, crusty tissue at either the bottom or the top of a wound]). Lastly, in April 2024, Resident 18 had worsening of their eating and swallowing abilities.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 06/04/2024 at 2:22 PM, Resident 18's Representative (RR) stated the resident did not want to have aggressive nutritional life-saving treatment such as enteral tube feeding (delivers liquid nutrition through a flexible tube that goes in through your nose or directly into your stomach or small intestine) to assist with their weight loss.</p> <p>During an interview on 06/12/2024 at 11:14 AM, Staff E, Minimum Data Set Coordinator, stated Resident 18 should have had a significant change MDS completed, and care plan updated to reflect the change in health status the resident had experienced over the past four months. Staff E stated they did not complete the MDS because they had hoped the resident would have improved, but only declined further.</p> <p>During an interview on 06/12/2024 at 11:33 AM, Staff B, Director of Nursing Services, stated their normal process was to discuss residents who have had a decline in their health in their morning meetings to help assist Staff E with identifying those areas. staff B further stated they failed to recognize Resident 18's overall decline in different areas and should have completed a significant change MDS assessment with care plan revisions.</p> <p>Reference: WAC 388-97-1000 (1)(a,b,d),(3)(b),(4)(b),(5)(a)</p> <p>Reference F-tag 686</p> |

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| <p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922</b></p> <p>Based on observation, interview, and record review the facility failed to review and validate the Preadmission Screening and Resident Reviews ([PASARR], an assessment to ensure individuals with serious mental illness [SMI] or intellectual/developmental disabilities are not inappropriately placed in nursing homes for long term care) were correct on admission nor corrected/updated as needed for 2 of 5 residents (Residents 26 and 36) reviewed for PASARR. This failure placed the residents at risk for not receiving the care and services appropriate for their needs.</p> <p>Findings included .</p> <p>&lt;Resident 26&gt;</p> <p>Review of the resident's medical records showed the resident admitted to the facility on [DATE] with a diagnosis of schizophrenia (a mental disorder characterized by reoccurring episodes of psychosis [a loss of contact with reality] that are correlated with a general misperception of reality) disorders. The 03/14/2024 comprehensive assessment, showed Resident 26's cognition was severely impaired and daily decision-making skills were difficult for the resident when placed in new situations. The assessment further showed the resident experienced hallucinations (an experience involving the apparent perception of something not present) and delusions (a false belief or judgment about external reality, held despite being given evidence to the contrary, as a symptom of SMI).</p> <p>During an observation on 06/05/2024 at 10:28 AM, Resident 26 was on the 700 hallway in their wheelchair (w/c), self-propelling with no direction and appeared with a confused look on their face with their eyebrows downward.</p> <p>During an observation on 06/10/2024 at 9:37 AM, Resident 26 was on the 700 hallway in their w/c and stopped a nursing assistant (NA) as they were walking by. The Surveyor observed the resident tell the NA that they were being watched and pointed to the surveyor. The Surveyor was standing close to the nurse's station at one end of the hall and the resident was outside of their room at the other end of the hall.</p> <p>Review of Resident 26's 02/22/2023 PASARR document, showed the resident had a diagnosis of schizophrenia disorders and was assessed to be an exempted hospital discharge (a condition in which a resident can be admitted to a nursing facility without having a PASARR level II [to confirm that an individual has a mental illness or intellectual disability and assesses their need for specialized services] completed prior to admission). According to the PASARR document, a physician, Advanced Registered Nurse Practitioner, or Physician's Assistant must sign to validate section III of the PASARR document to qualify as an exempted hospital discharge. Section III of the PASARR document was blank.</p> <p>During an interview on 06/12/2024 at 11:11 AM, Staff Z, Social Worker, and Staff AA, Social Services Designee, stated they were responsible for reviewing and updating PASARR's on admission and if incorrect, they would ensure they were corrected prior to the resident's admission to the facility. Staff Z and Staff AA were not knowledgeable in the exempted hospital discharge requirements and overlooked that on Resident 26's PASARR. Staff Z reviewed the PASARR and stated the PASARR had not been appropriately filled out or signed and was incorrect.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>48368</p> <p>&lt;Resident 36&gt;</p> <p>Review of the resident's medical records showed they were admitted to the facility on [DATE] with diagnoses including delusional disorder (a type of mental health condition in which a person cannot tell what is real from what is imagined) and developmental disorder (impairments in physical, cognitive, language, or behavioral development). The comprehensive assessment dated [DATE] showed that resident had an impaired cognition and required extensive assist of one staff member for activities of daily living.</p> <p>Review of a Physicians visit note dated 07/25/2023, showed a diagnosis of Paranoid Schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves. It causes a person to fear that others are watching them or trying to harm them) was added for Resident 36.</p> <p>Review of Resident 36's medical record showed no level I or level II PASARR had been updated since the new diagnosis of Paranoid Schizophrenia was added on 07/25/2023.</p> <p>During an interview on 06/06/2024 at 1:47 PM, Staff Z stated they reviewed the PASARR on admission and every quarter (three months). If something major changed with a resident, then they would update the residents PASARR immediately. Staff Z stated they were not aware of the new diagnosis of Paranoid Schizophrenia for Resident 36. Staff Z stated they expected to be notified during the daily morning meeting with any new behavioral diagnosis, and it was just missed.</p> <p>During an interview on 06/07/2024 at 10:17 AM, Staff B, Director of Nursing Services, stated their expectation was the charge nurses were to review the physician's dictation and bring any new changes including new diagnoses to the morning meetings. Staff B stated the correct process was not followed for Resident 36 PASARR.</p> <p>Reference: WAC 388-97-1915 (1)(2)(a-c)</p> |

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| <p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43280</p> <p>Based on interview and record review the facility failed to develop a baseline care plan (BCP) within 48 hours of admission that included resident specific initial goals and treatment plans, nor provide a summary of the required information from the BCP to the resident for 1 of 5 newly admitted residents (Residents 49) reviewed for baseline care plans. This failure placed the residents at risk for a lack of knowledge regarding the initial plan for delivery of care/services and unmet care needs.</p> <p>Findings included .</p> <p>&lt;Resident 49&gt;</p> <p>Review of the medical record showed the resident was admitted on [DATE] with diagnoses including a fracture of their right lower leg bone, that did not require surgery but had a compression bandage (a stretchable cloth that applies pressure when wrapped around a limb to help reduce/prevent swelling) wrapped around a hard immobilization brace (a rigid medical device that holds a joint or bone in place to aid in restricting movement of the injured area to assist with healing) and an open non pressure related left foot wound. The 05/13/2024 comprehensive assessment showed the resident was cognitively intact and able to make their needs known.</p> <p>Further review of Resident 49's medical record showed that a BCP had not been developed. Additionally, Resident 49 had not received a BCP summary of their initial goals, medications, dietary instructions, services/treatment that were to be administered by the facility nor the details of their BCP.</p> <p>During an interview on 06/12/2024 at 12:35 PM, Staff B, Director of Nursing Services, stated that Resident 49 did not have a BCP completed that went over the resident specific initial goals and treatment plans. Staff B stated there was a mix up with communications between the admissions nurse and the Resident Care Manager on who was going to complete it but that it never got done.</p> <p>Reference: WAC 388-07-1060(3)</p> |   |  |

