

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505409	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2025
NAME OF PROVIDER OR SUPPLIER Summitview Rehab and Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3801 Summitview Avenue 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0561</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 and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46722</p> <p>Based on interview and record review, the facility failed to ensure each resident's right to choose important aspects of their life including frequency and type of bathing preferences for 2 of 3 residents (Residents 19 and 29) reviewed for choices. This failure to honor resident choices placed the residents at risk for impaired hygiene and feelings of embarrassment.</p> <p>Findings included .</p> <p>Review of the policy titled, Resident Rights, revised on 02/2021, showed the resident has the right to self-determination and be supported by the facility when exercising their rights.</p> <p><Resident 19></p> <p>Review of the medical record showed Resident 19 was admitted to the facility on [DATE] with diagnosis including Alzheimer's (a progressive disease that destroys memory and other important mental functions), pressure ulcer (a wound that develops when constant pressure on the skin restricts blood flow to the area, leading to tissue damage), and chronic pain. The 01/31/2025 comprehensive assessment showed Resident 19 was dependent on one to two staff members for activities of daily living (ADLs) and had severely impaired cognition. Additionally, the assessment showed it was very important for Resident 19 to choose between a tub bath or a shower.</p> <p>During an interview on 04/14/2025 at 11:12 AM, Resident 19 stated they preferred tub baths and did not like showers. Resident 19 stated the tub bath was more comfortable and they did not like how the shower water sprayed their head and body and made them feel perturbed (a feeling of being anxious or unsettled).</p> <p>Review of Resident 19's nursing assistant (NA) shower record for April 2025 showed the resident's preference for a bath, but showers were provided on 04/03/2025, 04/11/2025, and 04/18/2025.</p> <p><Resident 29></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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0561</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 Resident 29 was admitted to the facility on [DATE] with diagnoses including stroke (happens when the blood supply to part of the brain is suddenly cut off, causing brain cells to die) with left-sided weakness, diabetes (a condition that results in too much sugar in the blood), and dementia (a progressive disease that destroys memory and other important mental functions). The 03/17/2025 comprehensive assessment, showed Resident 29 required substantial/dependent assistance of one to two staff members for ADLs and moderately impaired cognition. Additionally, the assessment showed it was very important for Resident 29 to choose their bathing preference.</p> <p>During an interview on 04/14/2025 at 1:15 PM, Resident 29 stated they had waited over a week for a shower, and it was embarrassing for them to have to ask for one.</p> <p>Review of Resident 29's NA shower record for March 2025 showed they were provided a shower on 03/18/2025 and the next shower was provided on 03/26/2025, eight days later.</p> <p>During an interview on 04/16/2025 at 9:34 AM, Staff R, NA, stated they worked as a shower aide with one more shower aide Monday through Friday. Staff R stated the second shower aide would often have to work elsewhere and would decrease the number of showers and/or baths that could be provided each day.</p> <p>During an interview on 04/18/2025 at 9:09 AM, Staff S, NA, stated residents were provided with one shower or bath per week. Staff S stated usually residents did not request another shower or bath, however when they did, they would be offered a bed bath as it was hard to squeeze residents into the bathing schedule.</p> <p>During an interview on 04/18/2025 at 10:29 AM, Staff A, Administrator, stated the residents should have the choice and be offered what they want for bathing.</p> <p>Reference WAC: 388-97-0180(1)(2)(3)</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46722</p> <p>Based on interview and record review, the facility failed to develop a baseline care plan within 48 hours of admission that included the minimum requirements of resident specific goals, physician orders, dietary orders, treatment plans and social service needs for 3 of 5 residents (Residents 29, 208, and 258) reviewed for baseline care plan. This failure placed residents at risk of not receiving necessary care and services, and a continuity of care.</p> <p>Findings included .</p> <p>Review of the facility's policy titled Care Plans-Baseline, revised March 2022, showed a baseline plan of care would be developed within 48 hours of admission to meet the resident's immediate health and safety needs. The baseline care plan would include effective, person-centered care of the residents and contain the minimum healthcare to include initial goals based on admission orders, discussion with residents/representatives, physician orders, dietary orders, therapy services, and social services.</p> <p><Resident 29></p> <p>Review of the medical record showed Resident 29 was admitted to the facility on [DATE] with diagnoses including stroke (happens when the blood supply to part of the brain is suddenly cut off, causing brain cells to die) with left-sided weakness, diabetes (a condition that results in too much sugar in the blood), and dementia (a progressive disease that destroys memory and other important mental functions). The 03/17/2025, comprehensive assessment, showed Resident 29 required substantial/dependent assistance of one to two staff for activities of daily living (ADLs) and moderately impaired cognition.