| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505434 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lynnwood Post Acute Rehabilitation Center | 5821 188th Street Southwest<br>Lynnwood, WA 98037 |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912<br><br>Based on observation, interview, and record review, the facility failed to ensure the call light (an alerting device for staff to assist residents in need) was within reach for 1 of 1 resident (Resident 102), reviewed for accommodation of needs. This failure placed the resident at risk for delayed care, accidents/falls, and a diminished quality of life.<br><br>Findings included .<br><br>Review of the facility's policy titled, Call Light/Bell, revised in May 2007, showed, Place the call device within resident's reach before leaving room.<br><br>Review of the admission minimum data set (an assessment tool) dated 07/07/2024, showed Resident 102 admitted to the facility on [DATE].<br><br>Observations on 07/16/2024 at 8:33 AM and at 12:18 PM, showed Resident 102's call light was on the floor next to their bed.<br><br>Observation on 07/16/2024 at 12:19 PM, showed Staff O, Certified Nursing Assistant (CNA), entered Resident 102's room and asked the resident if they needed help with their meal. The call light was still on the floor when Staff O exited the room.<br><br>Additional observations on 07/16/2024 at 12:21 PM and 2:40 PM, showed Resident 102's call light was on the floor next to their bed.<br><br>In an interview and joint observation on 07/16/2024 at 2:47 PM, Staff R, CNA, stated that Resident 102 used the call light sometimes. Staff R stated that every time they go into a resident's room, they should check to make sure the call light was within reach for the resident. Joint observation showed Resident 102's call light was on the floor next to their bed. Staff R picked it up and placed it on the bed. Staff R stated the call light was not supposed to be on the floor.<br><br>On 07/19/2024 at 3:22 PM, Staff D, Resident Care Manager, stated they expected resident call lights to be within reach and that staff should be checking the call light placement when checking on residents.<br><br>(continued on next page) |



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

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 07/22/2024 at 10:58 AM, Staff B, Director of Nursing, stated they expected the placement of a resident's call light to be within reach. Staff B stated they expected staff to be checking that a resident's call light was within reach when they went into the residents' rooms and would not expect that a resident's call light to be on the floor from the morning until the afternoon.<br><br>Reference: (WAC) 388-97-0860 (2) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48899<br><br>Based on interview and record review, the facility failed to ensure an advance directive (a written instruction, such as a living will or Durable Power of Attorney [DPOA] for health care) was obtained from the resident and/or their representative and ensure a copy was readily available in the medical records for 2 of 4 residents (Residents 37 & 102), reviewed for advance directives. Additionally, the facility failed to ensure the resident's right to refuse/discontinue medication for 1 of 1 resident (Resident 253). These failures placed the residents and/or their representatives at risk for losing their right to have their preferences honored to receive or refuse/discontinue care according to their choice.<br><br>Findings included .<br><br>Review of the facility's policy titled, Advance Directives, revised December 2023, showed that Advance Directive is a written instruction that relates to the provision of health care when the individual is incapacitated, such as a living will, DPOA for health care. These documents allow the individual to identify choices related to their medical treatment or designated someone to make treatment choices. The policy further showed when an Advance Directive is completed, obtain copy of the Advance Directive and conservatorship/guardianship documents and place in the resident health record.<br><br>RESIDENT 37<br><br>Review of the face sheet printed on 07/22/2024 showed that Resident 37 was admitted to the facility on [DATE].<br><br>Review of Resident 37's Electronic Health Record (EHR) showed no documentation that Resident 37 had an advance directive for health care.<br><br>In an interview and joint record review on 07/17/2024 at 9:49 AM, Staff N, Social Services Director, stated that a copy of Resident 37's DPOA was obtained and placed to their EHR. A joint record review of Resident 37's EHR showed no documentation that Resident 37 had an advance directive for healthcare. Staff N stated, they did not review Resident 37's DPOA document and did not know Resident 37 only had a financial DPOA. Staff D further stated that they should have reviewed the kind of DPOA Resident 37 had.<br><br>In an interview on 07/22/2024 at 12:14 PM, Staff A, Administrator, stated that they expected the facility to follow their advance directives policy.<br><br>46912<br><br>RESIDENT 102<br><br>Review of the admission minimum data set (an assessment tool) dated 07/07/2024, showed Resident 102 admitted to the facility on [DATE].<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility's document titled, Advance Directive Receipt, signed on 07/01/2024, showed Resident 102 had an advance directive and would provide a copy on 07/05/2024 or sooner.<br><br>Review of Resident 102's EHR showed no documentation that Resident 102 had an advance directive for healthcare and only had a financial DPOA on file.<br><br>In an interview and joint record review on 07/17/2024 at 11:23 AM, Staff N stated that a DPOA was a type of advance directive. Joint record review of Resident 102's EHR showed a financial DPOA document. When asked if this was a DPOA for health care, Staff N stated, I don't see anything medical. In a follow up interview at 12:54 PM, Staff N stated they thought any DPOA was for healthcare as well and we are going to ask (Resident 102's representative) if they have an advance directive that is for healthcare.<br><br>In an interview and joint record review on 07/22/2024 at 1:05 PM, Staff A stated that an advance directive could be a financial or a clinical DPOA. In a joint record review of the DPOA document on file for Resident 102, Staff A stated that the document does not show what medical care the resident wants or who they want making medical decisions for them.<br><br>48298<br><br>RESIDENT 253<br><br>Review of the facility's face sheet printed on 07/16/2024, showed Resident 253 was admitted to the facility on [DATE].