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| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43280</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents received timely treatment and care in accordance with professional standards of practice to prevent facility acquired pressure injury (PI) and worsening of PIs for 2 of 3 residents (Residents 49, and 18) reviewed for PIs. Resident 49 experienced harm when they developed a stage 4 medical device-related PI (MDRPI) to their right lower leg from an immobilization brace (a rigid medical device that holds a joint or bone in place to aid in restricting movement of the injured area to assist with healing) that became infected and resulted in extreme pain. Resident 18 experienced harm when they developed a right buttock PI that worsened, became infected, and required antibiotic treatment. These failures placed residents at risk for medical complications, and unmet care needs.</p> <p>Findings included .</p> <p>Review of the National Pressure Injury Advisory Panel's (NPIAP, the leading expert in PIs/wounds) guidelines and definitions, dated September 2016, defined pressure injury stages as follows:</p> <p>Stage 1 PI has intact skin with a localized area of non-blanchable erythema (redness).</p> <p>Stage 2 PI is a partial thickness skin loss with exposed dermis (the top inner layers of skin).</p> <p>Stage 3 PI is a full thickness loss of skin, in which adipose (fat) tissue is visible in the ulcer. Slough (dead tissue) and or eschar (dried blood and tissue) may be visible, granulation tissue and epibole (rolled or curled under edges) may include with undermining (a pocket of dead space under the visible wound edges) and tunneling (a passageway under the wounds surface which may be shallow or deep and impairs wound closure).</p> <p>Stage 4 PI is a full thickness loss of skin and tissue with exposed or directly palpable fascia (a layer of connective tissue), muscle, tendon, ligament, cartilage, or bone in the ulcer. Epibole undermining and tunneling often occur.</p> <p>Unstageable PI is a full thickness skin and tissue loss to which the extent of the tissue damage cannot be seen.</p> <p>Further review of the NPIAP, Best Practices for Prevention of Medical Device-Related Pressure Injuries in Long Term Care, dated January 2020, showed the medical device should be assessed for the correct size, and fit regarding the individual. Also, the skin under and around the device should be inspected daily and repositioned.</p> <p>&lt;Resident 49&gt;</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>Review of the medical record showed the Resident 49 was admitted on [DATE] with diagnoses including a fracture of their right lower leg bone, that did not require surgery but had a compression bandage (a stretchable cloth that applies pressure when wrapped around a limb to help reduce/prevent swelling) wrapped around a hard immobilization brace and an open non pressure related left foot wound. The 05/13/2024 comprehensive assessment showed the resident was cognitively intact and was able to make their needs known. Additionally, the resident was at risk for pressure injuries, but did not have any PIs during the assessment timeframe.</p> <p>Review of Resident 49's hospital wound care and discharge notes, dated 05/08/2024 showed they had an abrasion (a type of wound) to the left foot and a right lower leg fracture that required immobilization (no other open wound/injuries were noted in the resident's hospital records). Resident 49 was to follow up with their orthopedic provider (a doctor that specializes in injuries to the bone, muscles, joints, and soft tissues) due to their fractured right leg and showed no documented directives on whether the right leg's hard immobilization brace could be removed or had to stay in place.</p> <p>Review of Resident 49's physician's orders showed:</p> <p>On 05/09/2024 resident's right leg fracture was to be assessed once a day and to ensure that the hard immobilization brace was on at all times.</p> <p>On 05/16/2024 wound care provider was consulted for resident's left foot injury.</p> <p>Review of Resident 49's facility provider note dated 05/10/2024 at 2:05 PM, showed the facility staff needed to clarify the removal of the resident's right leg immobilization brace with the orthopedic provider (two days after the resident was admitted ).</p> <p>Review of a nursing progress note on 05/13/2024 at 2:46 PM showed, Staff G, Licensed Practical Nurse/Treatment Nurse (LPN/TN), stated that a call had been placed to the orthopedic provider for clarification of orders to Resident 49's right leg brace (five days after the resident was admitted ).</p> <p>Review of the wound care provider notes dated 05/16/2024 (eight days after the resident was admitted ) showed, Ace-wrapped (a type of compression bandage) immobilization brace on right upper leg has been in place since admission and has not been assessed .strong foul odor emanating (the source or what is producing something) from (Resident 49's) wounds . The wound care providers initial assessment, after removing the compression bandages/hard immobilization brace showed the resident had an infected Stage 4 MDRPI to the right/front lower leg from the immobilizing brace. Additionally, .culture was then obtained for concerns of wound infection ., and urgent follow-up with the orthopedic provider was recommended.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>During an interview on 06/12/2024 at 7:57 AM, when asked about the hard immobilization brace on their right leg, Resident 49 stated their pain when they first admitted was very minimal and then increased as the brace was kept in place around their leg. Resident 49 stated that it had gotten to the point that they were a 10 out of 10 on the zero to 10 pain scale (a method to measure an individual pain intensity, zero equals no pain and 10 is severe pain) and the immobilization brace was .cutting off circulation (how blood moves throughout the human body) . Resident 49 stated they were informing the nursing staff of the increasing pain in their right leg everyday but was told they could not take off the immobilization brace, even though it was hurting. Resident 49 stated that nursing staff told them their right leg would come out of the brace when they saw the orthopedic provider in two weeks.</p> <p>During an interview on 06/12/2024 at 9:52 AM, Staff N, Registered Nurse (RN), stated they had completed the admission assessment on Resident 49. Staff N stated they performed a full skin assessment but did not take off the compression wrap/immobilization brace to assess Resident 49's right leg because the resident did not have orders, when they came from the hospital, clarifying if the immobilization brace could be removed or not. Staff N stated the resident informed them that the compression bandage had recently been changed that day in the hospital. Staff N stated they called the hospital but were told they needed to clarify the orders with the orthopedic provider. Staff N stated that since they were not able to assess Resident 49's right leg skin, the process would be for the treatment nurse to complete the assessment.