STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. 46471 Based on observation, interview, and record review, the facility failed to ensure contact information of all pertinent State regulatory and informational agencies and advocacy groups were provided and/or posted in areas accessible to residents in a format and a language the residents understood for 8 of 8 residents (Residents 2, 22, 32, 25, 7, 38, 53, & 21) reviewed during Resident Council. This failure placed residents at risk for not being fully informed of their rights, potential abuse and/or neglect, and a decreased quality of life. Findings included . Review of the facility's admission packet on 05/06/2024 showed a Supplement To Health Facility Admission Agreement outlining Resident rights. The packet showed information and contact information for State and local advocacy organizations, including the State Survey Agency and the State Long-Term Care Ombudsman (LTCO) program were furnished to residents and/or their representatives. On 05/06/2024 at 2:18 PM during Resident Council meeting, the attendees stated they did not know the State and/or LTCO contact number or where to find the contact information. Observation and interview on 05/06/2024 at 2:22 PM of the 3rd floor nursing unit did not show the State and/or LTCO contact information was posted or accessible to the residents. Staff U (Personnel Scheduler - PS), who provided oversight and administrative assistance on this unit, confirmed the contact information was not posted. Observation and interview on 05/06/2024 at 2:28 PM of the 2nd floor nursing unit did not show the State and/or LTCO contact information was posted or accessible to the residents. Staff V (PS), who provided oversight and administrative assistance on this unit, confirmed the contact information was not posted. Staff V stated, .there used to be one posted on the communication board by the nurse station and elevator .maybe the sign got removed during the remodel and [staff] forgot to post it back up . In an interview on 05/06/2024 at 2:31 PM, Staff B (Director of Nursing) stated the State and/or LTCO contact information sign should be posted and visible to residents at a level the resident could read because it was a resident right, but was not. REFERENCE: WAC 388-97-0280(2),(3)(2-d).

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46471 Based on observations, interviews, and record review the facility failed to initiate and thoroughly investigate incidents in a timely manner for Pressure Ulcer (PU) and unwitnessed falls for 2 of 3 sampled residents (Resident 40 & 54) reviewed for incident reports to rule out abuse and/or neglect. Facility failure to initiate an investigation for the cause of Resident 40's PU and Resident 54's falls within five days left residents at risk for repeated incidents and unidentified abuse and/or neglect. Findings included . <Facility Policy> Review of the facility policy titled, Elder Abuse Prevention, Identification, Response, and Reporting Policy and Procedure, revised 10/18/2022, showed all incidents including unusual bruising, wounds, injury of unknown origin, and incident reports would be thoroughly investigated to rule out abuse and neglect and report the result of all investigations within five working days to the administrator and to other officials including to the State survey agency. <Resident 40> According to the 03/04/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 40 had clear speech, their memory was intact, and had medical conditions including a brain injury resulting in right sided weakness, heart failure, and malnutrition. The MDS showed Resident 40 was assessed to require substantial/maximum assistance from staff in rolling from left to right in bed and was at risk for developing PUs/injuries. The MDS showed Resident 40 developed two stage three PUs while in the facility. Review of the revised 03/01/2023 skin Care Plan (CP) showed Resident 40 had actual impaired skin integrity with wounds to their bilateral calf and heels. A 12/02/2022 CP intervention instructed the nursing staff to assess and monitor the resident's skin weekly and to refer Resident 40 to the wound care team for proper treatment. Observation and interview on 05/01/2024 at 10:17 AM showed Resident 40 was lying in bed, their legs were floated on pillows, and their bilateral calf wounds and heel PUs were dressed. Review of the 01/08/2024 wound care team documentation showed a new right heel deep tissue PU was identified measuring 3.5 cm x 3 cm x 0 cm. When the investigation report was requested, the facility did not provide any documentation to support the facility thoroughly investigated Resident 40's newly identified skin issue. Review of the 01/15/2024 incident report showed the facility identified the presence of the two Stage three PUs on Resident 40's bilateral heels but did not identify why or how the resident obtained the PUs. The report showed the staff completed the investigation on 02/15/2024, one month after identifying the event. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/09/2024 at 11:08 AM, Staff D (Resident Care Manager - RCM) stated they did not identify the root cause of Resident 40's bilateral heel Stage three PUs or ruled out abuse/neglect. Staff D stated the investigation was not completed within five days. In an interview on 05/09/2024 at 11:55 AM, Staff B (Director of Nursing) confirmed there was no facility investigation completed when Resident 40's right heel PU was discovered on 01/08/2024. Staff B reviewed the 01/15/2024 facility investigation report (bilateral heel PUs) and stated the event was not thoroughly investigated or completed timely as required. <Resident 54> According to the 03/13/2024 Admission MDS, Resident 54 was admitted to the facility on [DATE] for a fall with hip fracture and was assessed to have memory impairment. The MDS showed Resident 54 required one person assistance from staff with transferring and total assistance for toileting needs. Observations on 05/01/2024 at 9:23 AM, 05/02/2024 at 8:23 AM, and 05/03/2024 at 10:00 AM showed Resident 54 was lying in a lowered bed with a floor matt at the left side of the bed on the floor. Review of the undated Fall CP showed Resident 54 was at risk for falls related to a history of falls. The CP directed staff to remind the resident to call for assistance before moving out of bed or out of their chair. Review of the facility investigation log showed Resident 54 had two falls on 03/09/2024 at 3:15 AM and 9:15 AM. Review of the investigations showed Resident 54 had both falls on 03/09/2024 in their room while they tried to go to the bathroom on their own. Staff completed both investigations on 03/21/2024. In an interview on 05/07/2024 at 1:42 PM, Staff Q (RCM) stated the facility process was to complete the investigations in five days. When asked about Resident 54's fall investigations completed after 12 days, Staff Q stated they should have completed and locked the investigations within five days, but they did not. In an interview on 05/08/2024 at 11:33 AM, Staff B stated their expectations from staff was to complete all investigations within five days. Staff B reviewed these investigations and stated they were completed late. Staff B stated completing the investigation within five days was very important to rule out abuse and neglect, but they did not. Refer to F686- Treatment/Services to Prevent/Heal PU. REFERENCE: WAC 388-97-0640 (6)(a)(b)(c).