</p> <p>Review of Resident 29's baseline care plan dated 03/14/2025, showed no resident specific goals or interventions for Resident 29's specific care needs related to physician orders, treatments or social services.</p> <p><Resident 208></p> <p>Review of the medical record showed Resident 208 was admitted to the facility on [DATE] with diagnoses including lumbar osteomyelitis (an infection of the lower spine bones), sepsis (a life-threatening condition caused by the body's response to an infection that can cause organ failure), and urine retention (the inability to completely empty the bladder). A nursing admission note dated 04/10/2025, showed Resident 208 had a peripherally inserted central catheter (PICC, a long thin flexible tube inserted through a vein in the arm and passed through larger veins near the heart to deliver medications and fluids) and a urine catheter (a flexible tube inserted into the bladder to drain urine). The admission notes further showed Resident 208 was alert and oriented and able to make their needs known.</p> <p>(continued on next page)</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>Review of Resident 208's baseline care plan dated 04/11/2025, showed no focus areas, initial goals or interventions for Resident 208's specific care needs related to physician orders, treatments, dietary orders or social services.</p> <p><Resident 258></p> <p>Review of the medical record showed Resident 258 was admitted to the facility on [DATE] with diagnoses including respiratory failure, embolism (blood clot) of the left leg vein, alcohol withdrawal, chronic pain, and edema (excess fluid buildup in the body's tissues). The 04/07/2025 comprehensive assessment, showed Resident 258 required supervision/partial assistance of one staff member for ADLs and had intact cognition.</p> <p>Review of Resident 258's baseline care plan dated 04/06/2025, showed no resident specific goals or interventions for Resident 258's specific care needs related to their medical conditions or social services.</p> <p>During an interview on 04/16/2025 at 1:45 PM, Staff C, Resident Case Manager (RCM), stated the RCM's completed the baseline care plans when a resident was admitted to the facility and were to be fully completed within 48 hours. Staff C stated the baseline care plans were to include the resident's admission diagnoses, immediate goals, medications, types of therapy, specialty orders, and plans for discharge.</p> <p>During an interview on 04/18/2025 at 12:12 PM, Staff B, Director of Nursing, stated the baseline care plan process needed to be improved.</p> <p>Reference WAC: 388-97-1020(3)</p> <p>45642</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642</p> <p>Based on observation, interview, and record review, the facility failed to ensure resident care plans were developed with appropriate interventions for 2 of 2 residents (Resident 18 and 208) reviewed for care planning. This failure to develop care plans with appropriate interventions placed the residents at risk for inadequate or unsafe care.</p> <p>Findings included .</p> <p>Review of the facility's policy dated March 2022, titled Care Plans, Comprehensive Person Centered, showed assessments of residents were ongoing, and care plans were to be revised as information about the residents and/or their condition changed.</p> <p><Resident 18></p> <p>Review of Resident 18's medical records showed they were admitted to the facility on [DATE] with diagnoses to include muscle weakness, right shoulder pain, osteoporosis (a bone disease that weakens and makes bones brittle, increasing the risk of fractures), and dementia (the loss of thinking, remembering, and reasoning to the extent that interferes with Activities of Daily Living [ADLs]). Review of the comprehensive assessment dated [DATE] showed Resident 18 was dependent on staff for care needs and their cognition was severely impaired.</p> <p>An observation on 04/15/2025 at 9:22 AM, showed Resident 18 sitting in their wheelchair with the position of their right arm/hand lying down alongside their right leg. Their fingers were curled under, and their hand was red and swollen.</p> <p>During an observation and concurrent interview on 04/15/2025 at 12:07 PM, the Resident Representative (RR), stated they were waiting for a nurse to check Resident 18's right hand as their hand was very swollen. Resident 18's hand was red, swollen, and hanging down by their right side. The RR stated the resident had an arm rest on their wheelchair at one time to help with the position of their arm/hand. Resident 18 ' s wheelchair did not have an arm through/rest.</p> <p>Review of Resident 18's care plan dated 02/19/2025, showed Resident 18 had an ADL self-care performance deficit related to right-sided weakness. The care plan showed no person-centered interventions for Resident 18's right arm/hand positioning.</p> <p>Review of Resident 18's Kardex (care task assignments for nursing assistants) dated 05/28/2024, posted in the resident's closet, showed no positioning task for the nursing assistants to guide them on positioning of the resident's right arm/hand.</p> <p>During an interview on 04/16/2025 at 10:03 AM, Staff J, Nursing Assistant (NA), stated when providing care for a resident they referred to a care plan that was posted in the resident's closet. Staff J stated the care plan had information such as whether a resident required one or two people for care and transfers, positioning of a resident, and any medical equipment the resident may need to use.