</p> <p>During an interview on 06/12/2024 at 10:36 AM, Staff H, LPN/TN, stated they were one of the TN that had briefly worked with Resident 49 after they were first admitted to the facility. Staff H stated that Staff G, LPN/TN, worked with the resident the most but they did remember Resident 49 complaining about the right leg immobilization brace and that it was rubbing on the resident's right leg.</p> <p>During an interview on 06/12/2024 at 10:44 AM, Staff G, stated there was some confusion after Resident 49 had arrived in the facility on if the resident's right leg immobilization brace should have been removed or left in place and that they were requesting confirmation from the orthopedic provider. Staff G stated they had not assessed the resident's right leg skin, under the compression bandage, until 05/16/2024 when the wound care provider came in and took it off (eight days after the resident had admitted ). Staff G stated the resident did have a lot of pain in their right leg from the fracture but did not know of any wounds on the resident's right leg until the brace was taken off. Staff G stated that after the hard immobilization brace was removed the resident had immediate pain relief and it seemed like the positioning of the brace was malformed (not having the expected shape) and not fitting correctly, with obvious pressure from the device on the resident's right/front lower leg.getting (Resident 49) out of the brace was significant (regarding the resident pain).</p> <p>During an interview on 06/12/2024 at 12:35 PM, Staff B, Director of Nursing Services (DNS), stated the correct process was not followed for Resident 49 and that nursing staff should have assessed the resident's skin under the compression bandage/hard immobilization brace and confirmed orders for the right leg brace. Staff B stated they had made some attempts to contact the orthopedic provider but were unsuccessful and at that point they should have communicated with the facility provider and or the medical director to clarify what intervention/orders they would have wanted to implement. Staff B stated that Resident 49 should not had to wait eight days to have their orders clarified and skin check completed on the resident's right leg. Staff B stated that the brace could have been too tight and that it was most likely to have caused the resident's right/front lower leg MDRPI that was assessed by the wound care provider.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>During an interview on 06/12/2024 at 2:55 PM, Wound Care Provider, stated they had been consulted to evaluate Resident 49's left foot injury but was informed of a foul odor and drainage that was coming from the resident right leg hard immobilization brace. The wound care provider stated the hard immobilization brace needed to come off on their 05/16/2024 visit and when they assessed Resident 49's right leg skin, they noted the resident acquired a stage four MDRPI. The wound care provider stated it was clear where the hard immobilization brace was applying pressure and made an indentation over the same place that Resident 49 developed the PI.</p> <p>44922</p> <p>&lt;Resident 18&gt;</p> <p>Review of the resident's medical records showed they admitted to the facility on [DATE] with diagnoses to include a stroke (when the supply of blood to the brain is reduced or blocked completely, which prevents brain tissue from getting oxygen and nutrients) with right sided weakness and diabetes (a condition that affects your blood sugar levels and can cause serious complications, including delayed wound healing). The 05/30/2024 comprehensive assessment showed the resident's cognition was severely impaired and was dependent on the assistance of two or more staff for activities of daily living. The assessment further showed the resident was incontinent of their bowel and bladder, was at risk for developing PIs, and had an unhealed stage four PI. The 08/21/2023 comprehensive admission assessment showed the resident's skin was intact and was at risk for developing PIs.</p> <p>During a concurrent observation and interview on 06/04/2024 at 8:41 AM, Resident 18 was observed lying in bed, with the head of their bed elevated and had an alternating air mattress (APM, a therapeutic bed designed to prevent pressure sores and injuries by inflating and deflating air cells within the mattress in a rhythmic pattern). The resident had a blank stare, did not respond when spoken to, but followed movement with their eyes. Staff K, Nursing Assistant (NA), entered to assist the resident with their breakfast and stated the resident had declined in their health and had not been speaking for about a month.</p> <p>Review of Resident 18's medical record from 11/2023 through 06/12/2024 showed the resident's ongoing PIs as follows:</p> <p>11/11/2023, skin breakdown to the crease of the buttocks that was three centimeters (cm, a type of measurement) by 0.2 cm. Cleanse the wound and cover with an appropriate dressing and change per manufacturer's recommendations and PRN (as needed). (nursing progress notes showed this was a partial thickness opened wound, Stage 2 per NPIAP guidelines).</p> <p>02/07/2024, partial thickness, opened area to the right buttock, two cm by one cm. Cleanse, apply barrier cream, and place non-adhering dressing if resident is willing. Resident is allergic to adhesives. One time a day ensure written documentation had been completed.</p> <p>02/15/2024, full thickness, unstageable opened area to the right buttock, four and a half cm by four cm. Cleanse, skin prep to edges, cover with dressing, assess daily, and change per manufacturer's recommendations.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>02/15/2024, open area to the coccyx (tailbone), five cm by 0.2 cm. Cleanse, apply calmoseptine (a brand of skin barrier cream), apply non-adhering dressing, assess daily. One time a day ensure written documentation had been completed.</p> <p>03/05/2024, initiated an APM, to be monitored every shift (115 days after skin integrity began to deteriorate).</p> <p>Review of the 03/22/2024 through 06/06/2024 wound care provider notes and recommendations showed:</p> <p>03/22/2024, initial wound assessment, right buttock, 3.3 cm by 7.2 cm by two cm depth, 6.8 cm undermining, and the wound had visible muscle, tendon/ligament, and tissues exposed. The wound had 90 percent debridement (the process of removing dead skin and foreign material from a wound to reduce the risk of infection and promote healing), had heavy drainage, was macerated (when skin is in contact with moisture for too long and looks lighter, wrinkly, and wet) and had a strong odor. Treatment orders were to place a non-bordered adhesive foam over the wound and change the dressing daily and PRN for accidental removal, saturation, and/or soiling (order was inaccurately transcribed into the electronic health record and did not include to cover the wound with a foam dressing and change daily and PRN).</p> <p>Recommendations:</p> <p>03/22/2024, consider a temporary foley catheter (a tube placed into the bladder and carries the urine outside of the body into a bag connected to the tube) for moisture management due to incontinence (was not ordered or followed up on).</p> <p>03/22/2024, obtain labs, comprehensive metabolic panel ([CMP] measures 14 different substances in your blood), complete blood count ([CBC] provides information about the cells in your blood), high-sensitivity C-reactive protein (CRP-H, measures inflammation in the body. Normal range is zero to five milligrams per Liter [mg/L, a unit of measure]), showed an elevated level at 38.3 mg/L, and the erythrocyte sedimentation rate (ESR, helps detect inflammation and infection. Normal range is zero to 20 millimeters per hour, [mm/hr, a unit of measure]) was elevated at 56 mm/hr. (Labs were obtained on 03/28/2024, six days after ordered and there was no documentation of the facility provider notification or wound care provider regarding abnormal lab results.