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 47836 Based on interview and record review, the facility failed to ensure the information was documented showing the facility communicated necessary resident information to the receiving health care institution or provider for 3 of 5 sampled residents (Residents 56, 2, & 51) reviewed for hospitalization s. Failure to ensure necessary resident information was communicated to the hospital placed residents at risk for decreased quality of care, inadequate care/treatment, and decreased quality of life. Findings included . <Facility Policy> According to the facility policy titled Transfer or Discharge, Facility -Initiated, dated October 2022, the facility would provide the receiving provider/hospital the basis for the transfer, contact information of the practitioner responsible for the care of the resident, resident representative contact information, advanced directive information, all special instructions or precautions, comprehensive care plan, and all other information necessary to meet the resident's needs. <Resident 56> Review of Resident 56's records showed Resident 56 discharged to the hospital on 01/18/2024. Review of Resident 56's records on 05/08/2024 showed no documentation of necessary resident information had been provided for the 01/18/2024 transfer to the receiving hospital. During an interview on 05/08/2024 at 3:33 PM, Staff B (Director of Nursing) stated they did not know they had to report resident information to the receiving hospital. Staff B stated resident information was not reported to the receiving hospital on 01/18/2024 for Resident 56. <Resident 2> Review of Resident 2's records showed Resident 2 discharged to the hospital on 09/07/2023 and 11/24/2023. Review of Resident 2's records on 05/08/2024 showed no documentation of necessary resident information had been provided for the 09/07/2023 and 11/24/2023 transfers to the receiving hospital. During an interview on 05/08/2024 at 9:22 AM, Staff D (Resident Care Manager) stated there was no documentation necessary resident information was provided to the hospital for Resident 2 on 09//07/2023 or 11/24/2023, but there should be. 46471 <Resident 51> (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 51's medical records showed a 08/10/2023 nursing progress note that indicated the resident was sent to the hospital because of low blood pressure. Record review on 05/08/2024 showed there was no documentation to support the staff provided the receiving hospital with Resident 51's health status and resident information upon transfer and discharge to the hospital as required. In an interview on 05/08/2024 at 2:33 PM, Staff C (Assistant Director of Nursing) reviewed Resident 51's chart and stated there was no communication to the hospital in the resident's medical records. In an interview on 05/09/2024 at 10:40 AM, Staff B stated it was important to ensure the receiving provider (hospital) was notified when a resident was sent to them to ensure the hospital was informed of the resident's condition including the reason for the hospital transfer. REFERENCE: WAC 388-97-0120(1).

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on interview and record review, the facility failed to ensure a system by which residents received required written notices at the time of transfer/discharge and notify the Office of the State Long Term Care Ombudsman (LTCO) of transfer/discharge for 5 of 5 sampled resident's (Residents 54, 28, 51, 56, & 2) reviewed for hospitalization s. Failure to ensure written notification to the resident and/or the resident's representative of the reasons for the discharge in writing and in a language and manner they understood, placed residents at risk for a discharge that was not in alignment with the resident's stated goals for care and preferences. Failure to ensure required notification of LTCO prevented the Ombudsman's office the opportunity to educate residents and advocate for them regarding the discharge process. Findings included . <Facility Policy> According to the facility policy titled Transfer or Discharge, Facility -Initiated, dated October 2022, the facility would give the resident or resident representative a notice of transfer as soon as it was practicable but before the transfer or discharge for residents requiring urgent medical care. The policy showed the facility would submit a notice of all resident's transfers to the LTCO monthly. <Resident 54> In an interview on 05/02/2024 at 10:10 AM Resident 54's representative stated the resident was sent out to the hospital on 03/27/2024 and came back to the facility on [DATE]. According to a 03/27/2024 nursing progress note, Resident 54 was on their dialysis (a procedure that cleaned the blood when the kidneys could not) treatment at the Kidney Center when the resident experienced a change in condition requiring hospitalization . The facility was not able to provide documentation to support Resident 54 or their representative was provided a written notification regarding the reason for their transfer and/or discharge to the hospital as required. In an interview on 05/07/2024 at 10:00 AM, Staff Q (Resident Care Manager) stated they did not provide any written notification to Resident 54's representative of the transfer/discharge. In an interview on 05/07/2024 at 10:30 AM, Staff F (Social Services) stated the nursing department was responsible for providing the transfer/discharge notices to the resident or resident representative. Staff F reviewed Resident 54's record and was unable to provide any documentation to show the Long-Term Care Ombudsman (LTCO) was notified of the resident transferred to the hospital. In an interview on 05/08/2024 at 12:54 PM, Staff E (Social Services Director) stated Staff needed education regarding the provision of written transfer/discharge notices to residents and/or their representatives and the LTCO notification. Staff E stated the facility should have but did not provide Resident 54 the required written transfer/discharge notice or notified the LTCO as required. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	46471 <Resident 28> According to the 04/02/2024 Quarterly Minimum Data Set (an assessment tool - MDS), Resident 28 had an intact memory, clear speech, and medical conditions including end-stage kidney failure. On 05/02/2024 at 9:52 AM, Resident 28 stated they were hospitalized due to increased confusion. Review of Resident 28's records showed an 11/27/2023 nursing progress note indicating the resident came back to the facility after their dialysis (a treatment that cleaned the blood when the kidneys could not) looking confused and disoriented. The note showed Resident 28 was sent to the hospital. In an interview on 05/08/2024 at 2:33 PM, Staff C (Assistant Director of Nursing) reviewed Resident 28's chart and stated there was no written transfer/discharge notice found in the resident's medical records. The facility was not able to provide documentation to show Resident 28 was provided a written transfer/discharge notice or that the LTCO was notified of Resident 28's hospitalization as required. <Resident 51> According to the 02/16/2024 Quarterly MDS, Resident 51 had clear speech, understood others during communication, and had medical conditions including heart and kidney failure. Review of Resident 51's medical records showed a 08/10/2023 nursing progress note indicating the resident was sent to the hospital because of low blood pressure. In an interview on 05/08/2024 at 2:33 PM, Staff C reviewed Resident 51's chart and stated there was no written transfer/discharge notice found in the resident's medical records. The facility was unable to provide documentation to show Resident 51 and/or their representative was provided a written transfer/discharge notice or that the LTCO was notified of Resident 51's hospitalization as required. 47836 <Resident 56> Review of Resident 56's medical records showed they were transferred to the hospital emergently on 01/18/2024. Record review showed no documentation facility staff provided Resident 56 or their representative written notification of the discharge/transfer. Record review showed no documentation of a notice to the LTCO for Resident 56's transfer on 01/18/2024. In an interview on 05/06/2024 at 2:22 PM, Staff F stated there was no documentation staff notified the LTCO for Resident 56's transfer on 01/18/2024, but there should be. <Resident 2> (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 2's medical records showed they were transferred to the hospital emergently on 09/07/2023 and 11/24/2023. Record review showed no documentation facility staff provided Resident 2 or their representative written notification of the discharge/transfer. Record review showed no documentation of a notice to the LTCO for Resident 2's transfers on 09/07/2023 and 11/24/2023. In an interview on 05/06/2024 at 2:22 PM, Staff F stated there was no documentation of notification of transfer to the LTCO for Resident 2 on 09/07/2023 or 11/24/2023, but there should be. Staff F stated they did not have records of LTCO notifications prior to their employment at the facility and they had only started working at the facility three or four weeks ago. In an interview on 05/07/2024 at 4:12 PM, Staff I (Medical Records) stated there was no documentation of written transfer notification for Resident 56's transfer to the hospital on 01/18/2024. Staff I stated there was no documentation of written transfer notification for Resident 2's transfers to the hospital on 09/07/2023 and 11/24/202, but there should be. REFERENCE: WAC 388-97-0120(2)(a-d), -0140(1)(a)(b)(c)(i-iii).