<br><br>Review of Resident 253's progress note dated 07/11/2024 showed Resident 253 and their representative had declined a new order for an antidepressant (medication to treat depression).<br><br>Review of the July 2024 Medication Administration Record (MAR) showed an antidepressant was administered to Resident 253 from 07/12/2024 to 07/17/2024.<br><br>In a joint record review of the nursing progress note dated 07/11/2024 and interview on 07/18/2024 at 3:50 PM with Staff B, Director of Nursing, showed Resident 253, and their representative declined a new order for an antidepressant. A joint record review of the July 2024 MAR, showed that it was administered to Resident 253 from 07/12/2024 to 07/17/2024. Staff B stated, it [antidepressant] should have been discontinued. I have nothing else to say.<br><br>Reference: (WAC) 388-97-0280 (3)(a) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912<br><br>Based on observation, interview, and record review, the facility failed to identify, initiate, thoroughly investigate, and promptly resolve a grievance for 1 of 1 resident (Resident 17), reviewed for grievances. This failure placed the resident at risk for unmet care needs and a diminished quality of life.<br><br>Findings included .<br><br>Review of the facility's policy titled, Grievances, revised in March 2019, showed, Resident and/or Resident Representatives have the right to file grievances orally or in writing. It further showed that grievance forms are available and are to be initiated when concerns are made.<br><br>Review of the facility's policy titled, Personal Inventory/Missing Items, revised in May 2017, showed a grievance form will be filled out and processed for all non-theft/non abuse allegations.<br><br>Review of the annual minimum data set (an assessment tool) dated 05/05/2024, showed that Resident 17 admitted to the facility on [DATE]. It further showed that Resident 17 was dependent for transfers and used a manual wheelchair.<br><br>Review of the facility's document titled, Medical Necessity for Wheelchair Purchase for Nursing Facility (NF) Clients, signed on 09/23/2023, showed that Resident 17 required a custom wheelchair for positioning and mobility needs.<br><br>Review of the physical therapy note dated 07/02/2024, showed, Pt's [patient's {Resident 17}] .footrest missing, unable to locate.<br><br>Review of the facility provided grievance log from 07/02/2024 through 07/16/2024, showed no listed grievance for Resident 17.<br><br>Observation and interview on 07/18/2024 at 11:05 AM, showed Resident 17 had a custom wheelchair that was missing one footrest. Resident 17 stated they used a wheelchair, that it was missing a footrest and they had to set the bad foot on the other footrest. Resident 17 further stated that the footrest had been missing for four to five weeks and that they told someone who said they were looking into it. When asked how often they used the wheelchair, Resident 17 stated, often, at least five days a week.<br><br>Additional observation on 07/19/2024 at 10:47 AM, showed Resident 17 was up in their wheelchair, with no right footrest, and their right foot was placed on top of their left foot on the left footrest.<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 07/19/2024 at 10:49, Staff Q, Physical Therapist, stated they were looking for the other footrest for the wheelchair for Resident 17 and was not sure how long it had been missing. In a follow up interview at 12:40 PM, Staff Q stated that they had documented on 07/02/2024 that Resident 17 had a missing footrest. Staff Q stated, we have a grievance policy, we look for it first, then notify supervisor, then fill out a grievance form. Staff Q further stated that there should be a grievance for Resident 17's missing footrest.<br><br>In an interview and joint record review on 07/19/2024 at 12:58 PM, Staff N, Social Services Director, stated that if staff noticed a resident had a missing personal item, they expected them to fill out a grievance. Staff N stated that a custom wheelchair was considered a personal item and if a footrest was missing, they expected staff to give me a grievance [form]. When asked if a wheelchair footrest was identified as missing on 07/02/2024 would they expect a grievance form to be filled out, Staff N stated, yes. In a joint record review of the July 2024 grievance log, printed at the time of the interview, showed no grievances listed for Resident 17. Staff N stated that there was no grievance for Resident 17's missing footrest and there should be one.<br><br>In an interview and joint record review on 07/22/2024 at 1:10 PM, Staff A, Administrator, stated they expected staff to follow the grievance process if a resident stated they had a missing item. Staff A stated that a custom wheelchair was considered a personal item and if a footrest was missing, they expected staff to put information in a grievance form and give to me. In a joint record review of the Physical Therapy note dated 07/02/2024, showed that Resident 17 had a missing footrest for their wheelchair. Staff A stated, yes, it's [Resident 17's footrest] missing since July 2nd [07/02/2024]. In a joint record review of the grievance log from 07/02/2024 through 07/16/2024, showed no grievance listed for Resident 17. Staff A stated, If it was reported in the correct manner, it should be on this form.<br><br>Reference: (WAC) 388-97-0460 |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48899<br><br>Based on interview and record review, the facility failed to provide a written transfer/discharge notice to the residents and/or representatives for 3 of 4 residents (Residents 45, 47 & 46), reviewed for hospitalization . This failure placed the residents at risk for not having an opportunity to make informed decision about transfers/discharges.<br><br>Findings included .<br><br>Review of the facility's policy titled, Discharge and Transfer, revised in February 2016, showed that transfer or discharge of a resident will be in writing, in language the resident understands and be given to the resident, resident's surrogate decision maker, if any, and the resident's family.<br><br>RESIDENT 45<br><br>Review of the admission Minimum Data Set (MDS-an assessment tool) dated 05/19/2024, showed Resident 45 was admitted to the facility on [DATE].<br><br>Review of the nursing progress note dated 07/12/2024 showed that Resident 45 was sent to the emergency room due to bleeding.<br><br>Review of the Electronic Health Record (EHR) did not show documentation that a written notice of transfer/discharge was provided to Resident 45 and/or their representative.<br><br>In an interview on 07/17/2024 at 9:09 AM, Staff M, Licensed Practical Nurse, stated that they informed Resident 45's representative by phone and did not provide a written notice describing the reason for hospitalization .