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on 04/17/2025 at 11:40 AM, showed Resident 18 in therapy, with their right hand down to their right-side next to their knee. Resident 18's right hand was red and swollen.</p> <p>During an observation and interview on 04/17/2025 at 11:43 AM, Staff I, Resident Case Manager (RCM)/Restorative Coordinator (RC), stated Resident 18 had a right arm trough (an arm rest for a wheelchair) that was broken, and parts had been ordered. Staff I stated the arm trough had been broken and removed in November 2024 (five months ago). Staff I stated they (staff), used a teddy bear to help keep their right hand in an upright position. Resident 18's right hand was red and swollen while doing their therapy. Staff I lifted Resident 18's hand, and the resident voiced to Staff I their right arm was painful with the movement. Staff O, Restorative Assistant (RA), stated the resident needed something to elevate their right hand and arm while doing their therapy. Observation of a small brown, flat teddy bear was lying in Resident 18's lap. Staff I stated the NAs were to be placing a pillow under the resident's right arm for positioning.</p> <p>During an interview on 04/17/2025 at 3:13 PM, Staff I, RCM/RC, acknowledged that Resident 18's care plan did not reflect the residents' use of a right arm through/rest, a pillow, or the teddy bear for positioning of the resident's right arm/hand.</p> <p><Resident 208></p> <p>Review of Resident 208's medical records showed they were admitted to the facility on [DATE], with diagnoses to include heart disease, osteomyelitis (bone infection) of the low back, and urine retention (the inability to completely empty the bladder). Review of the comprehensive assessment dated [DATE] showed the resident was cognitively intact and dependent on staff for their care needs.</p> <p>An observation on 04/15/2025 at 3:29 PM, showed Resident 208 lying in bed with an indwelling urinary retention catheter (a tube that is inserted into your bladder, allowing your urine to drain freely) hanging on the bed rail of their bed.</p> <p>Review of the care plan dated 04/10/2025, showed Resident 208 did not have an indwelling urinary retention catheter. The care plan showed no goals or interventions for the care of Resident 208's indwelling urinary retention catheter.</p> <p>During an observation and concurrent interview on 04/16/2025 at 8:10 AM, Staff P Licensed Practical Nurse, and Staff Q, Nurse Technician, assisted Resident 208 with a transfer to bed. Staff P stated Resident 208 had orders to change their indwelling urinary retention catheter. Staff Q stated the resident had an upcoming appointment with urology (a part of health care that deals with diseases of the male and female urinary tract system) and wanted the catheter changed. Staff Q stated the NAs had information on how to care for a resident in the resident's closets, via the Kardex. The Kardex dated 04/10/2024 showed no task for Resident 208's indwelling urinary retention catheter.</p> <p>During an interview on 04/18/2025 at 9:10 AM, Staff B, Director of Nursing, stated they agreed that resident care plans and revisions should have reflected any changes and care needs of each resident.</p> <p>Reference: WAC 388-97-1020 (1), (2)(a)(b)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31168</p> <p>Based on observation, interview and record review, the facility failed to ensure the provision of bathing, nail care, and oral care for 3 of 10 dependent residents (Residents 26, 41 and 15) reviewed for activities of daily living (ADLs). This failure placed residents at risk for poor hygiene, body odor, dental caries (cavities or tooth decay), decreased self-worth and diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility's policy dated March 2018, titled Activities of Daily Living (ADL's), Supporting, showed appropriate care and services would be provided for residents who are unable to carry out ADLs independently and receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p><Resident 26></p> <p>Review of the resident's medical record showed the resident admitted to the facility on [DATE] with multiple sclerosis (MS-a disease that causes breakdown of the protective covering nerves causing trouble walking, vision changes and numbness). A stroke (happens when the blood supply to part of the brain is suddenly cut off, causing brain cells to die) with right side paralysis (loss of ability to move a body part due to nerve damage), difficulty swallowing, and inability to speak. Review of the 03/05/2025 comprehensive assessment showed Resident 26 was cognitively impaired, rarely spoke, but vision was adequate. The 03/05/2025 assessment showed the resident was impaired on both sides of their body and dependent on staff for all ADLs and could not brush their teeth, dress themselves, or bathe without staff assistance.</p> <p>During an observation on 04/14/2025 at 12:25 PM, Resident 26 was lying in bed with the head of the bed up. When asked if they were doing okay, Resident 26 smiled and nodded their head indicating yes but was unable to verbalize or speak. Resident 26 had food particles in their teeth that were white and brown in between the front upper and bottom teeth. The resident's fingernails were long with a dark brown substance under the fingernails, and their toenails were long.</p> <p>During an observation on 04/15/2025 at 1:00 PM, Resident 26 was sitting up in bed and when asked if they had pain, they shook their head (indicating no). Resident 26's mouth had dark, colored food packed in their upper back teeth. There was a broken tooth on the top left with visible food particles that were white and gray along the gum line. The resident's fingernails were long with dark brown substances.</p> <p>During an interview on 04/15/2025 at 11:00 AM, Staff M, Licensed Practical Nurse (LPN), stated the resident was to have their nails trimmed weekly, and the person who did them before was no longer at the facility, so the task was not being completed. Staff M stated that brushing the resident's teeth after meals was important to maintain clean and healthy teeth and gums.</p> <p>(continued on next page)</p>		