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	505455	A. Building B. Wing	05/09/2024

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on interview and record review, the facility failed to provide the resident and/or the resident's representative a written notice of the facility's bed hold (a process allowing residents who transfer from a facility temporarily to return to the same bed) policy, at the time of transfer or within 24 hours, for 5 of 5 sample residents (Resident 54, 28,51, 56 & 2) reviewed for hospitalization . This failure placed the residents and their representatives at risk of not being informed of their right to, and the cost of, holding the resident's bed while hospitalized that was necessary for decision-making. Findings included . <Facility Policy> According to the facility policy titled, Bed- Hold and Returns, revised October 2022, showed the facility would provide a copy of their bed hold paperwork to residents at time of emergent transfer or within 24 hours which would include the reserve bed payment information and agreement. <Resident 54> According to a 03/27/2024 nursing progress note, Resident 54 was out of facility for their dialysis (a procedure that cleaned the blood when the kidneys could not) treatment at the Kidney Center when the resident needed to be sent to the hospital for further evaluation. Review of Resident 54's medical record showed no documentation the facility discussed and/or offered a bed hold to the resident or their representative during their discharge to the hospital as required. In an interview on 05/07/2024 at 10:31 AM, Staff Q (Resident Care Manager - RCM) stated they were responsible for offering a bed hold to residents who discharged to the hospital. Staff Q reviewed Resident 54's record and stated there was no documentation showing staff offered bed hold to the resident or their representative. In an interview on 05/09/2024 at 10 :02 AM, Staff B (Director of Nursing) stated offering a bed hold was important because it was a resident right so the resident could make an informed decision. Staff B stated staff should have offered or discussed bed hold to the resident or their representative during Resident 54's transfer to the hospital, but they did not. 46471 <Resident 28> Review of the facility census showed Resident 28 was sent to the hospital on 11/27/2023. (continued on next page)

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	505455	A. Building B. Wing	05/09/2024

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An 11/27/2023 nursing progress note showed Resident 28 returned from their dialysis (a treatment that cleaned the blood when the kidneys could not) looking confused and disoriented and needed hospitalization . In an interview on 05/08/2024 at 2:33 PM, Staff C (Assistant Director of Nursing) confirmed Resident 28's medical records did not include documentation to support Resident 28 was offered a bed hold as required. <Resident 51> Review of the facility census showed Resident 51 was sent to the hospital on 08/10/2023. A 08/10/2023 nursing progress note showed Resident 51's blood pressure was trending low and required hospitalization . In an interview on 05/08/2024 at 2:33 PM, Staff C confirmed Resident 51's medical records did not include documentation to support Resident 51 was offered a bed hold as required. 47836 <Resident 56> Review of Resident 56's records showed Resident 56 discharged to the hospital on 01/18/2024. Review of Resident 56's records showed no documentation of the facility's bed hold policy or agreement being provided to the resident at time of, or within 24 hours of transfer to the hospital on 01/18/2024. In an interview on 05/08/2024 at 9:22 AM Staff D (Resident Care Manager - RCM) stated there was no documentation of the bed hold agreement or policy being provided to Resident 56 for their hospitalization on [DATE], but there should be. <Resident 2> Review of Resident 2's records showed Resident 2 discharged to the hospital on 09/07/2023 and 11/24/2023. Review of Resident 2's records showed no documentation of the facility's bed hold policy or agreement being provided to the resident at time of, or within 24 hours of transfer to the hospital on 09/07/2023 or 11/24/2023. In an interview on 05/08/2024 at 9:22 AM Staff D (Resident Care Manager - RCM) stated there was no documentation of the bed hold agreement or policy being provided to Resident 2 for their hospitalization on [DATE] or 11/24/2023, but there should be. REFERENCE: WAC 388-97-0120(4).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 46471 Based on observation, interview, and record review the facility failed to ensure the Minimum Data Set (MDS - an assessment tool) of 2 of 18 residents (Residents 40 & 7) were completed accurately to reflect the resident's condition and overall health status. The facility failed to identify Resident 40's bilateral hand contractures and failed to capture Resident 7's active use of a wander guard device for elopement (to elope). These failures placed Residents 40, 7, and other residents at risk for unidentified and/or unmet care needs and continued unnecessary device use. Findings included . <Facility Policy> Review of the facility policy titled, Comprehensive Assessments, revised October 2023, showed the comprehensive assessment process included direct observation and communication with residents, as well as communication with licensed and non-licensed direct care staff members. The policy showed comprehensive MDS assessments were conducted to assist in developing person-centered Care Plans (CP). <Resident 40> According to the 03/04/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 40 had an intact memory, clear speech, and medical conditions including a brain injury that resulted in right sided weakness. The MDS did not identify the presence of bilateral hand/finger contractures limiting Resident 40's functional Range of Motion (ROM). Observation and interview on 05/02/2024 at 8:51 AM showed Resident 40's bilateral hands/fingers were observed contracted in a closed fist; only the left thumb and index finger remained functional. Resident 40 stated they could barely use their hands in performing their activities of daily living including grabbing the bed side rails for independent mobility. Review of Resident 40's restorative CP on 05/06/2024 showed the resident had impaired ROM and needed assistance with their personal care. The CP showed the restorative aide applied a soft splint on Resident 40's hands to prevent further contractures. In an interview on 05/06/2024 at 9:26 AM, Staff H (MDS Coordinator) stated it was important for MDS assessments to be accurate so the resident's CP would be updated with the correct information, .the CP is what the staff follows when providing resident care . Staff H confirmed the 03/04/2024 Quarterly MDS was inaccurate and stated they should have, but did not capture Resident 40's bilateral upper extremity functional limitation in ROM. <Resident 7> (continued on next page)