</p> <p>03/22/2024, obtain an electromagnetic radiation ([X-ray] of the sacrum (a large triangular bone at the base of the spine), a quick, painless test that captures images of the structures inside the body, especially the bones) imaging to rule out osteomyelitis (an infection in the bone) (imaging obtained on 03/22/2024 but not addressed with the wound care provider until 04/18/2024).</p> <p>04/12/2024, referral for infectious disease specialist (this was not ordered or followed up on).</p> <p>04/18/2024, vascular study referral to be completed at the hospital due to discoloration to both lower extremities and treatment guidance. (Notes showed this referral was not followed up on until 05/30/2024, 42 days later).</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>04/18/2024, obtain a re-culture of the wound or polymerase chain reaction quantitative analysis (a test that can detect the presence of specific bacteria) of right buttock tunneling (culture not obtained until 04/22/2024 (four days after ordered, positive for infection on 04/25/2024 and started antibiotic treatment on 04/26/2024 (eight days after ordered).</p> <p>o04/18/2024, wound vac (negative wound pressure therapy, a technique using a suction pump, tubing, and a dressing to remove excess exudate and promote healing in acute or chronic wounds) recommended (was not ordered or followed up on).</p> <p>04/18/2024, magnetic resonance imaging ([MRI, a painless test that produces very clear images of the organs and structures inside your body) to assess bone level involvement in the wound (was not ordered or followed up on).</p> <p>04/25/2024, once antibiotic treatment is in place for 72 hours, initiate the wound vac (was not ordered or followed up on).</p> <p>05/02/2024, please provide update on lab order recommendations and repeat imaging to the sacrum. Please start wound vac if available.</p> <p>05/23/2024, wound care provider inquiring about the initiation of the wound vac for the right buttock wound, since it had not been started and Unable to locate updated labs/imaging, or updates on vascular study to the legs.</p> <p>Despite the wound care provider's recommendations above, there was no follow-up on the foley catheter, wound vac, or the infectious disease referral from 03/22/2024 through 06/06/2024.</p> <p>Review of Resident 18's lab results, obtained on 05/06/2024, showed an abnormal CRP-H level at 34.1 mg/L and no ESR had been obtained per the wound consultant's recommendations.</p> <p>Review of Resident 18's 02/06/2024 Braden skin assessment (a tool used to assess a person's risk for PIs using a scoring system) showed the resident had a score of 11 which placed them at high risk (score of 10-12 was high risk) for pressure injuries.</p> <p>A concurrent observation and interview on 06/07/2024 at 10:48 AM, during Resident 18's right buttock wound dressing change, showed a dressing, saturated with brownish exudate being removed. The wound was unmeasured (nursing staff stated they measured once a week) and observation showed an opened wound, with depth, undermining, tunneling, and visible bone in the wound bed. The wound was cleansed, barrier cream applied to the edges of the wound, packed with three sheets of calcium alginate (a biodegradable dressing made from seaweed that absorbs exudate and forms a gel), and covered with a foam dressing. Staff K stated they recalled going on vacation in October 2023 and when they returned the wound to the right buttock was present. Staff K stated the wound was dime size when they first observed it and the wound had never resolved, it only got bigger.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>During an interview on 06/11/2024 at 10:31 AM, Staff G, LPN/TN, stated when Resident 18's initial PI started they should have had an APM put into place to prevent further skin breakdown and a weekly head to toe skin assessment. Staff G recalled the foley catheter had been discussed, but did not know why one was not initiated, it would have helped with the moisture. Staff G stated they understood Resident 18 was treated with antibiotics for the infection to their right buttock PI in order to prepare them for use of the wound vac but did not know if the facility provider agreed. Staff G could not recall having a provider observe/assess the right buttock PI when they worked prior to the wound care provider's first visit. Staff G stated they had protocols for wounds, and they would enter orders that were not specific like change per manufacturer's recommendations, so they could have the freedom to change it as needed. Staff G stated they did not contact the facility provider prior to changing the type of dressing used or the duration of the days it needed to be changed prior to the wound care provider's recommendations on 03/22/2024. Staff G was unaware the order for daily dressing changes given by the wound care provider were entered incorrectly and Staff G did not complete daily documentation with Resident 18's PI dressing changes as ordered.</p> <p>During an interview on 06/11/2024 at 11:34 AM, Staff B, DNS, stated the charge nurse was responsible for reviewing the wound care provider notes and communicating with the facility providers on cultures, labs or imaging that was recommended, and all communication with the providers should have been documented. At times the facility provider did not agree with what the wound care provider ordered so they would have to wait for them to answer which trying to get clarification from the providers (Medical Director and other attending physicians/providers) had caused some delays in the management of Resident 18's PI. Staff B further stated they would have expected an APM be placed when Resident 18 started with skin issues in November 2023 and that was not done.</p> <p>During an interview on 06/11/2024 at 1:16 PM, Resident 18's Representative (RR), stated they were not asked or informed about a wound vac being used to heal the resident's pressure injury. The RR stated that if the wound vac could heal the wound and Resident 18 could be kept comfortable at the same time, that is what they would want.</p> <p>During an interview on 06/11/2024 at 2:08 PM, Staff D, Attending Physician, stated they had observed the right buttock wound once but did not document on it and did not give orders at that time for wound management. Staff D stated they would expect the wound care provider's recommendations be communicated with the facility provider or a call made to the on-call attending physician so that treatment could be started as soon as possible. Staff D stated they were not aware of the recommendation for the wound vac.</p> <p>During an interview on 06/12/2024 at 10:10 AM, Staff H, LPN/TN, stated when the order was not specific to a certain dressing and showed per manufacturer's recommendations they did not get clarification from any provider and would use the same type of dressing they removed from the previous dressing change. Staff H stated they would assess skin weekly for residents with a high Braden score and did not know why Resident 18 did not have an APM applied until 03/05/2024. Staff H stated they were not aware the wound care provider's order was incorrect but understood that if there was not as much drainage as before they were okay to not change the PI dressing daily. Staff H further stated they understood the wound vac was ordered but never came and did not know why (the wound vac was never ordered). Staff H stated Resident 18 did not have an allergy to adhesive dressings they just did not like them and thought they were uncomfortable.