<br><br>In an interview on 07/22/2024 at 10:25 AM, Staff D, Resident Care Manager, stated that their process to notify the resident and/or their representative was either by phone or verbally.<br><br>In an interview on 07/22/2024 at 10:33 AM, Staff B, Director of Nursing, stated that they expected the written notice to be provided to the resident and/or their representative.<br><br>46912<br><br>RESIDENT 47<br><br>Review of the discharge MDS dated [DATE], showed that Resident 47 discharged to the hospital on 05/20/2024.<br><br>Review of Resident 47's EHR showed the resident was transferred to the hospital for further evaluation on 05/20/2024. Further review of Resident 47's EHR showed no documentation that Resident 47 and/or their representative were provided written notification of transfer to the hospital.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 07/17/2024 at 11:16 AM, Staff D stated that when a resident transferred to the hospital, they notified residents and/or their representatives verbally, in person and/or a phone call. Staff D stated that it was not their policy to notify residents and/or their representatives in writing and as far as I know just verbally.<br><br>In an interview on 07/22/2024 at 11:14 AM, Staff B stated that they expected staff to provide notification to residents and/or their representatives when transferred to the hospital by telephone, unless in the building. Staff B stated that they did not expect there to be written documentation.<br><br>In an interview on 07/22/2024 at 12:59 PM, Staff A, Administrator, stated that they expected staff to follow the guidelines and regulations for notifying residents and/or their representatives when a resident was transferred to the hospital. When asked if a written notice was provided, Staff A stated, according to the guidelines, it should be.<br><br>47680<br><br>RESIDENT 46<br><br>Review of the discharge MDS dated [DATE], showed Resident 47 admitted to the facility on [DATE], and discharged to the hospital on 06/07/2024.<br><br>Review of the nursing progress note dated 06/07/2024, showed that Resident 47 was sent to the emergency room for evaluation.<br><br>Review of Resident 46's EHR did not show documentation that a written notice of transfer/discharge was provided to Resident 46 and/or their representative.<br><br>In an interview on 07/17/2024 at 12:45 PM, Staff D stated that they do not provide the resident or their presentative a written notice of transfer/discharge. Staff D further stated that they would notify them of the transfer verbally and would not provide them with a written notice.<br><br>In an interview on 07/18/2024 at 2:21 PM, Staff A stated that they expected staff to follow their policy.<br><br>Reference: (WAC) 388-97-0120 (2)(a)(b)(c) |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48899<br><br>Based on interview and record review, the facility failed to ensure bed hold (the opportunity to pay for the bed the resident currently occupied while out of the facility in order to ensure their bed/room was available when they are ready to return) notices were offered to residents and /or their representatives for 3 of 4 residents (Residents 45, 47 & 46), reviewed for hospitalization . This failure placed residents at risk for unwanted, avoidable room changes upon readmission, and frustration.<br><br>Findings included .<br><br>Review of the facility's policy titled, Bed-Hold, revised in December 2023, showed that the resident or their representative shall be informed in writing of their right to exercise the bed hold provision in the event of a transfer from the facility to a general acute care hospital or at the start of a resident's therapeutic leave. The policy further showed that the notice shall include the duration of the State bed hold policy (if any) and /or of the facility's policy that the resident's bed will be held, during which time the resident is permitted to return and resume residence in the facility.<br><br>RESIDENT 45<br><br>Review of the admission Minimum Data Set (MDS-an assessment tool) dated 05/19/2024, showed Resident 45 admitted to the facility on [DATE].<br><br>Review of the nursing progress note dated 07/12/2024 showed that Resident 45 was sent to the emergency room due to bleeding.<br><br>In interview on 07/17/2024 at 10:35 AM, Staff I, Admission Coordinator, stated that the facility was supposed to offer a bed hold notice to resident and /or their representative within 24 hours of the hospital transfer. Staff I stated that they did not offer a bed hold notice to Resident 45 and/or their representative.<br><br>In interview on 07/22/2024 at 12:14 PM, Staff A, Administrator, stated that they expected the facility to follow their bed hold policy.<br><br>46912<br><br>RESIDENT 47<br><br>Review of the discharge MDS dated [DATE], showed that Resident 47 discharged to the hospital on 05/20/2024.<br><br>Review of Resident 47's EHR showed the resident was transferred to the hospital for further evaluation on 05/20/2024. Further review of Resident 47's EHR showed no documentation that Resident 47 and/or their representative was provided a bed hold notice.<br><br>(continued on next page) |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview and joint record review on 07/17/2024 at 10:35 AM, Staff I stated that when a resident transferred to the hospital, they notified residents and/or their representatives via telephone and then would chart a progress note. Joint record review of Resident 47's EHR, showed no documentation that a bed hold was provided to the resident. Staff I stated, there's no note in there. I should've put one in there.<br><br>In an interview on 07/22/2024 at 11:14 AM, Staff B, Director of Nursing, stated that they expected staff to provide bed hold notices to residents and/or their representatives when transferred to the hospital. Staff B stated they expected there to be documentation that a bed hold notice was provided.<br><br>In an interview on 07/22/2024 at 12:59 PM, Staff A stated that they expected staff to follow the policies and regulations for providing bed hold notices to residents and/or their representatives when transferred to the hospital. Staff A stated they expected there to be documentation that a bed hold notice was provided.<br><br>47680<br><br>RESIDENT 46<br><br>Review of the discharge MDS dated [DATE], showed that Resident 47 admitted to the facility on [DATE], and discharged to the hospital on 06/07/2024.<br><br>Review of the nursing progress note dated 06/07/2024, showed that Resident 47 was sent to the emergency room for evaluation.<br><br>On 07/17/2024 at 10:35 AM, Resident 46 stated that they were not informed of a bed hold when they were discharged to the hospital.