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	505455	A. Building B. Wing	05/09/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 04/12/2024 Quarterly MDS, Resident 7 had clear speech, understood others during communication, and had medical conditions including memory decline and mental health disorders. The MDS showed Resident 7 did not exhibit any wandering behavior during the assessment period and the resident's over-all behavior had improved after comparison with the prior MDS assessment. The MDS did not capture the presence of Resident 7's wander/elopement alarm that was used daily. In an observation and interview on 05/02/2024 at 10:08 AM, Resident 7 was observed with a wander guard device attached to their left wrist. Resident 7 stated they did not attempt to leave the facility because they did not have a home, .there is no place for me to go to anymore. Observation on 05/06/2024 at 12:54 PM showed Resident 7 was sitting at the dining room alone and was working crossword puzzles while waiting for the resident council meeting to take place. In an observation and interview on 05/08/2024 at 8:18 AM, Resident 7 was observed sitting on a chair outside of their room. Resident 7 stated they were waiting for the nurse. In an interview on 05/08/2024 at 10:14 AM, Staff O (Charge Nurse) stated Resident 7 did not exhibit wandering or elopement behaviors for months and the resident was pleasant to take care of. In an interview on 05/06/2024 at 9:33 AM, Staff H stated they referred to the Resident Assessment Instrument (RAI) Manual for coding guidance in completing MDS assessments. Staff H stated they were unsure if Resident 7's wander guard device should be coded in the MDS and would do their research for the accurate answer from the RAI manual. In an interview on 05/07/2024 at 2:25 PM, Staff G (Social Services) stated they were responsible for completing the behavior section on the MDS and confirmed Resident 7's behavior had improved. Staff G stated they were not aware Resident 7 had a wander guard device on because it was not captured in the MDS. On 05/08/2024 at 9:28 AM, Staff H came back with the RAI coding information and stated Resident 7's wander guard device should have been coded under Alarms in the MDS, but was not. In an interview on 05/08/2024 at 3:01 PM, Staff C (Assistant Director of Nursing) stated the appropriateness of use of Resident 7's wander guard device was evaluated quarterly during MDS completion. Staff C stated Staff D (Resident Care Manager) was responsible for assessing Resident 7's wander guard use. The facility did not provide any documentation to support Resident 7 continued to need or require the use of a wander guard device. Refer to F700- Bedrails. REFERENCE: WAC 388-97-1000(1)(b).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on observation, interview, and record review the facility failed to ensure Care Plans (CP) were updated and/or revised as needed for 3 of 18 sampled residents (Residents 20, 54, & 18) reviewed, and failed to ensure residents were provided an opportunity for a Care Conference (CC) for 1 of 18 sampled residents (Resident 40). Failure to ensure CPs were updated to reflect current care needs and residents were given the opportunity to participate in CCs left residents at risk for unmet care needs, lessened participation in care planning, and a diminished quality of life. Findings included . <Facility Policy> According to a facility policy titled, Care Plans, Comprehensive Person-Centered, dated March 2022, assessments of residents were ongoing and residents' CPs would be revised as information about residents and their conditions changed. The policy showed the interdisciplinary team, including residents and/or resident's representative, would participate in the development and implementation of the residents CPs at admission and as needed. The policy showed CPs should be reviewed and revised at least quarterly. <CP Revision> <Resident 20> According to the 04/11/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 20 was admitted to the facility on [DATE] with a breathing problem. The MDS showed Resident 20 had an indwelling catheter (IC - a tube inserted into the bladder to drain urine) for bladder and was continent of bowel. The 04/15/2024 Risk of infection CP showed Resident 20 had an IC and directed staff to wear gown and gloves while providing care. Observations on 05/01/2024 at 11:02 AM, 05/02/2024 at 1:00 PM, and on 05/06/2024 at 11:01 AM showed Resident 20 had no IC. In an interview on 05/06/2024 at 11:01 AM, Resident 20 stated they had an IC and staff removed the IC a few weeks ago. Review of Resident 20's May 2024 Physician Orders showed no documentation of an IC. In an interview on 05/07/2024 at 12:42 PM, Staff R (Resident Care Manager - RCM) stated Resident 20 had an IC and that was removed in April 2024. Staff R stated the CP was not updated. <Resident 54> (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 03/13/2024 Admission MDS, Resident 54's memory was impaired and had medical diagnoses including chronic kidney failure with dialysis (a procedure that cleaned the blood when the kidneys could not) treatment three times a week. The MDS showed Resident 54 was incontinent of bowel and bladder and was dependent on staff for toileting needs. Observation on 05/03/2024 at 09:32 AM showed Resident 54 was trying to get out of bed and stated bathroom. Observation on 05/06/2024 at 8:31 AM showed Resident 54 transferred from their bed into their wheelchair and went to the bathroom. Record review showed Resident 54 was observed crawling on the floor in their room on 04/19/2024 at 9:50 AM, 04/26/2024 at 6:50 AM, 04/27/2024 at 3:00 PM, and on 05/04/2024 at 9:30 AM. Review of Resident 54's CP showed no directions staff should follow for Resident 54's bowel and bladder needs. In an interview on 05/07/2024 at 9:45 AM, Staff Y (Certified Nursing Assistant) stated, Resident is very confused and did not use the call light for help, she crawls on the floor to go to the bathroom. Staff Y stated they followed the CP for Resident 54's toileting needs. Staff Y reviewed Resident 54's CP and stated there was no CP for Resident 54's toileting needs. In an interview on 05/07/2024 at 10:18 AM, Staff Q (RCM) stated nursing managers were to assess the residents, and initiate and update the CPs for staff to follow for specific resident's care needs. Staff Q reviewed Resident 54's CPs and stated there was no bowel and bladder CP for staff to follow. Staff Q stated there should be bowel and bladder CP but there is none. Review of an undated Dialysis CP showed Resident 54 had dialysis treatment three times a week. Staff were directed to send a completed pre-dialysis communication sheet to the kidney center and Resident 54 was to bring the post-dialysis sheet back to the facility. In an interview on 05/07/2024 at 10:03 AM, Staff Q stated they did not have any communication sheet. Staff Q stated the CP was not accurate and should be updated, but it was not. 46471 <Resident 18> According to the 03/27/2024 Quarterly MDS, Resident 18 had clear speech, understood others during communication, and had medical conditions including enlargement of their prostate (an organ surrounding the tube that emptied urine from the bladder). In an observation and interview on 05/01/2024 showed Resident 18 was lying in bed and an IC was observed in place. Resident 18 stated they had a bladder infection and trouble urinating. A 03/27/2024 hospital discharge summary showed Resident 18 presented to the emergency room with blood in their urine and urinary retention. The summary showed Resident 18 was being discharged from the hospital with an IC including care instructions for the nursing facility. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 18's CP showed the resident had an IC in place but did not list any care instructions or interventions for staff to follow while taking care of the resident's IC. In an interview on 05/07/2024 at 1:05 PM, Staff C (Assistant Director of Nursing) stated the CP should be revised or updated because it served as the guide for staff to follow when providing resident care. Staff C confirmed Resident 18's CP did not include IC care instructions and stated Resident 18's CP should have interventions in place, but did not. <Care Conference> <Resident 40> According to the 03/04/2024 Quarterly MDS, Resident 40 had clear speech, their memory was intact, and they understood others during communication. On 05/02/2024 at 8:57 AM, Resident 40 stated they were not aware of their CP'd interventions and were not involved in any CC. Review of Resident 40's social services progress notes from 01/01/2023 until 05/08/2024 showed no documentation to support a CC was conducted for, or with, Resident 40. In an interview on 05/08/2024 at 2:32 PM, Staff G (Social Services) stated Staff E (Social Services Director) was assigned to Resident 40's care and confirmed there were no CC documents in the resident's medical records. Staff G stated it was important to conduct a CC because it informed residents and/or their representatives of the care being provided and was an opportunity to collaborate for any updates or questions. REFERENCE: WAC 388-97-1020(2)(c)(d).