</p> <p>(continued on next page)</p> |   |  |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few  | <p>During an interview on 06/12/2024 at 12:34 PM, Staff I, Charge Nurse, stated they were responsible for reviewing the wound care provider's notes and processed dressing changes, cultures, imaging, and labs when they received them and was not aware of, nor had they communicated with the facility provider regarding Resident 18's recommendations for NWPT, MRI, or the foley catheter. Staff I stated they were not aware the order for the right buttock PI was incorrect and did not update the order after each visit if it remained the same.</p> <p>During an interview on 06/12/2024 at 12:44 PM, Staff C, Resident Care Manager, stated their normal process would be to initiate an APM when the resident was a higher risk for skin issues or started to develop skin issues and could not recall why this was not done for Resident 18. Staff C stated they were unaware the wound care provider requested a foley catheter be used to manage Resident 18's moisture and did not know why the order had not been completed.</p> <p>During an interview on 06/12/2024 at 2:35 PM, Wound Care Provider, stated the DNS communicated that there were stipulations in place and would need permission from the facility providers for labs, cultures, antibiotics, and imaging. The wound care provider stated they would ask the nursing staff about their recommendations and preventative measures and was told by the staff they were being held up by the facility providers. The wound care provider stated they would have expected the staff to follow their dressing recommendations as they were written and to have communicated any recommended changes. The wound care provider further stated they felt the preventative measures could have been used during palliative care (aimed at optimizing quality of life and mitigating suffering among people with serious, complex, and often terminal illnesses) and would continue to make wound care recommendations and it would be up to the facility to implement them.</p> <p>Reference: WAC 388-97-1060(3)(b)</p> |   |  |

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| <p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31168</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident with limited range of motion (ROM) received the necessary services to maintain their level of positioning in their tilt in space wheelchair (a wheelchair that can be tilted from the head rest to the seat of the wheelchair without changing the angle of the whole wheelchair) without further decline for 1 of 1 resident (Resident 20), reviewed for limited ROM and wheelchair positioning. This failure placed the resident at risk for increased pain, skin breakdown, and diminished quality of life.</p> <p>Findings included .</p> <p>&lt;Resident 20&gt;</p> <p>Review of the medical records showed the resident was admitted to the facility on [DATE] with gastric reflux disease, a stroke with left sided hemiparesis (muscle weakness/partial paralysis), significant contractures (shortening of a muscle or tendon resulting in joints and other areas to become stiff) of the which hands, arms, legs, and hips bilaterally. The resident was dependent on staff for all their daily functions which included transfers with a mechanical lift, eating, bathing, oral care, position changes in their wheelchair, or bed and basic hygiene care. The resident had swallowing complications and would pocket liquids in their mouth and cheeks.</p> <p>During an observation on 06/04/2024 at 8:45 AM, the resident was lying on their back in their bed. Resident 20's left arm was stiff and bent at the elbow at the level of the resident's chest. The right arm was bent at the level of the resident's chest with their right hand contracted with a plastic carrot shaped roll in their hand. The resident was able to move their contracted right hand to their mouth and under their chin. There was a bruise to the top of the right hand where the resident rested their chin. The resident's hips and knees were flexed and contracted from the hips and knees at a 90-degree angle with both feet in a foot drop position (due to a neurological condition where the feet are pointed out). The resident was assisted by staff with a mechanical lift to their wheelchair. The wheelchair was tilted back where the lower part of the resident's buttock was flush and resting against the lower back of the wheelchair and pressed on the top edge of the wheelchair cushion that was located under the resident and the resident complained of pain. The resident was taken to breakfast in the dining room where they were assisted with their liquid diet.</p> <p>During an observation on 06/04/2024 at 10:00AM, the resident was in their room seated in their wheelchair tilted back to where the resident was able to look up to see the ceiling. The resident was alone, and liquid was drooling from their mouth. The resident stated their back side (bottom) hurt and wanted to lay down. Additionally, the resident's head and neck were hanging toward their right shoulder, and they were unable to maintain an upright head position. The head rest that was attached to the upper part of the wheelchair for head support did not fit to support the resident's head and neck. There was a neck pillow around the resident's back of the neck but not much support to maintain alignment of the neck and head.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During an observation and concurrent interview on 06/05/2024 at 1:45 PM, the resident was up in their tilt in space wheelchair in their room. The resident's wheelchair was tilted back after their afternoon meal. Staff Q, Nursing Assistant (NA) stated that the resident was tilted back after meals and at times Resident 20's head did hang to the right side by their right upper chest. Staff Q stated the resident could not always hold their head up when they were tired and wanted to lay down. Staff R, NA, who had assisted Staff Q with the mechanical lift to transfer Resident 20 to bed from wheelchair, stated they did not receive formal training on how Resident 20 should be positioned/tilted when up in their w/c other than during mealtimes.</p> <p>During an observation and concurrent interview on 06/06/2024 at 10:39 AM, Staff O, NA prepared the resident for a skin assessment by the wound care nurse and stated the resident's bottom was red. Resident 20's bottom was scarred with previous skin/wound complications that had healed on both sides of the buttock.</p> <p>Review of Resident 20's 05/24/2024 care plan, showed the resident was to have staff change their position of the tilt in space wheelchair for eating and skin pressure relief while seated in their wheelchair.</p> <p>Review of the 06/03/2024 hospice assessment, showed the resident stated they experienced pain in their buttock if they stayed up in their wheelchair too long.</p> <p>During an interview on 06/07/2024 at 2:30 PM, Staff N, Registered Nurse, stated Resident 20's tilt in space wheelchair should have been adjusted and repositioned by staff to decrease pressure on the resident's skin and provide alignment of the resident's position. Staff N stated they recognized the NAs were not consistently providing appropriate positioning for pressure relief and they had witnessed the NAs tilting the resident back after meals. Staff N stated that since Resident 20 pocketed foods/liquids during meals they should be kept in an upright sitting position after meals, or the liquids would leak out of the resident's mouth.</p> <p>Reference: WAC 388-97-1060(3)(d)</p> |   |  |