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<p>F 0677</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 04/16/2025 at 12:00 PM, Resident 26 was observed at the assisted dining table with Staff R, Nursing Assistant (NA), who reminded the residents to eat and to take a bite of food. Staff R stated the resident had to be reminded to eat their meal. Staff R stated the only concerns for Resident 26 during meals was to watch if they were not eating and/or prevent them from choking.</p> <p>During an observation on 04/17/2025 at 10:40 AM, Resident 26 was up in wheelchair in front of the television. Resident 26 had food located in their lower back teeth and food particles white in color between their front teeth and side of bottom teeth.</p> <p>Review of the 02/24/2024 care plan showed the resident was to be monitored during meals for holding food in their mouth, pocketing food, choking and refusing to eat. Additionally, the resident was to be cued several times to swallow their food during the meal. Resident 26 was on a mechanical soft diet with nectar thickened fluids (for people with difficulty swallowing and to help them less likely to aspirate while swallowing).</p> <p>Review of the 12/18/2024 Dental Evaluation showed the dentist had to brush and clean out food of Resident 26's mouth to visualize the resident's teeth that were broken and had cavities. There was no follow up for further care.</p> <p><Resident 41></p> <p>Review of the medical record showed the resident was readmitted to the facility with diagnoses to include a stroke with right side paralysis and difficulty with swallowing and speaking. The 04/05/2025 quarterly assessment also showed Resident 41 was alert with impaired cognition and spoke limited English. Resident 41 was dependent on staff for all ADLs.</p> <p>During an observation and concurrent interview on 04/14/2025 at 9:50 AM, Resident 41's fingernails were long with a brown substance under the nails. Resident 41 was scratching their neck and left side with their left hand. During observation of the resident back, brown scratch marks to their left side of their back, neck and chest area were noted. The scratch marks were red on the chest and neck with scratches to the left back side with slightly small, scabbed areas. Resident 41 stated they were itchy and could not stand it (the itching of their skin). Resident 26 stated they needed a bath and continued to state a preference for a bath. The resident had opened their mouth, their teeth were observed to be yellow in color and black and white food particles were between their teeth. Resident 41's breath was odorous with a stale sour smell.</p> <p>During an observation and concurrent interview 04/15/2025 at 3:15 PM, Resident 41's fingernails were dirty with brown substances under the fingernails. The residents' skin on their chest and back was dry. Staff M, LPN, stated Resident 41 could answer questions about their care. Staff M stated the residents receive one bath a week, and resident's oral care should be done between meals and before bed.</p> <p>Review of the Bath Team Schedules for 04/01/2025 through 04/15/2025 showed Resident 41's last shower was 04/01/2025 with a resident refusal of a bed bath on 04/11/2025.</p> <p>(continued on next page)</p>		

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<p>F 0677</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 04/16/2025 at 8:40 AM, Resident 41's fingernails to left and right hands continued to be long with a brown colored substance under the nails. The resident's mouth was with food particles that were white, dark brown and black particle substances between the teeth. Resident 41 had not eaten breakfast yet and continued to scratch their chest and neck with their left hand.</p> <p>During an interview on 04/16/2025 at 9:00 AM, Staff M stated the resident was supposed to have a bath on the evening of 04/15/2025 but was charted as a resident refusal. Staff M stated that the licensed nurses were to clip the resident's finger and toenails but was not documented in the resident's record as completed for two months.</p> <p>During an observation and concurrent interview on 04/17/2025 at 12:19 PM, Staff B, Director of Nursing Services (DNS), observed Resident 41's unclean teeth and stated the oral care and bathing on Resident 41 had not been completed.</p> <p>45642</p> <p><Resident 15></p> <p>Review of the medical record showed the resident was admitted on [DATE], with diagnoses including dementia (the loss of thinking, remembering, and reasoning- to the extent that interferes with ADL's), dysphagia (difficulty swallowing), weakness, and need for assistance with personal care. Review of the comprehensive assessment dated [DATE], showed Resident 15's cognition was severely impaired and was dependent on staff for personal hygiene.</p> <p>During an interview on 04/16/2025 at 2:51 PM, Resident Representative, (RR) stated Resident 15 had been disheveled when they come in to visit. The RR stated the resident's fingernails and toenails were horrible the last time they visited.</p> <p>Review of the Physician orders dated 06/01/2024, showed .provide fingernail and toenail care.Trim nails, remove debris (grime, substances), and clean the resident's hands. Document refusals. Notify MD if any issues are present.</p> <p>During an observation on 04/15/2025 at 11:20 AM, Resident 15 was fully dressed in bed, resting and covered with a blue blanket. The resident's left hand exposed, their fingernails long, dry, flakey and had a brown substance underneath the nails.