STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505430	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Harmony House Rehab & Nursing	100 River Plaza Brewster, WA 98812

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 40297 Based on interview and record review, the facility failed to implement their Abuse and Neglect Prohibition Policies and Procedures when they failed to report an allegation of abuse to the State Agency (SA) within the required timeframe and failed to complete a thorough investigation for 1 of 2 sampled residents (Resident 23) reviewed for abuse. This failure placed the resident and other residents at risk for repeated abuse. Findings included . The 10/2022 revised facility policy titled Abuse/Neglect/Misappropriation/Exploitation documented the facility protected residents from abuse and neglect by implementing procedures designed to prevent, identify, report, and investigate allegations of abuse and neglect. The policy instructed staff to report immediately to the Abuse Hotline (a SA), but no later than 2 hours after an allegation of abuse or neglect was made if the events that caused the allegation resulted in serious bodily injury, and no later than 24 hours if the events that caused the allegation did not involve abuse or result in serious bodily injury. The policy documented that all alleged incidents of abuse or neglect were thoroughly investigated to determine what occurred and to make necessary changes to the provision of care and services to prevent recurrence. The policy documented a thorough investigation included but was not limited to an interview with the alleged resident victim, the assigned caregiver and caregivers in the immediate area, and a physical examination of the resident. This policy defined sexual abuse as any form of non-consensual contact including but not limited to unwanted or inappropriate touching. The policy instructed staff to evaluate whether the resident had the capacity to consent to sexual activity when determining if the incident met the definition for an allegation of sexual abuse. Appendix D of the October 2015 Nursing Home Guidelines The Purple Book, instructed a facility to report sexual abuse/assault to the SA, log the incident in the facility's Incident Log within 5 days of discovery and notify the police. <Resident 23> A review of the 08/01/2024 significant change assessment documented Resident 23 had medically complex conditions, was cognitively intact, used a wheelchair and was independent with mobility throughout the facility. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505430	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Harmony House Rehab & Nursing	100 River Plaza Brewster, WA 98812

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 01/19/2024 Social Services progress note documented Resident 23 and an unnamed resident were witnessed by staff kissing on the lips while in the dining room. The unnamed resident had severe cognitive impairment and was unable to give consent. The note further documented staff met with Resident 23, who stated they were not aware the unnamed resident was cognitively impaired. Resident 23 stated they understood that any further physical contact would not be appropriate. Resident 23 was assigned to a different table in the dining room, and the unnamed resident was moved to a room closer to the nurse's station to allow closer supervision. Staff A, Administrator, and Staff B, Director of Nursing, were notified of the incident. The January 2024 Incident Log was reviewed and there was no entry on the log that documented the 01/19/2024 observation of a potential sexual abuse incident, that the incident was reported to the SA, investigated, or reported to law enforcement as instructed by The Purple Book. During an interview on 09/09/24 at 8:39 AM, Staff A confirmed the resident observed kissing with Resident 23 currently resided in the facility on the same hall as Resident 23. Staff A acknowledged the 01/19/2024 allegation of sexual abuse had not been logged on the incident log, reported to the SA, and investigated as required and should have been. Staff A agreed an investigation would have allowed the facility to determine the extent of any nonconsensual contact between Resident 23 and other residents, if any. Staff A also confirmed the incident had not been reported to law enforcement. Reference: WAC 388-97-0640(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505430	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Harmony House Rehab & Nursing	100 River Plaza Brewster, WA 98812

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 40297 Based on interview and record review, the facility failed to assess, identify triggers that might prompt a recall of previous traumatic events, and develop care planned goals and interventions for a resident who was a trauma survivor for 1 of 2 sampled residents (Resident 7) reviewed for trauma informed care. This failure placed the resident at risk for re-traumatization, psychological harm and a diminished quality of life. Findings included . The 10/2022 revised facility policy titled Trauma Informed Care described a traumatic event as either a single or enduring repeated or multiple experiences that completely overwhelmed a resident's ability to cope or integrate ideas and emotions involved in that experience. Trauma-Informed Care promoted an environment of healing and recovery rather than practices that might inadvertently re-traumatize a resident. Staff were instructed to screen residents for trauma-informed care needs upon admission and identify the triggers and history of trauma in residents, with the help of family/friends/responsible parties. A care plan was to be developed that aimed to reduce re-traumatization, provide interventions for de-escalation, and provide a safe and secure environment. <Resident 7> A review of the 08/14/2024 annual assessment documented Resident 7 had diagnoses including post-traumatic stress disorder (PTSD, a disorder that developed when a person experienced or witnessed a scary, shocking, terrifying, or dangerous event that usually included a threat to life or a severe injury.) The assessment documented Resident 7 had severe cognitive impairment, was mildly depression, experienced delusions (a false belief or judgment about external reality, held despite undeniable evidence to the contrary), and occasionally rejected care and wandered. Their behavior had worsened compared to the prior assessment. Review of the 09/18/2020 Psychosocial History and Discharge Plan confirmed Resident 7 had a history of traumatic events that might include abuse/neglect, war, assault, PTSD, or natural disasters, for example. The resident also had sleep disturbances and adjustment/mood/behavior problems. A Trauma-informed Care Plan was initiated in this section of the electronic medical record that carried over to the electronic version of the care plan. It documented Resident 7 had a potential alteration in psychosocial well-being related to survivor of traumatic event. The goal was that the resident verbalized feeling safe and secure in their living environment through the next review period. There was no documentation to show what type of traumatic event Resident 7 had experienced, any triggers that could re-traumatize the resident, and what measures the staff needed to take to prevent or de-escalate re-traumatization. A 09/03/2024 revised care plan documented Resident 7's PTSD was related to having served in the military during war time. The goal developed was that triggers of the traumatic event would be minimized. The care plan did not include what the triggers for re-traumatization were. Additionally, there were no interventions to instruct the staff how to minimize or prevent the triggers or de-escalate episodes of re-traumatization. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505430	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Harmony House Rehab & Nursing	100 River Plaza Brewster, WA 98812