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	505455	A. Building B. Wing	05/09/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 46471 Based on observation, interview, and record review, the facility failed to ensure residents who were dependent on facility staff for assistance with their Activities of Daily Living (ADLs) received the assistance they were assessed to require for 2 of 7 residents (Residents 18 & 40) reviewed for ADLs. The failure to provide clean-up care after eating assistance (Residents 18) and personal grooming care (Resident 40) left residents at risk for unmet care needs and a decreased self-worth, dignity or quality of life. Findings included . <Facility Policy> Review of the facility policy titled, ADLs, Supporting, revised March 2018, showed the residents who were unable to carry out ADLs independently would be provided by the facility with the necessary care, services, and assistance to maintain grooming and personal hygiene in accordance with the resident's Care Plan (CP). <Resident 18> According to the 03/27/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 18 had clear speech, understood others during communication, and had medical conditions including heart failure, history of brain injury, and malnutrition. The MDS showed Resident 18 was assessed to require substantial/maximum assistance with their personal hygiene. The undated ADL CP showed Resident 18 had impaired ADL ability due to weakness, activity intolerance, and pain on their hands. The CP instructed the staff to provide Resident 18 one-to-one mealtime assistance. On 05/01/2024 at 12:18 PM, Resident 18 was observed with bilateral hand/finger contractures and was being assisted by staff with their lunch in the room. At 2:32 PM, Resident 18 was observed lying in bed in their room with smudges of the chocolate cake dessert (served during lunch) on their face including around their mouth and on the right side of the resident's cheek. Several dessert crumbs were observed sitting on top of Resident 18's bare chest and lined the left side of the resident's bedding's. In an observation and interview on 05/01/2024 at 2:34 PM, Staff D (Resident Care Manger) was brought in Resident 18's room; the staff saw the condition Resident 18 was left in after being assisted their meal in bed. Staff D stated Resident 18's condition was not acceptable and expected the nursing staff to provide clean-up assistance when the resident was done eating for dignity. <Resident 40> According to the 03/04/2024 Quarterly MDS, Resident 40 had an intact memory, clear speech, and medical conditions including a brain injury resulting in right sided weakness. The MDS showed Resident 40 was assessed to require substantial/maximum assistance with their personal hygiene. (continued on next page)

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	505455	A. Building B. Wing	05/09/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The undated ADL CP showed Resident 40 had impaired ADL ability due to weakness, deconditioning, and activity intolerance and required staff assistance with their personal grooming and hygiene. The undated skin CP showed Resident 40's skin was at risk for impairment and an intervention was listed instructing the staff to keep the resident's fingernails short. Observation and interview on 05/02/2024 at 8:40 AM showed Resident 40's bilateral hands/fingers were contracted; three of the fingers on Resident 40's left hand (except the thumb and index finger) were permanently bent and the fingernails were long and growing inwards into the resident's left palm. In an interview on 05/03/2024 at 9:30 AM, Staff O (Charge Nurse) stated it was important to ensure the residents' nails were kept clean and trimmed for infection prevention and dignity. Staff O stated all nursing staff were responsible for ensuring the residents were well-groomed. Staff O confirmed three of the contracted fingers on Resident 40's left hand had long, jagged nails and stated, .oh my, yes, these [fingernails] need to be trimmed because they could dig into [Resident 40] skin and cause skin breakdown. Refer to F641- Accuracy of Assessments. Refer to F657- Care Plan Timing and Revision. REFERENCE: WAC 388-97-1060(2)(c).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 46471 Based on observation, interview, and record review, the facility failed to ensure 1 of 4 residents (Resident 40) was provided physician ordered pressure relief interventions. Failure to implement use of off-loading boots, in accordance with the wound care team's recommendation, placed residents at risk for PU development, worsening of PU, and a diminished quality of life. Findings included . <Facility Policy> Review of the facility policy titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol, revised April 2018, showed the nursing staff and practitioner would assess and document a resident's significant risk factors for developing PUs including immobility. The policy showed when new wounds develop despite existing interventions, the current approaches should be reviewed and the physician would order pertinent wound treatments including pressure reduction surfaces for PU treatment and management. Review of the facility policy titled, Pressure Injuries Overview, revised March 2020, showed the facility used the National Pressure Injury Advisory Panel Classification System for staging PUs. The policy defined Stage 3 PU as full-thickness skin loss where fat was visible in the ulcer and defined a Deep Tissue Pressure Injury (DTPI) as an intact or non-intact skin with localized area of persistent, non-blanchable, deep red, maroon or purple discoloration or epidermal separation that revealed a dark wound bed or blood-filled blister. <Resident 40> According to the 03/04/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 40 had clear speech, their memory was intact, and had medical conditions including a brain injury resulting in right sided weakness. The MDS showed Resident 40 was assessed to require substantial/maximum assistance from staff in rolling from left to right in bed. The MDS showed Resident 40 was at risk for developing PUs/injuries and had two new stage three PUs (not present upon admission) during the assessment period. Review of the revised 03/01/2023 skin CP showed Resident 40 had actual impaired skin integrity with wounds to their bilateral calf and heels. A 02/22/2023 CP intervention directed the nursing staff to apply off-loading boots on Resident 40 for their bilateral PUs. Observation and interview on 05/01/2024 at 10:17 AM showed Resident 40 was lying in bed, their legs were floated with pillows, and their bilateral calf wounds and heel PUs had dressings applied. Resident 40's feet were not observed to be in off-loading boots. The resident was observed without boots on 05/02/2024 at 8:42 AM, on 05/03/2024 at 12:53 PM, on 05/06/2024 at 2:45 PM, and on 05/07/2024 at 1:48 PM. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 01/08/2024 wound care team documentation showed a new right heel PU (classified as DTPI) was identified measuring 3.5 centimeters (cm) x 3 cm x 0 cm when Resident 40's bilateral calf wounds were being assessed at the time. The 01/15/2024 wound care team documentation showed a new left heel Stage three PU was identified measuring 2 cm x 2.9 cm x 0 cm, actual wound size was 5.8 cm and was the result of reopening from Resident 40's history of PU to this location. The right heel (identified during the week prior as DTPI) had opened and was classified as a Stage three PU measuring 3.8 cm x 3.4 cm x 0 cm, actual wound size was 12.29 cm. The 04/29/2024 wound care team documentation showed the bilateral heels were increasing in measurement: The left heel measured 3.4 cm x 1.7 cm x 0.1 cm; and the right heel measured 4 cm x 4 cm x 0.1 cm. The document showed Resident 40's feet were observed being floated only using pillows in bed, so the wound care team recommended the use of off-loading boots. Review of Resident 40's Skin Management Assessments showed weekly nursing skin assessments were not initiated for the resident until 03/25/2024, more than two months after the PUs were discovered on 01/08/2024 and reported/investigated by the facility on 01/15/2024. In an observation and interview on 05/09/2024 at 9:36 AM, Staff O (Charge Nurse) conducted a room search and confirmed there were no off-loading boots anywhere in the resident's room. Resident 40 stated they never had any boots applied on them by staff. In an interview on 05/09/2024 at 10:26 AM, Staff C (Assistant Director of Nursing) stated the nursing staff were expected to follow the recommendations coming from the wound care team because they were considered the experts. Staff C stated they confirmed Resident 40's lack of offloading boots with Staff D (Resident Care Manager) and was told [Staff D] have tried it [boots] before and it did not work. The facility was not able to provide any documentation to support Resident 40's trial use of off-loading boots and how it failed. In an interview on 05/09/2024 at 11:55 AM, Staff B (Director of Nursing) stated Resident 40's PUs should have been addressed properly, but unfortunately, they were not. Refer to F610- Investigate/Prevent/Correct Alleged Violation. REFERENCE: WAC 388-97-1060 (3)(b).