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| <p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide routine and 24-hour emergency dental care for each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280</b></p> <p>Based on observation, interview, and record review the facility failed to provide prompt routine dental services for 1 of 3 resident (Resident 29) reviewed for dental services. The failure placed the resident at an increased risk for dental care complications and unmet care needs.</p> <p>Findings included .</p> <p>&lt;Resident 29&gt;</p> <p>Review of the medical record showed the resident was admitted on [DATE] with diagnoses including a stroke, severe dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and moderate protein calorie malnutrition (an imbalance between the nutrients your body needs and he nutrient it gets). The 05/13/2024 comprehensive assessment showed the resident had severe cognitive impairment, had difficulty communicating but was usually understood. The resident was dependent on staff for oral hygiene and required maximal assistance from staff with eating.</p> <p>During an interview on 06/05/2024 at 9:19 AM, Resident 29's representative stated they had concerns that Resident 29 had not been seen by a dentist or had their teeth cleaned in over a year.</p> <p>During a concurrent observation and interview on 06/07/2024 at 11:08 AM, showed Resident 29 in their room watching TV. When asked about their teeth the resident smiled and showed that all their teeth were dark gray/black in color and their front bottom tooth was broken in half with the top part missing. Resident 29 stated their teeth did not hurt and they were still able to eat without complications, but their teeth needed to be fixed.</p> <p>During an interview on 06/10/2024, Staff S, Nursing Assistant, stated that Resident 29 had a blackish color to their teeth and a partially broken front tooth, but they were unsure of how the resident's tooth had broken. Staff S stated they assisted the resident with oral care daily but that the resident would refuse when nursing staff would try to brush their teeth but would let them use an oral swab to completed oral hygiene.</p> <p>Review of Resident 29's most recent dental visit, dated 09/22/2022, showed the resident was diagnosed with gingivitis (a mild form of gum disease that causes irritation, redness, swelling and bleeding of the gums). Additionally, the resident was noted to have a chip in a front bottom tooth.</p> <p>During an interview on 06/10/2024 at 9:03 AM, Staff B, Director of Nursing Services, stated they had a contract for a third-party dental service to come into the facility, but it was not renewed and were in the process of trying to get another one completed. Staff B confirmed that Resident 29's last dental appointment was in September 2022, and they had not been seen since then. Staff B stated they should be providing routine dental care and services but had not been able to do so.</p> <p>Reference: WAC 388-97-1060(1)(3)(j)(vii)</p> |   |  |

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| <p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide or obtain dental services for each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31168</b></p> <p>Based on observation, interview and record review, the facility failed to ensure routine dental services were provided for 1 of 2 residents (Resident 20) reviewed for dental services. The failure to act on a routine dental referral for examinations, x-rays, and cleaning, resulted in a delay in treatment and placed the resident at risk for dental pain, difficulty chewing, and unmet dental needs.</p> <p>Findings included .</p> <p>&lt;Resident 20&gt;</p> <p>Review of the medical record showed the resident was admitted to the facility on [DATE] with a stroke, left sided paralysis, significant contractures (shortening of muscle, tendon causes tightening and lack of flexibility and makes movement difficult) of the left and right arms and legs, and many other health related conditions. The resident's 05/24/2024 comprehensive assessment, showed the resident was able to make needs known and was dependent on staff for all needs to include transfers by a mechanical lift, eating, bathing, personal care, oral care, and positioning. There were no identified dental issues.</p> <p>During an observation on 06/05/2024 at 9:00 AM, Resident 20's teeth had a whiteish substance around their bottom teeth and substance in their lower cheek area on both sides of their mouth. The resident's teeth were dark around the base of their teeth in the front and back area with noticeable brownish crusty film on the upper and lower back teeth.</p> <p>Review of the resident's 05/24/2024 care plan, showed the resident was to get their teeth brushed after meals.</p> <p>During an interview on 06/05/2024 at 11:30 AM, the Resident's Representative (RR), stated the staff did not always clean the resident's teeth. The RR stated that it had been years since the facility had referred Resident 20 to routine dental care checkups.</p> <p>During an interview on 06/05/2024 at 1:15 PM, Staff B, Director of Nursing Services (DNS), stated they no longer used their mobile dental services since 2020. Staff B stated the Resident Care Managers were to set up routine appointments for resident's routine dental cares and were to make appointments for residents to see dentists.</p> <p>An observation on 06/06/2024 at 1:17 PM, showed Resident 20's teeth were not clean with some white substances in the resident's lower inner cheek area on both sides. Resident 20's teeth were dark gray at the base of the upper teeth and upper back teeth. There was brownish crusty film on the resident's upper and lower back teeth.</p> <p>Review of Resident 20's last routine dental service clinical note, showed that on 06/16/2021 the resident was seen by a mobile dental service. The 06/16/2021 dental note stated there were no signs/symptoms of infection and there was generalized tooth wear due to bruxism (teeth grinding).</p> <p>Reference: WAC 388-97-1060 (2)(c), (3)(j)(v)(ii)</p> |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280</b></p> <p>Based on observation, interview, and record review, the facility failed to implement components of their infection prevention and control precautions for, 1) hand hygiene and glove change for 3 of 10 staff (Staff BB, CC, and DD) reviewed during resident cares and wound treatment, 2) central venous catheter (central line, a tube often place through the skin in a large vein in the neck, chest or groin so that the tip of the tube sits near the heart in order to give medication/fluids or to collect blood and can remain in place for a longer period of time than normal venous catheters) sterile (free from bacteria ,totally clean) dressing change for 1 of 1 resident (Resident 8) reviewed for infection control practices, and 3) use of Personal Protective Equipment (PPE) in an enhanced barrier precautions (EBP, indicated with high contact resident care activities with an infection, a long term wound, central line device or colonization [the presence of a bacteria that has not yet started its infection process] of an multi drug resistant organism) room for 1 of 3 staff (Staff C) reviewed for PPE with EBP. These failures placed residents at an increased risk for exposure to cross contamination (harmful spread of diseases) and transmission of infectious diseases.</p> <p>Findings included .</p> <p>Review of the facility's policy titled, Handwashing/Hand Hygiene, updated October 2023, showed that hand hygiene was to be implemented to reduce the harmful spread of infections in the nursing home. The policy further showed common situations that required staff to perform hand hygiene were before/after contact with a resident, before handling clean or soiled dressings, before moving from a contaminated body site to a clean body site during resident care, before/after assisting a resident with meals, after touching the resident's environment, and immediately after glove removal.</p> <p>Review of Centers for Disease Control and Prevention recommendations titled, Central line-associated Bloodstream Infection (CLABSI) Basics, updated 02/21/2024, showed an implanted port, which is placed surgically under the skin, was a type of central venous catheter otherwise known as a central line. All central lines accessed a major vein that is close to the heart and was more likely to be a source of serious infection.