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/09/24 at 8:20 AM, Staff D, Social Services Director, stated Resident 7 had a diagnosis of PTSD because of the war. They stated Resident 7's diagnosis was there, but the resident had never displayed any behaviors related to it. Staff D was unable to state what Resident 7's triggers were because the resident had not had any episodes of PTSD, it was just a diagnosis. Staff D acknowledged Resident 7's plan of care lacked clarity and guidance on how the diagnosis of PTSD impacted the resident, what triggers might re-traumatize the resident, what signs or symptoms the resident could exhibit, and what staff were to do to prevent or de-escalate re-traumatization. Staff D stated they needed to do more research to determine what events might trigger Resident 7. During an interview on 09/09/24 at 8:29 AM, Staff E, Nursing Assistant-Registered, stated PTSD was a behavior that came about from previous situations. Staff E stated they were familiar with Resident 7, but they were unsure if Resident 7 had PTSD. During an interview on 09/09/2024 after breakfast hours, Staff F, Nursing Assistant (NAC), described PTSD as people being really stressed and frustrated. Staff F stated they were familiar with Resident 7, but they were unsure if Resident 7 had PTSD. During an interview on 09/09/24 at 1:19 PM, Staff G, NAC, stated that they had heard of PTSD, it stood for post-traumatic stress disorder, but they did not know what that meant. Staff G thought they had received training about PTSD. Staff G was unsure if Resident 7 had PTSD. No Associated WAC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505430	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Harmony House Rehab & Nursing	100 River Plaza Brewster, WA 98812

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on observation, interview and record review, the facility failed to adequately date food items and ensure expired food items were disposed of when indicated during 1 of 1 inspections in the main kitchen. This failure placed the residents at risk for food-borne illnesses. Findings included . Review of the undated facility guideline titled Dry, Refrigerated and Freezer Storage Chart documented proper storage times for opened and unopened dry, refrigerated and frozen food items. The guideline instructed the staff to follow manufacturer's directions and expiration dates and those expiration dates superseded the guidelines. The guideline instructed that once a food item was opened it was not to be stored longer than the total unopened time. An observation and interview in the facility's kitchen on [DATE] at 11:15 AM was completed with Staff C, Dietary Services Manager with the following findings: <REFRIGERATED GOODS> 1. A bag of Caesar salad was dated ,d+[DATE] but had no clear indication if that was the date the food item was received by the facility, or the discard or expiration date. 2. 16 to 20 margarine blocks were undated. 3. Four bags of romaine lettuce had no discard by or expiration date. Staff C stated the staff repackaged the romaine lettuce and did not usually date them. Staff C stated they would find out when the lettuce was to be discarded. 4. One opened bag of celery heads had no discard by or expiration date. The storage chart recommended celery had a storage time of one week. <DRY STORAGE> 1. Five unopened and undated loaves of sliced bread and one opened and undated loaf of bread with about , d+[DATE] of the loaf inside the bag were in the storage area. Staff C stated they did not date the bread; it was used up quickly. The storage chart documented unopened bread was to be stored for four to five days. Opened and unrefrigerated bread was to be stored for 1 day. 2. A jar of basil leaves had no opened or expiration date. The storage chart documented herbs were to be stored for six months, whether opened or unopened. 3. A jar of bay leaves had a handwritten opened date of [DATE]. Staff C acknowledged the food item expired six years ago and disposed of it. The storage chart recommended a storage time for whole spices of one to two years. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505430	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Harmony House Rehab & Nursing	100 River Plaza Brewster, WA 98812

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. A plastic tub with the word cocoa, ,d+[DATE], and ,d+[DATE] handwritten on it had no actual manufacturer label. Staff C confirmed the tub contained cocoa powder, but stated they did not know how long it had been sitting there. 5. Two large cans of chunky light tuna had no discard by or expiration date. The storage chart recommended unopened canned foods, specifically fish and seafood, were to be discarded within one year of receipt by the facility. 6. A gallon bag of opened dry cereal had no opened or expiration date on it. 7. A bottle of [NAME] cooking wine had two dates written on it, ,d+[DATE] as the date received, and , d+[DATE] as the date opened. No year was identified for either date. The storage chart recommended opened [NAME] wine was to be discarded within six to nine months. 8. A bottle of olive oil had an opened date of ,d+[DATE] and no expiration date. The storage chart provided no guidance for the recommended storage time. 9. Eight large bins contained different dry pastas that included spaghetti, macaroni, penne, and lasagna. The pastas were not labeled with an opened date or discard by date. When interviewed on [DATE] at 11:26 AM, Staff C acknowledged that adequate dates had not been documented on the foods identified. Staff C agreed that dating foods allowed staff to know when food items needed to be discarded and how long foods could be stored. Reference: WAC [DATE](3), -2980