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on observation, interview, and record review the facility failed to ensure residents who were dependent on facility staff for bowel and bladder (B/B) needs were accurately assessed to require for 1 of 4 residents (Resident 54) reviewed for B/B incontinence. Failure to accurately assess and provide care for Resident 54's B/B needs placed the resident at risk for unmet care needs and diminished quality of life. Findings include . <Resident 54> According to the 03/13/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 54 was admitted to the facility on [DATE] for a fall with hip fracture and was assessed with memory impairment. The MDS showed Resident 55 was incontinent of B/B and required total assistance for toileting needs. Review of the 04/01/2024 B/B assessment showed Resident 54 was occasionally incontinent of B/B and unable to get to the bathroom physically and mentally. Observation on 05/03/2024 at 9:32 AM showed Resident 54 was trying to get out of bed and stated bathroom. Observation on 05/06/2024 at 8:31 AM showed Resident 54 transfer from their bed into their wheelchair and went to the bathroom. Record review showed Resident 54 was observed crawling on the floor in their room on 04/19/2024 at 9:50 AM, 04/26/2024 at 6:50 AM, 04/27/2024 at 3:00 PM, and on 05/04/2024 at 9:30 AM trying to go to the bathroom. In an interview on 05/07/2024 at 9:45 AM, Staff Y (Certified Nursing Assistant) stated, Resident is very confused and did not use the call light for help, she crawls on the floor to go to the bathroom. Staff Y stated they took Resident 54 to the bathroom whenever the resident asked them to go to the bathroom. In an interview on 05/07/2024 at 10:18 AM, Staff Q (Resident Care manager) stated nursing managers were to assess the resident for B/B care needs and update the assessment as needed to provide the care as required. Staff Q confirmed Resident 54 was noticed crawling on the floor multiple times trying to go to the bathroom. Staff Q stated they should have updated Resident 54's B/B assessment accurately once staff became aware of the resident's B/B needs, but they did not. REFERENCE: WAC 388-97-1060(3)(c).

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	505455	A. Building B. Wing	05/09/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on observation, interview, and record review the facility failed to administer the medications as ordered and to communicate with the provider to adjust the time for those medications while residents were out of the facility for dialysis (a procedure to clean and filter the body's waste products) treatment for 2 of 2 sampled residents (Resident 28 & 54) reviewed for dialysis care. These failures placed residents at risk for unmet care needs, unidentified medical complications, and adverse health outcomes. Findings included . <Resident 28> According to the 04/02/2024 Quarterly Minimum Data Set (an assessment tool - MDS), Resident 28 had an intact memory, clear speech, and medical conditions including end-stage kidney failure. The MDS showed Resident 28 received dialysis during the assessment period. On 05/02/2024 at 9:52 AM, Resident 28 stated they were hospitalized on [DATE] due to increased confusion related to kidney disease. Resident 28 stated the physician prescribed a medication that facilitated their bowel movements, so they could get rid of their body's waste. Review of Resident 28's Physician Orders (POs) showed a 12/01/2023 order for a bowel medication that promoted bowel movements, taken three times daily (scheduled for 8:00 AM, 12:00 PM, and 5:00 PM) and a 02/20/2024 order for a medication to control high blood levels of phosphorus (a chemical element found in the body that if in excess could cause increased risk of heart attack, stroke, or death), taken three times daily (scheduled for 8:00 AM, 12:00 PM, and 8:00 PM); both medications were indicated to decrease the accumulation of toxic waste products in Resident 28's body due to the residents chronic kidney failure and dialysis status. Review of the May 2024 Medication Administration Record on 05/06/2024 showed, on 05/01/2024 and on 05/03/2024, the 12:00 PM dose for both the bowel medication and the phosphate binder were not administered to Resident 28 because the resident was out of facility to dialysis. Review of Resident 28's progress notes from 05/01/2024 until 05/07/2024 showed no documentation staff communicated with the provider to adjust the medication timing on dialysis days. In an interview on 05/07/2024 at 3:24 PM, Staff C (Assistant Director of Nursing) stated they expected the nursing staff to notify the physician immediately for any missed medications and/or refusals for safety and proper monitoring. In a joint interview on 05/08/2024 at 1:25 PM with Staff A (Administrator), Staff B (Director of Nursing), and Staff DD (Nurse Practitioner), Staff DD stated it was important for Resident 28 to receive their scheduled dialysis medications timely to prevent the reoccurrence of Resident 28's hospitalization . <Resident 54> (continued on next page)