<br><br>Review of the EHR did not show documentation that Resident 46 and/or their representative were notified of a bed hold notice.<br><br>In an interview on 07/17/2024 at 10:37 AM, Staff I stated that their process was to call the resident's representative within 24 hours, inform them of the bed hold and document it. Staff I stated that they did not see any bed hold notice documentation for Resident 46. Staff I stated that they had a conversation with Resident 46's representative to inform them of the bed hold but did not document it and that they should have.<br><br>In an interview on 07/18/2024 at 2:21 PM, Staff A stated that they expected staff to follow their policy and that it would be documented somewhere.<br><br>Reference: (WAC) 388-97-0120 (4)(a)(b)(c) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680<br><br>Based on interview and record review, the facility failed to ensure a written summary of the baseline care plan was provided to the residents and/or their representatives for 2 of 2 residents (Residents 49 & 102), reviewed for baseline care plan. This failure placed the residents at risk for unmet care needs and a diminished quality of life.<br><br>Findings included .<br><br>Review of the facility's policy titled, Comprehensive Person-Centered Care Planning, revised in December 2023, showed, within 48 hours of the resident's admission, the facility will develop and implement a baseline care plan that includes instructions needed to provide effective and person-centered care. The policy further showed, the facility team would provide a written summary of the baseline care plan to the resident and their representative and would be provided by the time of the completion of the comprehensive care plan. The comprehensive care plan is developed within seven days of completion of the comprehensive Minimum Data Set (MDS-an assessment tool).<br><br>RESIDENT 49<br><br>Review of the admission MDS dated [DATE], showed that Resident 49 admitted to the facility on [DATE]. It further showed that the admission MDS was completed on 07/05/2024.<br><br>On 07/18/2024 at 8:40 AM, Resident 49 stated that they did not remember receiving a summary of their baseline care plan and that they did not remember hearing the term care plan.<br><br>Record review of Resident 49's Electronic Health Record (EHR) did not show documentation that the baseline care plan was reviewed and/or a written summary of the baseline care plan was provided to the resident and/or their representative.<br><br>In an interview on 07/17/2024 at 2:02 PM, Staff D, Resident Care Manager, stated that they verbally went over the baseline care plan with the resident and would offer them a copy. Staff D further stated that it was not documented when a written summary of the baseline care plan was offered to residents' and/or their representative.<br><br>In a follow up interview on 07/18/2024 at 1:03 PM, Staff D stated that they were not able to find documentation that Resident 49 and/or their representative were given and/or offered a summary of their baseline care plan.<br><br>In an interview and joint record review on 07/18/2024 at 1:47 PM, Staff B, Director of Nursing, stated that they developed the baseline care plan within 48 hours and would provide a written summary of their baseline care plan during the initial 72 hour care conference. Staff B stated that it would be documented in the care conference assessment in Point Click Care (charting system). Joint record review of Resident 49's EHR showed no documentation that a care conference assessment was completed. Staff B stated that they expected the written summary of the baseline care plan be provided to Resident 49 and/or their representative during their 72 hour care conference.<br><br>(continued on next page) |

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|---|---|---|---|
| | 505434 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lynnwood Post Acute Rehabilitation Center | 5821 188th Street Southwest<br>Lynnwood, WA 98037 |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 46912<br><br>RESIDENT 102<br><br>Review of the admission MDS dated [DATE], showed Resident 102 admitted to the facility on [DATE]. It further showed that the admission MDS was completed on 07/07/2024.<br><br>Review of Resident 102's EHR showed no documentation that Resident 102 and/or their representative was provided a written summary of their baseline care plan.<br><br>In an interview on 07/18/2024 at 2:16 PM, Staff D stated that they verbally provided a summary of the baseline care plan but did not provide a written summary. When asked if there should be documentation that a written summary was provided, Staff D stated, I've never provided copies of the baseline care plan to residents or families.<br><br>In an interview and joint record review on 07/22/2024 at 11:16 AM, Staff B stated that the baseline care plan was completed within 48 hours of admission and that a written summary was provided to residents and/or their representatives by completion of the comprehensive care plan. Joint record review of Resident 102's EHR showed no documentation that a written summary of the baseline care plan was provided. Staff B stated they expected staff to offer a written summary of the baseline care plan to residents and/or their representatives.<br><br>Reference: (WAC) 388-97-1020 (3) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>46912<br><br>Based on observation, interview, and record review, the facility failed to meet professional standards of practice to ensure 2 of 2 licensed staff (Staff P & Staff F) observed for medication administration followed medication administration practices regarding unlabeled and undated medication at a resident's bed side and pain medication patch application. These failures placed the residents at risk for possible medication errors, potential negative outcomes, and a diminished quality of life.<br><br>Findings included .<br><br>Review of the facility's policy titled, Medication Storage in the Facility, revised in January 2018, showed, when the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated and the nurse shall place a 'date opened' sticker on the medication and enter the date opened. It further showed that the medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.<br><br>Review of the facility's policy titled, Specific Medication Administration Procedure, revised in January 2018, showed, check expiration date on package/container before administering any medication. When opening a multi-dose container, place the date on the container.<br><br>STAFF P<br><br>Review of Resident 20's physician orders dated 01/05/2024, showed an order for Artificial Tears (eye drops) to instill 2 drops in both eyes three times a day for dry eyes.