</p> <p>During an observation and concurrent interview on 04/16/2025 at 2:32 PM, Resident 15 was lying in bed, awake, visiting with their RR. The RR removed the resident's slipper, stated look at their toenails the toenails were raised, long, dry, and flakey. During the same observation Resident 15 had food stuck in their dentures. The RR stated that the resident's dentures do not get brushed regularly.</p> <p>During an interview on 04/16/2025 at 2:46 PM, Staff U, Nursing Assistant (NA), stated they were responsible for the resident's personal care. Staff U stated that the personal care tasks were brief changes, putting on clothing, and setting up or doing the resident's oral care.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/17/2025 at 9:39 AM, Staff S, NA, stated staff used a binder that gives a list for weekly showers. Staff S, stated that they did nail care, skin checks, apply lotion, shaving and sometimes haircuts when bathing/showering a resident. Staff S stated they had no documentation for nail care, skin checks, lotion application, shaving or haircuts.</p> <p>During an interview on 04/18/2025 at 10:13 AM, Staff B, DNS, stated they were aware of Resident 15's lack of nail care. Staff B stated that they had a process in place and that the residents had been receiving nail care services weekly. Staff B stated they had trouble with nail care recently related to losing staff and had to pull the nurse assigned to that task to work on the floor. Staff B stated they were having some issues with getting the residents' nails done.</p> <p>Reference: WAC 388-97-1060 (2)(c)</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31168</p> <p>Based on observation, interview and record review the facility failed to ensure 2 of 3 sampled residents (Residents 41 and 18) reviewed for positioning and range of motion received services to prevent further decrease in range of motion and hand contracture (a permanent tightening of the muscles, tendons, skin and nearby tissues that causes the joints to shorten and become very stiff) through use of assistive devices. This failure increased the resident's risk of being unable to maintain their current level of functioning, increased risk of pain and breaks in skin integrity related to a contracture.</p> <p>Findings included .</p> <p><Resident 41></p> <p>Review of the medical record showed the resident was readmitted to the facility on [DATE] with diagnoses to include a stroke (happens when the blood supply to part of the brain is suddenly cut off, causing brain cells to die) with right side paralysis (loss of ability to move a body part due to nerve damage), and difficulty with swallowing and speaking. The 04/05/2025 comprehensive showed Resident 41 had cognitive impairment with behaviors to include hallucinations. Resident 41 was dependent on staff for all Activities of Daily Living (ADLs).</p> <p>During an observation and interview on 04/14/2025 at 9:48 AM, Resident 41 was observed lying in bed positioned on their right side. The paralyzed right hand was located under the resident's right side. Resident 41 had stated they were in pain and their right shoulder was painful.</p> <p>During an observation and interview on 04/15/2025 at 3:11 PM, showed Resident 41 lying in bed positioned on their right (affected) side, lying on their right upper arm and hand without any support. Staff M, Licensed Practical Nurse, (LPN) stated Resident 41 had a right-hand brace but it had been removed by nursing staff. Staff M stated the resident sustained a right thumb injury due to the splint. Staff M stated Resident 41's arm should have been on a pillow and positioned correctly.</p> <p>During an observation and concurrent interview on 04/16/2025 at 8:20 AM, Resident 41 was in bed lying on their right shoulder, and their lower right arm was underneath their right side. Staff K, Nursing Assistant (NA), stated they were getting Resident 41 up for breakfast. Staff K repositioned Resident 41 to their left side and the resident complained of pain in their right side, right lower wrist and hand. Resident 41's skin to the right lower arm and hand appeared red and swollen. Staff K stated Resident 41 was wearing a soft hand brace, but it had been removed due to a laceration between the thumb and index finger of the right hand. There was no other support or positioning device in place for Resident 41's right arm and hand.</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 04/17/2025 at 9:24 AM, Staff N, Occupational Therapist (OT), stated they had applied a soft wrist/ hand brace to maintain the position of Resident 41's wrist and hand. Staff N stated they were unaware the resident was not wearing their soft hand restraint on their right wrist and hand. Staff N stated had they known the hand brace had been removed, they would have suggested a wrist positioning device to maintain Resident 41's wrist and arm position.</p> <p>Review of Resident 41's 11/15/2025 care plan showed the resident was dependent on staff for turning in bed, transfers with assistance of two to and from wheelchair, positioning of body and right arm /shoulder, assistance with eating, oral care, and bathing. The care plan showed no documentation for the use of the right-hand soft brace application or any intervention for the positioning of the right hand. Review of the 01/17/2025 Bedside Care Plan showed the resident's right arm was painful, but no documentation was found regarding interventions for right arm positioning or devices for Resident 41's right arm or hand.