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	505455	A. Building B. Wing	05/09/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 03/13/2024 Admission MDS, Resident 54 was admitted with medical diagnoses including hip fracture, and chronic kidney failure with dialysis treatment. The MDS showed Resident 54 received dialysis treatment during the assessment period. Review of Resident 54's POs showed a 03/07/2024 order for a phosphate binder to administer with meals three times daily (at 8:00 AM, 12:00 PM, and 5:00 PM) for chronic kidney disease. Review of the April and May 2024 MARs showed, on 04/05/2024, 04/12/2024, 04/19/2024, 04/24/2024, 04/26/2024, 04/29/2024, 05/01/2024, and 05/06/2024, the 5:00 PM dose was not administered to Resident 54 as ordered because the resident was out of facility to dialysis. Review of Resident 54's record showed no documentation staff communicated with the provider to adjust the medication timing on dialysis days. In an interview on 05/07/2024 at 11:16 AM, Staff Q (Resident Care Manager) stated staff should clarify the order with the provider to adjust the medication timing on dialysis days, but they did not. Staff Q stated they expected staff to notify the provider for any missed medications or refusals, but they did not. REFERENCE: WAC 388-97-1900 (1), (6)(a-c). 46471

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	505455	A. Building B. Wing	05/09/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 46471 Based on observation, interview, and record review, the facility failed to ensure attempts to use appropriate alternatives prior to installing side rails were conducted and residents with side rails installed on their beds were: (1) assessed, evaluated, and did not pose as an entrapment risk, (2) risk and benefits were reviewed with the resident and/or their representative, and (3) an informed consent was obtained prior to device installation to ensure the device was and remained safe and appropriate to use for 3 of 4 sampled residents (Residents 40, 28, & 51) reviewed for accident hazards. This failure placed residents at risk for harm and significant injury. Findings included . <Facility Policy> Review of the facility policy titled, Bed Safety and Bed Rails, revised August 2022, showed the use of bed side rails (including temporarily raising the side rails for episodic use during care) was prohibited unless the criteria for use of bed rails was met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. The policy showed the resident assessment determined the risk of entrapment including the resident's ability to toilet self safely, mobility in and out of the bed, and risk of falling. <Resident 40> According to the 03/04/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 40 had an intact memory, clear speech, and medical conditions including a brain injury that resulted in right sided weakness. Observation and interview on 05/02/2024 at 8:51 AM showed Resident 40's bed had bilateral side rails in the up position. Resident 40's bilateral hands/fingers were observed contracted in a closed fist; only the left thumb and index finger remained functional. Resident 40 stated they could barely use their hands to grab the side rails. Review of Resident 40's medical records on 05/03/2024 did not show an assistive device assessment was completed and the consent was not obtained prior to the resident's side rails use. On 05/03/2024 at 12:38 PM, Staff I (Medical Records) confirmed Resident 40 did not have an informed consent on file. Review of Resident 40's 03/04/2024 Nursing Quarterly Evaluation form showed the Side Rail Evaluation section was not updated; the nurse signature and date for the side rail evaluation was blank. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	05/09/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a joint interview on 05/03/2024 at 10:08 AM with Staff C (Assistant Director of Nursing) and Staff D (Resident Care Manager), Staff D stated the side rails were used to help the staff when providing care, .so [Resident 40] could have something to hold on to . When asked if two-person staff assistance during provision of care was attempted instead of utilizing the side rail in consideration of Resident 40's contracted hands and fingers, Staff D had no response. Staff D confirmed a consent should have but was not obtained from Resident 40 and stated the quarterly side rails evaluation was not completed. Staff C stated the use of bed side rails should be appropriate for the resident for safety based on the resident's evaluation. In an observation and interview on 05/03/2024 at 11:03 AM, Staff J (Director of Rehabilitation) stated bed side rails were primarily indicated to encourage mobility. When asked if side rails were appropriate for residents with hand/finger contractures, Staff J stated, generally, no. At 12:38 PM, Staff J evaluated Resident 40 to determine if the side rails were appropriate; Staff J stated the side rails were not helpful or indicated for the resident. Staff J stated the nursing department should have, but did not send a physical therapy referral for Resident 40. <Resident 28> According to the 04/02/2024 Quarterly MDS, Resident 28 had an intact memory, clear speech, and medical conditions including a brain disorder characterized by sudden, uncontrolled bursts of involuntary muscle movement. The MDS showed Resident 28 was capable of performing independent bed mobility and transfers after set-up. Observation and interview on 05/02/2024 at 9:33 AM showed Resident 28's bed had bilateral side rails in the up position. Resident 28 stated they do not use the side rails because they had no problem getting in and out of their bed on their own. Review of Resident 28's 04/03/2024 Nursing Quarterly Evaluation form showed the Side Rail Evaluation section was not updated; the nurse signature and date for the side rail evaluation was blank. In an interview on 05/06/2024 at 10:02 AM, Staff C confirmed the side rails section of the Quarterly Nursing Assessment form for Resident 28 was not done or updated and stated, I could not understand why this [side rail] part of the evaluation was not signed off/dated and the other items were . Staff C stated it was important to ensure residents with bed side rails were assessed to ensure safety because the resident could get in a lot of trouble if not. <Resident 51> According to the 02/16/2024 Quarterly MDS, Resident 51 had clear speech, understands during communication, and had medical conditions including heart and kidney failure. The MDS showed Resident 51 was capable of performing independent bed mobility and transfers after set-up. Observation and interview on 05/01/2024 at 11:28 AM showed Resident 51's bed had bilateral side rails in the up position. Resident 51 stated they do not need them when moving in and getting out of bed and demonstrated their ability to perform this task without any difficulty. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 51's medical records showed a 05/26/2023 Assistive Device Assessment/Consent form regarding the use of side rails. Review of Resident 51's records for the last six months did not show a Quarterly Nursing Assessment was completed. The facility was not able to provide documentation to support Resident 51's ongoing use of side rails remained helpful or necessary. A 02/26/2024 fall incident report showed Resident 51 had a fall while getting in and out of bed to go to the bathroom. The report showed, based on the investigation, Resident 51 rolled out of their bed and fell . In an interview on 05/03/2024 at 10:08 AM, Staff O (Charge Nurse) confirmed Resident 51 was independent with bed mobility and could get in and out of their bed on their own. Staff O stated the side rails could pose a safety risk for the resident. In an observation and interview on 05/03/2024 at 11:17 AM, Staff J evaluated Resident 51 and stated bed side rails were not appropriate for residents who could get up and move independently. In an interview on 05/03/2024 at 12:27 PM, Staff C reviewed Resident 51's medical records and stated the quarterly assessment regarding side rails use should have, but was not completed for Resident 51. REFERENCE: WAC 388-97-1060 (3)(g), -0260 (1)(a)(b), -2100(1).