<br><br>Observation on 07/17/2024 at 8:45 AM, showed an unlabeled and undated container of eye drops on Resident 20's nightstand.<br><br>Observation on 07/17/2024 at 9:28 AM, showed Staff P, Registered Nurse, took the eye drops off Resident 20's nightstand and instilled them into the resident's eyes.<br><br>In an interview on 07/17/2024 at 10:12 AM, Staff P stated they had used the eye drops on Resident 20's nightstand. Staff P stated, it [the eye drops] didn't have a date on it and they should have not used it. Staff P further stated that the eye drops should not be at the resident's bed side unless the doctor puts in an order.<br><br>In an interview on 07/18/2024 at 2:42 PM, Staff D, Resident Care Manager, stated they expected medications to be identified with the resident's name. Staff D stated they would not expect staff to use eye drops found on a resident's nightstand that were unlabeled and undated. Staff D further stated they would expect staff to only use medications, including eye drops, that came from the medication cart.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 07/22/2024 at 11:20 AM, Staff B, Director of Nursing, stated that eye drops should be dated upon opening and they would not expect staff to use eye drops found on the nightstand that were unlabeled and undated. Staff B stated that Staff P, should have gotten rid of the eye drops and not used them. Staff B further stated that there should not be medications at a resident's bed side unless they had an order that they could self-administer medications.<br><br>48298<br><br>STAFF F<br><br>Review of Resident 252's July 2024 medication administration record showed an order for a pain medication patch. Apply to skin topically [applied directly to the surface of the body] one time a day for pain . The order did not include the location where the lidocaine patch was to be applied.<br><br>Observation on 07/18/2024 at 9:33 AM, showed Staff F, Licensed Practical Nurse placed the pain medication patch on Resident 252's left upper leg.<br><br>In a joint record review and interview on 07/18/2024 at 12:38 PM with Staff F, showed Resident 252's physician orders dated 07/09/2024 did not specify where the pain medication patch should be applied. Staff F stated that they asked residents where to apply it [pain medication patch] because their pain location sometimes changes. Staff F stated that they would clarify with the physician if a resident was unable to verbalize their pain location.<br><br>In a joint record review and interview on 07/18/2024 at 2:19 PM with Staff D, showed Resident 252's physician orders dated 07/09/2024 did not specify where the pain medication patch should be applied. Staff D stated, It says skin but was not specified. Staff D further stated, It [pain medication patch] should be clarified to show the location where to place the patch.<br><br>In an interview on 07/22/2024 at 11:48 AM with Staff B, stated that, We normally would ask the resident where their pain is and that is where we would apply the patch. When asked if they would clarify with the physician regarding Resident 252's pain medication patch order, Staff B stated, I would but I don't [do not] see anything wrong with that.<br><br>Reference: (WAC) 388-97-1620 (2)(b)(i)(ii) |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observe each nurse aide's job performance and give regular training.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680<br><br>Based on interview and record review, the facility failed to complete required annual performance evaluations for 1 of 3 staff (Staff J), whose personnel files were reviewed for Certified Nursing Assistant (CNA) performance evaluations. Failure to complete a performance review of every nurse aide at least once every 12 months and provide regular in-service education based on the outcome of these reviews, placed residents at risk for receiving care from underqualified nursing staff and unmet care needs.<br><br>Findings included .<br><br>Review of Staff J, CNA, personnel file on 07/17/2024 showed that they were hired on 07/23/2018 and transferred to the facility on [DATE]. The facility was not able to provide documentation that an annual performance evaluation was completed as required.<br><br>On 07/18/2024 at 1:57 PM, Staff B, Director of Nursing, stated that staff performance evaluations were completed yearly. Staff B stated that they were new to the facility and that they thought it was unfair for them to evaluate staff when they just got there. Staff B stated that it was low on their priority list, but they know they have to get it going. Staff B further stated that they would try to look for Staff J's annual performance evaluation. In a follow up interview at 3:15 PM, Staff B stated that they were not able to find Staff J's annual performance evaluation and that it should have been completed yearly.<br><br>Reference: (WAC) 388-97-1680 (2)(b)(i) |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>47680<br><br>Based on observation, interview, and record review, the facility failed to ensure the daily nurse staffing form was accurately completed for the number of staff worked, actual hours worked and included the census for 30 of 30 days, reviewed for posted nurse staffing information. The failure to post a complete and accurate form daily placed the residents, family members and visitors, at risk of not being fully informed of the current staffing levels.<br><br>Findings included .<br><br>Observation on 07/15/2024 at 9:32 AM, showed that the Daily Nursing Staffing Information posting did not include the census and the actual hours worked. The column under Actual Hours worked were the same numbers under the column # [number] Staff.<br><br>Additional observations on 07/16/2024 at 8:37 AM, 07/17/2024 at 9:08 AM, 07/18/2024 at 8:33 and 07/19/2024 at 8:59 AM, showed that the Daily Nursing Staffing Information posting did not include the actual hours worked. The column under Actual Hours worked were the same numbers under the column # [number] Staff.<br><br>Record review of the Daily Nursing Staffing Information and the Daily Schedule from 06/19/2024 to 07/18/2024 showed that the actual hours worked was not accurately completed on the Daily Nursing Staffing Information posting from 06/19/2024 to 07/19/2024. It further showed that the census was not included on 06/29/2024, 06/30/2024, 07/12/2024, and 07/15/2024. Additionally, the number of staff for Certified Nursing Assistants (CNAs) were not updated when there were call outs for 06/23/2024, 07/04/2024, 07/10/2024, 07/11/2024, 07/13/2024 and 07/17/2024.