</p> <p>During an interview on 04/17/2025 at 9:50 AM, Staff C, Resident Case Manager (RCM), stated the right hand/ wrist soft brace had been removed to allow healing of the wound between the right thumb and index finger. Staff C stated they did not believe that Resident 41's right arm positioning was an issue and were unaware Resident 41 had not been being positioned correctly.</p> <p>45642</p> <p><Resident 18></p> <p>Review of Resident 18's medical records showed they were admitted to the facility on [DATE] diagnosis to include muscle weakness, lymphedema (a condition causing swelling, typically in the arms or legs, due to a buildup of protein-rich fluid within the tissues), right shoulder pain, osteoporosis (a bone disease that weakens and makes bones brittle, increasing the risk of fractures) and dementia (the loss of thinking, remembering, and reasoning- to the extent that interferes with ADL's).</p> <p>Review of the comprehensive assessment dated [DATE] showed Resident 18's was dependent on staff for care needs and that their cognition was severely impaired.</p> <p>An observation on 04/15/2025 at 9:22 AM, showed Resident 18 was sitting in their wheelchair, their right arm /hand was lying down next to their leg. Their fingers were curled under, their hand appeared red and swollen.</p> <p>During an observation and concurrent interview on 04/15/25 12:07 PM, Resident Representative, (RR), stated Resident 18 had a right arm positioning device on their wheelchair to support their right arm and hand but it was no longer attached to the right arm of the wheelchair. During the 04/15/2025 observation, Resident 18 was seated in their wheelchair their right arm and hand was swollen without a positioning support device to their right arm/hand.</p> <p>Review of Resident 18's Kardex (care task assignment for NAs) dated 5/28/24, posted in the resident's closet, did not show a positioning task for the nursing assistants to guide them on positioning of the resident's right arm/hand.</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 interview on 04/16/2025 at 10:03 AM, Staff J, NA, stated to care for a resident they refer to a care plan that is posted in the resident's closet. Staff J stated the care plan has information such as whether a resident requires one or two people for care and transfers, positioning of a resident and any medical equipment the resident may need to use.</p> <p>An observation on 04/17/2025 at 11:40 AM, showed Resident 18 in therapy, Their right hand was red and swollen hanging down to their right-side next to their knee.</p> <p>During an observation and interview on 04/17/2025 at 11:43 AM, Staff I, Resident Case Manager (RCM)/Restorative Coordinator (RC), stated Resident 18 had a right arm trough (an arm rest for a wheelchair) that was broken and had been removed in November 2024 (5 months ago). Staff I stated they use a teddy bear to help keep the resident's r hand up. During an observation of Resident 18's right hand (red and swollen) while in therapy. Staff I lifted Resident 18's hand, and the resident expressed pain with the movement. Staff O, Restorative Assistant (RA), stated that the resident needed something to elevate her hand and arm during their therapy. Observation of a small brown, flat teddy bear in Resident 18's lap. Staff I stated the NAs were to be placing a pillow under the resident's arm.</p> <p>During an observation and concurrent interview on 04/17/2025 at 11:44 AM, Staff I, RCM / RC, stated Resident 18 had a teddy bear to help keep their right arm/ hand elevated. Observation of the resident's right hand showed it was red and swollen. Staff I lifted the resident's hand, and the resident complained of discomfort with the movement. Staff I stated the nursing assistants were to place a pillow under the resident's arm to assist in the elevation of the resident's right arm/hand.</p> <p>During an interview on 04/17/2025 at 3:13 PM, Staff I, acknowledged Resident 18 did not have any interventions in place for the nursing assistants to follow regarding the positioning of Resident 18's right arm/ hand.</p> <p>Reference: WAC 388-97-1060 (3)(d),(j)(ix)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>45642</p> <p>Based on observation, interview, and record review, the facility failed to provide food at the proper temperatures, appetizing and palatable to taste for 4 of 7 residents (Resident 20, 25, 42, and 43) reviewed for nutrition. This failure placed residents at risk for foodborne illnesses, a decreased nutritional intake, and potential for weight loss.</p> <p>Findings included .</p> <p>Review of the facility's undated policy, titled Food Safety, showed food would be served in such a way as to prevent bacterial growth and served immediately. Additionally, to provide food that is fresh at the proper temperature to keep food safe, wholesome and appetizing.</p> <p><Resident 20></p> <p>During an interview on 04/16/2025 at 11:07 AM Resident 20 stated that they were served eggs daily in their room for breakfast, which were cold, and they are unable to eat them.</p> <p><Resident 25></p> <p>During an interview on 04/16/2025 at 11:10 AM Resident 25 stated that the food served was sometimes cold and reported this to the staff.</p> <p><Resident 42></p> <p>During an interview on 04/16/2025 at 11:15 AM Resident 42 stated that the meal service was too long, and depending on whether they eat in the dining room or in their room, the food was cold on the hallway trays.</p> <p><Resident 43></p> <p>During an interview on 04/16/2025 at 11:22 AM Resident 43 stated that the food is cold by the time it arrived to their room, and they were one of the last ones served.</p> <p>During an observation on 04/16/2025 at 1:09 PM, Staff V, Dietary Manager (DM), served two test trays (1 puree tray and 1 regular texture tray), per request of the survey team, and measured the temperatures of various items on the tray.