</p> <p>Review of Lippincott's nursing procedures manual, 8th edition, Sterile Technique, Basic and Central Venous Access Catheters, dated 2019, showed some key points when donning (to put on) sterile gloves (special disposable gloves that come sterile in a package) were, to perform hand hygiene prior to donning sterile gloves, to not touch the skin of arm or sleeve with the outer sterile part of the gloves, to not touch nonsterile surfaces during the donning process. During dressing changes the sterility and integrity of the device must be maintained at all times to reduce the risk of infection and that failure to follow sterile technique (is maintaining sterility and is the use of a practice that restrict bacteria in the environment and prevent cross contamination of a central line) may result in infection.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Review of the undated facility's policy titled, Catheter Insertion and Care, showed that implanted port dressing changes were to be performed using sterile technique with donning (to put on) sterile gloves. Additionally, the policy showed that during the dressing change procedure after staff had removed the old dressing, they would prepare a sterile field, don sterile gloves and clean implanted port site with chlorhexidine (a type of liquid disinfectant use on human skin to prepare a site) while maintaining sterility.</p> <p>Review of the undated Center for Disease Control and Prevention facility guidelines titled, EBP, showed that staff were to wear gloves and a gown for the following high-contact resident care activities .device care or use: central line .</p> <p>&lt;Hand Hygiene&gt;</p> <p>&lt;Resident 18&gt;</p> <p>Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses to include diabetes (a condition that affects your blood sugar levels and can cause serious complications) and chronic pain. The 05/30/2024 comprehensive assessment, showed the resident had severely impaired cognition and required one to two staff assistance for all activities of daily living. The assessment further showed Resident 18 had an unhealed wound.</p> <p>A concurrent observation and interview of a wound dressing change on 06/06/2024 at 10:48 AM, showed Staff CC providing incontinent care to Resident 18 prior to their wound dressing change. Resident 18 had a bowel movement (BM) and Staff CC cleaned the BM with wet wipes, removed their BM soiled gloves, applied new gloves they had pulled out of the pocket of their uniform, and did not perform hand hygiene. Then, Staff BB, Licensed Practical Nurse, applied clean gloves, removed, and disposed of Resident 18's saturated wound dressing from their right buttock, and cleansed the wound. Staff BB removed their soiled gloves, applied new gloves, and did not perform hand hygiene. Staff CC stated they knew the normal process was to wash their hands when removing dirty soiled gloves before applying new ones, and it was not their normal process to have/use gloves that had been in their pocket. Staff CC stated they did not follow that process. Staff BB stated they knew the process for hand hygiene when going from a dirty area to a clean area and should have performed hand hygiene in between glove changes. Staff BB stated they did not follow that process.</p> <p>&lt;Resident 14&gt;</p> <p>Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include heart failure and absence of speech. The 03/19/2024 comprehensive assessment, showed the resident's cognition was moderately impaired and required one to two staff assistance for activities of daily living.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>A concurrent observation and interview on 06/05/2024 at 2:34 PM, showed Staff DD, NA, provided incontinent care to Resident 14. Staff DD applied clean gloves, removed the resident's soiled brief, cleansed the resident, and placed a clean brief. Staff DD then removed their soiled gloves and did not perform hand hygiene before continuing to pull up Resident 14's pants and assisting them into their recliner. Staff DD stated they did not need to perform hand hygiene because they had two pairs of gloves on and also carried gloves in their pockets. Staff DD further stated they did not follow their normal process and they did not realize they did not perform hand hygiene nor was it normal practice to apply two gloves.</p> <p>During an interview on 06/11/2024 at 11:34 AM, Staff B, Director of Nursing Services, stated the staff completed hand hygiene training during their skills fair in May 2024 and did not know why Staff BB, CC, and DD did not follow the correct process for hand hygiene. Staff B stated it was not the normal process for the NA's to keep or use gloves that had been placed in their uniform pockets nor were they to be using two gloves at a time to keep from performing hand hygiene. Staff B further stated when moving from a dirty area to a clean area, soiled gloves should have been removed and hand hygiene should have been completed prior to applying clean gloves. Staff B stated Staff BB, CC, and DD did not follow the correct process for hand hygiene.</p> <p>&lt;Central Line&gt;</p> <p>&lt;Resident 8&gt;</p> <p>Review of the resident's medical records showed they were admitted to the facility on [DATE] with diagnoses including after care following spinal surgery, low magnesium (an electrolyte that is responsible for many important functions in the body) blood levels and a right chest implanted port. The 04/02/2024 comprehensive assessment, showed Resident 8 was cognitively intact, able to make their needs known, and had been receiving medication that required an intravenous infusion (IV, a way to administer liquid medication into the body, like through a central line).</p> <p>Observations on 06/07/2024 at 7:43 AM showed Staff W, Registered Nurse (RN), entering Resident 8's room to perform the weekly sterile central line dressing change on the resident's right chest implanted port. During Staff W's process, after preparation of the sterile field and donning sterile gloves, Staff W grabbed the unopened/non-sterile, Huber needle (an IV device designed for implanted ports) and proceeded to prepare the device while not maintaining sterility within their sterile field. Staff W then doffed (to take off) their sterile gloves and donned a pair of non-sterile gloves without performing hand hygiene. Staff W proceeded to grab the chlorhexidine sponge applicator from their sterile field and scrubbed Resident 8's implanted port site without maintaining sterility with their non-sterile gloves. Then using the same gloves, touched Resident 8's bed/gown and their own shirt before donning a new pair of sterile gloves over their non-sterile soiled gloves and broke sterility when the soiled non-sterile gloves came in contact with the outer side of the new donned sterile gloves.</p> <p>During an interview on 06/07/2024 at 8:09 AM, Staff W stated they did not realize they had used non-sterile glove to disinfect the resident's implanted port site until they had gone over the dressing change process with the surveyor. Staff W stated they did not maintain sterility during Resident 8's dressing change, did not follow the process correctly, and that the resident's implanted port was at risk of becoming infected. Staff W stated the sterile dressing change needed to be redone.</p> <p>(continued on next page)</p> |   |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>505409  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY COMPLETED<br><br>06/12/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Summitview Rehab and Health Center   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3801 Summitview Avenue<br>Yakima, WA 98902 |  |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |   |   |  |