<br><br>In an interview and joint record review on 07/19/2024 at 12:57 PM, Staff K, Staffing Coordinator, stated that all direct contact nurses, CNAs, charge nurse, scheduled and actual hours worked were documented in the daily nursing staffing information posting. Staff K stated that when staff call outs on night shift, the staff on night shift would update the daily nursing staffing information posting to reflect the change. Staff K stated that the actual hours worked were updated and documented in another sheet. Joint record review of the Daily Nursing Staffing Information and the Daily Schedule of the above dates showed missing census, inaccurate number of actual hours worked, and number of staff. Staff K stated that the numbers under the column Actual Hours worked were not the number of actual hours worked. Staff K stated they did know the number of actual hours worked and that they just documented the number of staff scheduled in that column. Saff K further stated that the daily nursing staffing information posting should have included the census and updated with staff call outs.<br><br>In an interview on 07/22/2024 at 10:26 AM, Staff L, Administrative Assistant, stated that they were in charge of updating the nurse staffing information posting and worked on them Monday to Wednesday. Staff L stated that they looked at the labor hours report where they get the staff's actual hours worked for the day. Staff L stated that when the nurse staffing posting information were updated, it was not posted as they were completed the next day or the days after.<br><br>In an interview on 07/22/2024 at 11:05 AM, Staff A, Administrator, stated that they expected staff to follow the regulation.<br><br>(continued on next page) |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | No associated WAC |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298<br><br>Based on observation, interview, and record review, the facility failed to ensure expired medication was disposed of timely in accordance with current accepted professional standards for 1 of 2 medication carts (Cascade Hall Cart) and the facility failed to appropriately label and store drugs or biologicals (diverse group of medicines made from natural sources) for 1 of 2 residents (Resident 20) reviewed for medication storage and labeling. These failures placed the residents at risk for receiving compromised and ineffective medications.<br><br>Findings included .<br><br>Review of the facility's policy titled, Medication Storage In The Facility, revised in January 2018 showed that medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. It showed that certain medications or package types, such as IV solutions, multiple dose injectable vials, ophthalmics, nitroglycerin tablets, blood sugar testing solutions and strips, once opened, require an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency. The policy showed that all expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. It showed, when the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated and the nurse shall place a 'date opened' sticker on the medication and enter the date opened. It further showed that the medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.<br><br>CASCADE HALL CART<br><br>In a joint observation and interview on 07/18/2024 at 12:46 PM with Staff F, Licensed Practical Nurse showed a container of Vitamin E (a supplement) 90 milligrams (a unit of measurement) dated 06/17/2024 with an intact foil cover with an expiration date of 06/2024 found in the Cascade medication cart. Staff F stated that the expired medication should not be kept in the cart and that they should be discarded.<br><br>In an interview on 07/19/2024 at 3:02 PM, Staff D, Resident Care Manager, stated that expired Vitamin E should be discarded.<br><br>In an interview on 07/22/2024 at 11:54 AM, Staff B, Director of Nursing, stated that expired medications should be removed from the cart. Staff B further stated, But this is just Vitamin E, and it is still covered, not used. Expired just last month.<br><br>46912<br><br>RESIDENT 20<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the quarterly minimum data set (an assessment tool) dated 04/12/2024, showed Resident 20 admitted to the facility on [DATE].<br><br>Review of Resident 20's physician orders dated 01/05/2024, showed an order for Artificial Tears (eye drops) to instill 2 drops in both eyes three times a day for dry eyes.<br><br>Observation on 07/16/2024 at 9:46 AM, showed an unlabeled and undated container of eye drops on Resident 20's nightstand.<br><br>Additional observations on 07/16/2024 at 1:46 PM and on 07/17/2024 at 8:45 AM, showed an unlabeled and undated container of eye drops on Resident 20's nightstand.<br><br>Observation on 07/17/2024 at 9:28 AM, showed Staff P, Registered Nurse, took the eye drops off Resident 20's nightstand and instilled them into the resident's eyes.<br><br>In an interview on 07/17/2024 at 10:12 AM, Staff P stated they had used the eye drops on Resident 20's nightstand. Staff P stated, it [the eye drops] didn't have a date on it and they should have not used it. Staff P further stated that the eye drops should not be at the resident's bed side unless the doctor puts in an order.<br><br>In an interview on 07/18/2024 at 2:42 PM, Staff D stated they expected medications to be identified with the resident's name. Staff D stated they would not expect staff to use eye drops found on a resident's nightstand that were unlabeled and undated. Staff D further stated they would expect staff to only use medications, including eye drops, that came from the medication cart.<br><br>In an interview on 07/22/2024 at 11:20 AM, Staff B stated that eye drops should be dated upon opening and they would not expect staff to use eye drops found on the nightstand that were unlabeled and undated. Staff B further stated that there should not be medications at a resident's bed side unless they had an order that they could self-administer medications.<br><br>Reference: (WAC) 388-97-1300 (2) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912<br><br>Based on observation, interview, and record review, the facility failed to ensure hand hygiene and infection control practices were followed during meal tray pass for 2 of 7 staff (Staff O and Staff G), failed to ensure Personal Protective Equipment (PPE-special equipment worn to protect from germs) protocols were followed for 1 of 3 staff (Staff G), and failed to ensure medical equipment was disinfected between resident use for 1 of 2 staff (Staff H) reviewed for infection control. These failures placed the residents, visitors, and staff at an increased risk for infection and related complications.<br><br>Findings included .<br><br>Review of the facility's undated policy titled, Hand Hygiene, showed, the facility considers hand hygiene the primary means to prevent the spread of infections. It further showed to sanitize hands with alcohol-based hand rub or soap and water before and after direct contact with residents and after contact with objects in the immediate vicinity of the resident.