</p> <p>The following temperatures [in Fahrenheit (F)] were obtained from the two test trays:</p> <p>Tray 1</p> <p>Mashed potatoes - 153.0 F (normal range-180.0 F)</p> <p>Puree cheese pizza - 136.0 F (normal range-155.0 F)</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Mixed vegetables -113.0 F (normal range-135.0 F)</p> <p>Tray 2</p> <p>Cheese pizza - 124.0 F (normal range-155.0 F)</p> <p>Cold slaw - 42.9 F (normal range-40.0 F or below)</p> <p>Ambrosia salad - 44.0 F (normal range-41.0 F or below)</p> <p>During an interview on 04/16/2025 at 1:22 PM, Staff V, DM agreed the temperatures of the food were not at the required temperatures to be served.</p> <p>Reference: WAC 388-97-1100 (1), (2)</p> <p>46722</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46722</p> <p>Based on observation, interview and record review, the facility failed to honor food preferences for 2 of 4 residents (Resident 29 and 32) reviewed for dietary preferences. This failure placed the residents at risk for dissatisfaction with their dining experience and weight loss.</p> <p>Findings included .</p> <p><Resident 29></p> <p>Review of the medical record showed Resident 29 was admitted to the facility on [DATE] with diagnoses including a stroke (happens when the blood supply to part of the brain is suddenly cut off, causing brain cells to die) with left-sided weakness, diabetes (a condition that results in too much sugar in the blood), and dementia (a progressive disease that destroys memory and other important mental functions). The 03/17/2025 comprehensive assessment showed Resident 29 required substantial/dependent assistance of one to two staff for activities of daily living (ADLs) and had moderately impaired cognition.</p> <p>Record review of a document titled, Nutrition Food Preference form, dated 03/28/2025, showed no selections had been identified for likes and/or dislikes, preferences, goals, comments or mealtime, menu and if alternates had been explained to the resident.</p> <p>An observation and interview on 04/14/2025 at 1:04 PM, showed a lunch tray on Resident 29's bedside table. The lunch tray contained a chicken salad sandwich on white bread, cooked broccoli, soup, cola and a cupcake. Resident 29 stated the food was salty all the time. Resident 29 further stated they had not been asked about their food preferences.</p> <p>During an interview on 04/16/2025 at 1:45 PM, Staff C, Resident Case Manager, (RCM), stated they were responsible for performing the resident food preferences when residents were admitted to the facility. Staff C stated they did not always document the resident preferences as they would be too busy to complete. Staff C stated they did not ask Resident 29 if they had any cultural food preferences.</p> <p>During an interview on 04/17/2025 at 9:42 AM, Resident 29 stated their preference for breakfast would be eggs, potatoes and refried beans, lunch would be salad, tomatoes, Mexican rice, refried beans and tortillas and dinner would be Mexican chili and tortillas. Resident 29 stated they preferred fish and salmon for meat options, and fresh fruits and vegetables. Resident 29 further stated the food they were provided did not come hot when served and was usually cold.</p> <p><Resident 32></p> <p>(continued on next page)</p>		

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<p>F 0806</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 Resident 32 was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses to include chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), malnutrition, and arthritis. The 03/21/2025 comprehensive assessment showed Resident 32 required supervision/partial assistance of one to two staff for ADLs and their cognition was intact.</p> <p>Record review of a document titled, Nutrition Food Preference form, dated 03/24/2025, showed no selections had been identified for likes and/or dislikes, preferences, goals, comments or mealtime, menu and if alternates had been explained to the resident.</p> <p>During an interview on 04/14/2025 at 3:00 PM, Resident 32 stated the facility food needed more variety and was bland and repetitive. Resident 32 stated they had asked staff for a banana a few times and it would take a week or two before they would be provided a banana. Resident 32 further stated they asked daily for condiments that included salt, pepper and sugar for their hot tea, as the items had not been provided with their meals even after they had asked for them.</p> <p>During an observation and concurrent interview on 04/16/2025 at 9:50 AM, showed a breakfast tray on Resident 32's bedside table. The breakfast tray contained French toast, oatmeal and mandarin oranges. Resident 32 stated they were not provided with any butter or sugar for their breakfast, and they had told staff they did not like oatmeal but the facility continued to serve oatmeal for breakfast.</p> <p>During an interview on 04/16/2025 at 2:15 PM, Staff V, Dietary Manager, stated they did not discuss food preferences with residents. Staff V stated they would be notified by e-mail by staff when a resident wanted a change to their order or did not like a certain food. Staff V further stated they did not follow up with residents to ensure their change and/or preference was completed.</p> <p>During an interview on 04/16/2025 at 3:39 PM, Staff B, Director of Nursing Services, stated the dietician would speak with residents about their individual food preferences and the dietary aides would speak to each resident daily about what they wanted to eat the following day based off the menu options.