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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During an interview on 06/07/2024 at 9:27 AM, Staff B stated that Staff W did not follow the correct process and had not maintained sterility during Resident 8's central line dressing change. Staff B stated the resident dressing would be changed again due to the first not being performed correctly.</p> <p>&lt;PPE&gt;</p> <p>Observation on 06/07/2024 at 10:23 AM showed, Staff C, Resident Care Manager, in Resident 8's EBP room performing a high contact resident care activity, central line dressing change. Staff C had donned gloves but did not don the required gown when entering the EBP room to perform the central line dressing change.</p> <p>During an interview on 06/07/2024 at 10:23 AM, Staff C stated the process for entering a resident room on EBP would be to don a gown and gloves. Staff C stated they should have donned a gown when entering Resident 8's EBP room and performing their central line dressing change.</p> <p>During an interview on 06/10/2024 at 1:23 PM, Staff F, Infection Preventionist, stated that Staff C did not follow the correct process and should have donned a gown when performing a high contact resident care activity for a resident that was on EBP.</p> <p>Reference: WAC 388-97-1320(1)(c)(2)(b)(5)(c)</p> <p>44922</p> |   |  |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48368</p> <p>Based on observation and interview the facility failed to provide a safe, functional, and sanitary environment for 3 of 10 resident rooms (rooms [ROOM NUMBER]) that had large gouges (indentation or groove made in a surface to cause holes or damage)/peeling paint from the walls, 1 of 2 soiled utility rooms (600 hallway), 1 of 2 clean utility rooms (600 hallway), and 1 of 1 laundry room (LR1), reviewed for a safe and sanitary environment. This failure placed staff and residents at an increased risk for infections related to non-cleanable surfaces and not feeling safe/secure with their environment.</p> <p>Findings included .</p> <p>Review of the Document titled, [Name of Facility] Schedule of Charges, dated 04/01/2024, showed part of the services included in the daily rate were, the facility would provide maintenance and housekeeping services to ensure a safe and comfortable environment.</p> <p>Review of the facilities undated job description titled, Director of Building and Grounds, showed, .The Director of Building and Grounds is responsible for monitoring and maintaining all standards for safety and infection control, maintaining a schedule of maintenance service to assure the buildings, grounds and equipment are maintained in a safe and operable manner .</p> <p>&lt;Resident Rooms&gt;</p> <p>An observation of resident room [ROOM NUMBER], on 06/04/2024 at 8:41 AM, showed the wall behind the head of the bed had 2 areas that were round in shape 10 inches (a unit of measure) by eight inches with deep gauges in the sheet rock with missing paint.</p> <p>An observation of resident room [ROOM NUMBER], on 06/04/2024 at 8:46 AM, showed the wall behind the bed had eight vertical deep gouges two feet (ft, a unit of measure) by one inch in the sheet rock and was missing paint.</p> <p>An observation of resident room [ROOM NUMBER], on 06/10/2024 at 9:16 AM, showed the wall behind the bed had four vertical deep gauges 12 inches by one inch in width in the sheet rock and was missing paint.</p> <p>During an interview on 06/10/2024 at 9:25 AM, Staff A, Administrator, stated they would expect wall gauges to be fixed within 48 hours. Staff A further stated their expectation was for the charge nurses to notify maintenance with any repairs that were needed, and they did not know if this had been done.</p> <p>During an interview on 06/10/2024 at 10:15 AM, Staff Y, Director of Building Grounds, stated they normally completed a weekly audit specifically for drywall damages, but they did not audit the 600 hallway resident rooms this last week and should have.</p> <p>&lt;Clean Utility&gt;</p> <p>(continued on next page)</p> |   |  |

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| NAME OF PROVIDER OR SUPPLIER<br><br>Summitview Rehab and Health Center   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3801 Summitview Avenue<br>Yakima, WA 98902 |  |
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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During an observation on 06/04/2024 at 8:50 AM, showed in the clean utility room on the 600-hallway on the left side there was a three ft by two ft piece of plywood unpainted, uncleanable surface. A hole had been cut out for the electrical outlets 10 inches by five inches with jagged edges. The light covers closest to the door had a brown water stain one and a half feet long. The light cover, furthest from the door had a brown water stain a ft long.</p> <p>&lt;Soiled Utility&gt;</p> <p>During an observation on 06/04/2024 at 9:03 AM, showed the soiled utility room on the 600-hallway had 13 holes in the drywall on the left wall, the holes were the diameter of a 1/4 inch screw. The sink located to the right had no back splash, the wall behind the sink had areas of an unpainted, uncleanable surfaces with brown and yellow stains. Above the sink halfway up the wall there was a piece of wood unfinished, unpainted, and uncleanable with three rusty hooks attached to the wood.</p> <p>During an observation and concurrent interview on 06/10/2024 at 10:15 AM, Staff Y, Director of Building Grounds, stated the uncleanable surfaces in the utility's rooms should have been painted and completed and were not. Staff Y stated all the issues they are seeing in both rooms should have been completed. Staff Y further stated they were unaware of these issues because they did not do routine audits on the utility rooms and should start doing that.</p> <p>During an observation and concurrent interview on 06/10/2024 at 2:25 PM, Staff F, Infection Preventionist, stated the surfaces in the clean and dirty utility rooms were not cleanable or sanitary.</p> <p>&lt;Laundry Room&gt;</p> <p>Observation on 06/06/2024 at 2:08 PM showed a water leak coming from the hot water hose on the washing machine. The water was actively leaking onto the floor behind the washing machine where a bucket had been placed but was unable to collect the water where it was leaking onto a three-inch diameter black pipe and then onto the floor of LR1. The floor beneath the washing machine had a four ft by four ft section of laminate flooring that was missing and the water that had been leaking was noted to be spreading underneath the washing machine and through the intact laminate flooring surrounding the washing machine. A thick white chemical substance had accumulated on the side of the washing machine where the water had spread and the laminate flooring surrounding the washing machine had noted bubbling (a condition that occurs when moisture/water penetrates the flooring causing it to have insufficient room for the floor to expand). The wall behind the facility's two washing machines had previous water damage (an accidental leakage or discharge of water that caused possible losses or value of materials) and a one ft by two ft sections of the sheet rock had been waterlogged (saturated or full of water) at one point, that had since dried, with the sheetrock now peeling off the wall.</p> <p>During an interview on 06/06/2024 at 2:39 PM, Staff Y, Director of Building Grounds, stated that the active leak from the hot water hose was not the first leak that had been noted behind the washing machine. Staff Y stated they could see how the water was being soaked up under the laminate flooring, the water damage on the sheetrock wall behind the washing machine and that it was not clean. Staff Y stated that it was time to replace the flooring under the washing machine and fix the water damaged sheetrock/leaking water pipe.</p> <p>Reference: WAC 388-97-3220(1)</p> |   |  |