<br><br>HAND HYGIENE/MEAL TRAY PASS<br><br>Observation on 07/15/2024 at 7:50 AM, showed Staff O, Certified Nursing Assistant (CNA), removed a meal tray from the meal cart, dropped a sealed cup of juice on the floor, picked it up and placed it back on the tray and brought it to Resident 5. Staff O touched the utensils and touched the tray and left the room without performing hand hygiene. Staff O went into the hallway, touched the meal cart and brought a meal tray into Resident 1's room. Staff O helped Resident 1 set up their food tray and left the room without performing hand hygiene. Staff O exited Resident 1's room, touched the meal cart in the hallway and then performed hand hygiene.<br><br>Additional observation on 07/15/2024 at 7:56 AM, showed Staff O entered Resident 102's room, set up the meal tray, stirred the oatmeal, raised the bed and left the room without performing hand hygiene.<br><br>In an interview on 07/15/2024 at 10:12 AM, Staff O stated they should perform hand hygiene before and after going into resident's rooms during meal tray pass. Staff O stated they typically try to do hand hygiene after leaving and entering each resident's room. When asked what they should do if something was dropped off the meal tray, Staff O stated, if it's contaminated then take to the kitchen and get a new one. Staff O stated they knew it was contaminated if it's open or dirt gets in. Staff O further stated that they placed the dropped cup on a napkin on the meal tray so it's ok.<br><br>In an interview on 07/19/2024 at 1:56 PM, Staff C, Infection Preventionist, stated they expected staff to perform hand hygiene between passing meal trays to residents and before and after leaving resident rooms. Staff C stated they expected staff to get a new cup if it was dropped on the floor and stated, if it touches the floor, considered dirty. Staff C further stated that Staff O should have gotten a new cup even if it was not visibly dirty.<br><br>(continued on next page) |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 07/22/2024 at 11:05 AM, Staff B, Director of Nursing, stated they expected staff to perform hand hygiene between passing meal trays and before and after leaving resident rooms. Staff B further stated they expected staff to get a new cup if it was dropped on the floor.<br><br>48298<br><br>HAND HYGIENE/MEAL TRAY PASS<br><br>Observation on 07/15/2024 at 8:02 AM, showed Staff G, CNA, exited room [ROOM NUMBER] and touched the doorknob to close the door. Staff G did not perform hand hygiene. Staff G then took a meal tray from the meal cart and delivered it to room [ROOM NUMBER]. Staff G removed the plate cover and went back to the meal cart without performing hand hygiene. Staff G took another meal tray and delivered it to room [ROOM NUMBER]. Staff G removed a used plastic cup from the resident's table, removed the plate cover and handed the knife and fork to the resident. Staff G went back to the meal cart and touched the remaining meal tray without performing hand hygiene.<br><br>HAND HYGIENE/DONNING PPE<br><br>Observation on 07/15/2024 at 8:07 AM, showed Staff G pulled a disposable yellow gown from the plastic bin outside room [ROOM NUMBER] (an Enhanced Barrier Precaution [EBP- an infection control intervention to reduce transmission of organisms by wearing PPE] room) and put on the disposable yellow gown. Staff G then put on a pair of gloves and entered room [ROOM NUMBER]. Staff G then left room [ROOM NUMBER], closed the door as they exited the room and walked back to the meal cart without performing hand hygiene. Staff G did not perform hand hygiene before and after entering room [ROOM NUMBER] on EBP precaution.<br><br>In an interview on 07/15/2024 at 8:10 AM, Staff G stated, I do not need to sanitize my hands because I did not have direct contact with the residents. I was just passing trays. When asked if they had performed hand hygiene before entering and after exiting room [ROOM NUMBER], Staff G stated, No. Staff G further stated that they should have performed hand hygiene before and after using PPE, during meal tray passes, and before entering and after exiting residents' rooms.<br><br>In an interview on 07/18/2024 at 2:57 PM, Staff D, Resident Care Manager, stated they expected staff to perform hand hygiene between visits to residents' rooms even if there was no direct contact with residents, during meal tray pass, and before/after using PPE.<br><br>In an interview on 07/19/2024 at 1:55 PM, Staff C stated they expected staff to perform hand hygiene during meal tray passes, visits to residents' rooms, and before/after using PPE.<br><br>In an interview on 07/22/2024 at 1:53 PM, Staff B stated they expected staff to perform hand hygiene prior to using and after removing PPE, entering/exiting residents' rooms, and during meal tray pass.<br><br>47680<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505434 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lynnwood Post Acute Rehabilitation Center | 5821 188th Street Southwest<br>Lynnwood, WA 98037 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility's policy titled, ICPC [Infection Prevention and Control Program] Standard and Transmission-Based Precaution, revised October 2023, showed, Patient-care equipment (e.g. [for example] blood pressure cuffs). It is preferred dedicated or disposable patient-care equipment be used. If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another patient.<br><br>DISINFECTION OF VITAL SIGN EQUIPMENT<br><br>Observation on 07/15/2024 at 6:32 AM, showed Staff H, CNA, exit room [ROOM NUMBER] with the vital signs (a measurement of the body's most basic functions [blood pressure (amount of force your blood uses to get through blood vessels), pulse rate and temperature]) equipment. Staff H applied PPE and entered room [ROOM NUMBER] (an EBP room) with the vital signs equipment. After taking the resident's vital signs, Staff H removed their PPE, exited room [ROOM NUMBER] and performed hand hygiene. Staff H did not disinfect the vital signs equipment between resident use and there were no disinfecting wipes on the vital signs equipment. Additional observations showed Staff H enter room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] with the vital signs equipment, and exited the rooms after taking the residents' vital signs with the vital signs equipment without disinfecting the vital signs equipment before each use.