</p> <p>During an interview on 04/17/2025 at 10:15 AM, Staff W, Dietary Aide, stated they reviewed with residents daily for the following days meal for any changes they may want to make from the menu. Staff W stated condiments were not always included with meals and should be available in each unit or other staff may obtain from the dining room.</p> <p>During an interview on 04/18/2025 at 10:29 AM, Staff A, Administrator, stated condiments should be on the residents' meal tray when they were served.</p> <p>Reference WAC: 388-97-1120(3)(a)(c)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642</p> <p>Based on observation, interview, and record review, the facility failed to ensure the nutritional refrigerator was kept in a sanitary manner and undated /expired foods were discarded, for 1 of 2 nutritional refrigerators (recreational room refrigerator), reviewed for food safety. This failure placed residents at risk of consuming contaminated, expired foods and obtaining a food-borne (a disease transmitted to people by food) illness.</p> <p>Findings included .</p> <p>An observation on [DATE] at 4:01 PM, of the nutritional refrigerator located in the resident recreation room, showed within the freezer there was a large container of ice cream without a resident's name or a date to show a open or use by date. The freezer contained three chocolate ice cream bars with resident names and had no date of when they were placed in the freezer, or a date of expiration.</p> <p>During the same observation of the nutritional refrigerator, showed a strong foul, sour odor of spoiled food. The shelves were filled with trays of food sitting on top of other plates or boxes of food. The refrigerator had five Jello cups in the refrigerator door with a resident's name and no date, a large birthday cake without a name or date, and a large paper bag with a name and no date, and two zip lock bags with fruit inside.</p> <p>During an interview on [DATE] at 12:19 PM, Staff V, Dietary Manager, stated the kitchen staff did not clean the residents' nutritional refrigerator. Staff V stated the nursing staff had the responsibility for cleaning the nutritional refrigerator.</p> <p>During an interview on [DATE] at 9:28 AM, Staff Y, [NAME] Clerk, stated they were responsible for monitoring the daily temperatures and had not been told that the cleaning of the nutritional refrigerator was their responsibility.</p> <p>During an interview on [DATE] at 11:59 AM, Staff Z, Housekeeper, stated they were unsure who had the responsibility of cleaning the nutritional refrigerator.</p> <p>During an interview on [DATE] at 12:09 PM, Staff H, Infection Preventionist Nurse, stated they were aware of the condition of the residents' nutritional refrigerator and noticed the refrigerator had food with no dates or names on items and that it was a mess.</p> <p>Reference: WAC [DATE] (3)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>45642</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection prevention and control practices were maintained by not performing hand hygiene and glove changes between dirty and clean tasks for 3 of 4 staff (Staff R, T and Q) reviewed during resident cares and dining. This failed practice placed residents at an increased risk for exposure to cross contamination (harmful spread of infections) and the development of communicable diseases.</p> <p>Findings included .</p> <p>Review of the facility's policy dated August 2019, titled Handwashing/Hand Hygiene showed the facility considered hand hygiene the primary means (define or source/action/infection preventions) for preventing the spread of infections.</p> <p><Dining></p> <p>An observation on 04/14/2025 at 11:58 AM, showed Staff R, Nursing Assistant, grabbed Resident 35's spoon and assisted the resident with a bite of food without performing hand hygiene. Staff R then grabbed an unidentified resident's napkin, wiped the unidentified resident's face and then placed the napkin in their hand. Staff R then proceeded to assist Resident 35 with their drink without performing hand hygiene.</p> <p>A dining observation on 04/14/2025 at 12:09 PM, showed Staff T, Nurse Technician (NT), rubbed the shoulder of Resident 30. Staff T then grabbed Resident 12's spoon and fed Resident 12 without performing hand hygiene. Staff T then assisted Resident 15 with a spoon full of food into their mouth, without performing hand hygiene in between the residents.</p> <p><Personal Care></p> <p>An observation on 04/16/2025 at 9:17 AM, showed Staff P Licensed Practical Nurse (LPN), and Staff Q, NT, assisted Resident 208 with a urinary retention catheter (a type of catheter designed to remain in the bladder for an extended period to drain urine) replacement. Staff Q explained the procedure to Resident 208 and began to remove their pants. Staff Q explained they would have to clean their groin area before the nurse began. Staff Q grabbed a cleansing wipe and began to wipe the resident's groin. Staff Q did not change gloves or perform hand hygiene and held onto the resident's hand while Staff P placed the retention catheter. After the procedure, Staff Q, with the same dirty gloves on, explained to Resident 208, they had to clean their groin again and secure a leg strap (an elasticized thigh strap to securely anchor Foley catheters in place) for their retention catheter.</p> <p>During an interview on 04/16/2025 at 9:55 AM, Staff Q, NT, stated they did not realize they had not changed their gloves or performed hand hygiene and acknowledged they should have.</p> <p>During an interview on 04/18/2025 at 9:10 AM, Staff H, Infection Preventionist Nurse, stated they acknowledged the lack of hand hygiene. Staff H mentioned that we constantly reviewed hand hygiene and conducted in-services to discuss the importance of hand hygiene.</p> <p>(continued on next page)</p>		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference: WAC 388-97-1320 (1)(c) 46722