<br><br>In an interview and joint observation on 07/15/2024 at 7:09 AM, Staff H stated that they disinfected the vital signs equipment between use and that they disinfected the vital signs equipment while they were in the residents' room after they took the resident's vital signs. Staff H stated that they had disinfectant wipes inside the basket of the vital signs equipment. Joint observation of the disinfectant wipes that Staff H stated they used, showed, personal cleansing cloth. Staff H took a container from an unknown staff and stated that they used Micro-Kill One (brand-germicidal alcohol disinfectant wipes) and that they were using it to disinfect the vital signs equipment. Staff H stated they used both the personal cleansing cloth and the Micro-Kill One wipes to disinfect the vital signs equipment. Staff H further stated that they were supposed to use the Micro-Kill One wipes when disinfecting the vital signs equipment.<br><br>In an interview on 07/19/2024 at 1:52 PM, Staff C stated that their process was to disinfect the vital signs equipment between resident use with the correct disinfectant wipes. Staff C stated that they used the purple top Micro-Kill One wipes, and that staff should be using it when disinfecting the vital signs equipment.<br><br>In an interview on 07/19/2024 at 2:02 PM, Staff B stated that they expected the vital signs equipment to be disinfected between resident use and expected staff to use the purple top wipes [Micro-Kill One].<br><br>Reference: (WAC) 388-97-1320 (1)(a)(c)(5)(c) |

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|---|---|---|---|
| | 505434 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lynnwood Post Acute Rehabilitation Center | 5821 188th Street Southwest<br>Lynnwood, WA 98037 |

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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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912<br><br>Based on interview and record review, the facility failed to ensure the pneumococcal vaccine (used to prevent pneumonia [a lung infection]) and influenza vaccine (used to prevent influenza [an infection of the nose, throat, and lungs]) were provided for 1 of 5 residents (Resident 34) reviewed for immunizations and infection control. This failure placed residents at risk of acquiring, transmitting, and/or experiencing potentially avoidable complications from pneumococcal and/or influenza disease.<br><br>Findings included .<br><br>Review of the facility's policy titled, Immunizations-Residents, revised in July 2023, showed, It is the policy of this facility to offer and administer influenza, pneumococcal .immunization to eligible residents. It further showed, Residents admitted late in the influenza season [typically February or March] should be offered the influenza vaccine as late season outbreaks do occur.<br><br>Review of the face sheet printed on 07/24/2024, showed Resident 34 admitted to the facility on [DATE].<br><br>Review of the facility's document titled, Resident Consent for Influenza, Pneumococcal, and COVID-19 Vaccination, signed on 02/09/2024, showed that Resident 34 consented to receive the influenza and pneumococcal vaccines per Centers for Disease Control and Prevention recommendations.<br><br>Review of Resident 34's Electronic Health Record (EHR) showed no documentation that Resident 34 was provided an influenza or pneumococcal vaccination.<br><br>In an interview and joint record review on 07/19/2024 at 2:05 PM, Staff C, Infection Preventionist, stated residents were offered the pneumococcal vaccine on admission if they were eligible and offered the influenza vaccine on admission during flu season. Joint record review of the facility's document titled, Resident Consent for Influenza, Pneumococcal, and COVID-19 Vaccination, showed Resident 34 consented for the influenza and pneumococcal vaccine. Staff C stated they expected residents to receive the influenza and pneumococcal vaccines if they wanted them and if they were eligible for them. Joint record review of Resident 34's EHR, showed no documentation that Resident 34 received the influenza and pneumococcal vaccines. Staff C stated Resident 34 should have received the influenza and pneumococcal vaccines.<br><br>In an interview and joint record review on 07/22/2024 at 11:05 AM, Staff B, Director of Nursing, stated that a resident should be offered the pneumococcal vaccine on admission if they were eligible and offered the influenza vaccine on admission during flu season. Joint record review of Resident 34's EHR, showed Resident 34 consented to receive the influenza and pneumococcal vaccines and showed no documentation that they were given the vaccines. Staff B stated that Resident 34 was eligible to receive the influenza and pneumococcal vaccines and should have received it.<br><br>Reference: (WAC)388-97-1340 (1), (2) |

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|---|---|---|---|
| | 505434 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Lynnwood Post Acute Rehabilitation Center | 5821 188th Street Southwest<br>Lynnwood, WA 98037 |

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| F 0912<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298<br><br>Based on observation, interview, and record review of room size measurement, two single resident rooms (Rooms 17 & 18) failed to meet the minimum room size requirement of at least 100 square feet (sq ft) for a single resident room. The failure to ensure residents reside in rooms which met the regulatory requirements for square footage, placed them at risk for living in a physical environment too small to meet their needs.<br><br>Findings included .<br><br>Square footage:<br><br>-room [ROOM NUMBER]- 93.02 sq ft<br><br>-room [ROOM NUMBER]- 92.03 sq ft<br><br>Review of the facility's census dated 07/17/2024, showed rooms [ROOM NUMBERS] were occupied with residents.<br><br>RESIDENT 32<br><br>In an interview and observation on 07/17/2024 at 9:28 AM, Resident 32 stated that the room size did not bother them. Observation showed Resident 32 was in room [ROOM NUMBER] and was not found to be negatively impacted by their room size.<br><br>RESIDENT 41<br><br>In an interview and observation on 07/17/2024 at 9:38 AM, Resident 41 stated that they don't care about their room size. Observation showed Resident 41 was in room [ROOM NUMBER] and was not found to be negatively impacted by their room size.<br><br>In an interview on 07/17/2024 at 1:34 PM, Staff E, Maintenance Supervisor, stated there were no changes in the rooms' square footage since last recertification survey.<br><br>In an interview on 07/19/2024 at 9:47 AM, Staff A, Administrator, stated that there were no changes in the rooms' square footage since the last recertification. Staff A further stated that rooms [ROOM NUMBERS] did not meet the required square footage for single resident room per federal and state regulations.<br><br>Reference (WAC) 388-97-2440 (1) |