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	505455	A. Building B. Wing	05/09/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 47836 Based on observation, interview, and record review the facility failed to ensure a medication error rate of less than 5 Percent (%). Failure to properly administer 2 of 25 medications for 2 of 6 residents (Resident 70 & 9) observed during medication pass resulted in a medication error rate of 8%. This failure placed residents at risk for not receiving the correct dose or receiving less than the intended therapeutic effects of physician ordered (PO) medication. Findings included . <Resident 70> Observation of medication pass on 05/03/2024 at 9:31 AM, showed Staff BB (Registered Nurse -RN), training with Staff S (RN), enter Resident 70's room and administered the resident's morning medication's crushed in applesauce to include a blood pressure medication. Review of resident 70's records on 05/03/2024 showed a PO for a blood pressure (BP) medication with parameters to hold the medication for a heart rate (HR) of less than 60 beats per minute (BPM). These records showed Resident 70 had a HR of 56 BPM prior to medication administration. In an interview on 05/03/2024 at 9:49 AM, Staff S stated Resident 70's HR was 56 BPM prior to administration of their morning medications and the parameters for the BP medication was to hold if HR less than 60 BPM. Staff S stated they should have held the BP medication per PO/parameters. Staff S stated this was a medication error and they should follow the medication order and hold per parameters. <Resident 9> Observation of medication pass on 05/03/2024 at 10:50 AM, showed Staff CC (Licensed Practical Nurse) prepared to administer Resident 9's eye drops as Eye drops original formula (compare to Visine ingredient-Tetrahydrozline 0.05% redness reliever.) Review of Resident 9's records on 05/03/2024 showed a PO for Artificial Tears 1% eye drop 1 drop in both eyes. In an interview on 05/03/2024 at 11:01 AM, Staff CC stated the eye drop bottle prepared for Resident 9 was incorrect and they should have administered the correct eye drops per PO, but they had administered the same eye drops to Resident 9 before and not realized they were an incorrect medication. Staff CC stated they were expected to compare all medications to the PO's to verify the residents name, medication name, form, dose, route, and correct time, but they had not. In an interview on 05/08/2024 at 10:17 AM Staff B (Director of Nursing) stated they expected staff to verify the correct resident name, medication name, form of medication, dosage amount, route to take medications, parameters, and the correct time the medication should be given. Staff B stated staff should compare the pharmacy medication card to the PO's to ensure they were administering the correct medications. (continued on next page)

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	505455	A. Building B. Wing	05/09/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	REFERENCE: WAC 388-97-1060(3)(k)(ii). 45941

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 46471 Based on observation and record review, the facility failed to ensure residents were provided the correct meal portion size by dietary staff as part of the prescribed therapeutic diet for 1 of 4 residents (Residents 7) reviewed for food concerns and 1 additional sample resident (Resident 1) identified during meal service observation. Failure to ensure residents were provided food as ordered in their diet placed residents at risk for nutritional compromise and related negative health outcomes. Findings included . <Facility Policy> Review of the Resident Food Services policy titled, Special Food Needs, revised January 2024, showed all food and beverages served would be assessed and determined by the Food and Nutrition staff to be safe for residents with special dietary needs. The policy showed all staff were in-serviced on therapeutic diets orders. Review of the Resident Food Services policy titled, Resident Dining Profile And Food Preferences, revised January 2024, showed a nutrition file was used to maintain accurate records of resident diets including individualized meal plan for small and large portions per diet order and/or resident preferences. The policy showed a small portion consisted of half the serving of items on the main plate served as regular portion. <Resident 7> According to the 04/12/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 7 had medical conditions including unstable blood sugar levels in the body. The MDS showed Resident 7 was provided a therapeutic diet during the assessment period. Observation on 05/07/2024 at 12:34 PM showed Staff W (Food Service Worker) prepared Resident 7's lunch tray; the meal ticket showed the resident was on a low concentration sweets, small portions diet and a note on the ticket instructed dietary staff to provide 1/2 portion desserts or fresh fruits. Staff W was observed to dish out a whole portion of the dessert pie on Resident 7's meal tray. In an interview on 05/07/2024 at 12:36 PM, when Staff W was asked why a full slice of the pie was provided to Resident 7, the staff stated they chose a smaller cut piece of the pie. In an interview on 05/07/2024 at 12:43 PM, Staff L (Corporate Dietary Personnel) stated all sliced pies that were plated represented a regular portion serving size. Staff L stated a half-serving as prescribed (and written on a resident's meal ticket) meant physically cutting the prepared dessert size in half prior to serving. Staff L confirmed Resident 7 was given a full serving of the dessert pie and not a small portion as prescribed. <Resident 1> (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's medical records showed a 04/19/2022 diet order indicating the resident was to be provided small portions of mechanically soft ground meats. Observation and interview on 05/07/2024 at 12:19 AM showed Staff W was preparing Resident 1's lunch tray; Staff W opened the food warmer drawer, took a bowl of mechanically ground meat, and stated dishing it on the resident's plate without measuring or following a guide that corresponded to a small portion size. Observation on 05/07/2024 at 12:20 PM showed the Menu/Diet Spread Sheet Report observed posted in front of Staff W by the tray service line did not indicate any portion size guidelines for serving mechanically altered meats. When Staff W was asked how they determined the correct amount/portion size of the ground meat to put in Resident 1's plate, Staff W stated they approximated the amount. In an interview on 05/07/2024 at 12:45 PM, Staff L stated it was important for residents to be served their therapeutic diets and in the correct portion sizes ordered or prescribed to ensure the residents met their nutritional and dietary needs. REFERENCE: WAC 388-97-1200(1).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46471 Based on observation and interview, the facility failed to ensure food was stored and prepared under sanitary conditions for 1 of 1 kitchen observed. Facility staff failed to: Label and date food; discard damaged/spoiled food; and perform Hand Hygiene (HH) during food preparation. The facility failed to ensure 1 of 2 resident refrigerators in the nursing units (Cascadia Neighborhood) were monitored for food brought in from outside sources. These failures contributed to an unsanitary and unsafe storage and preparation of food, and placed residents at risk for food-borne illness and a decreased quality of life. Findings included . <Facility Policy> Review of the facility policy titled, Use and Storage of Foods Brought to Residents from Home, revised January 2019, showed if the prepared food was not served immediately to the resident, the food must be stored in stored in a container with a tight-fitting lid, clearly labeled with the resident's name and room number, dated when the food was brought in for the resident, and indicate the use-by date. The policy showed outside foods should be consumed or used by 3 days (72 hours). <Cascadia Resident Refrigerator> Observation on 05/09/2024 at 09:31 AM showed a bag of food brought in from outside for Resident 51 dated 05/06/2024; the food items observed inside in the bag were wilted carrots and lettuce on one side, and mushed up blue and blackberries on the other in an unsealed sectional container. The bag was observed with a good-thru or used-by date of 05/09/2024. In an interview on 05/09/2024 at 10:18 AM, Staff T (Dietary Manager) confirmed, in counting for the use-by date, day 1 was the date the outside food was brought into the facility. Staff T stated Resident 51's outside food was four days old (more than 3 days) and should be thrown away. <Main Kitchen - Unlabeled, Undated, Leftover Food> In an observation and interview on 05/01/2024 at 9:13 AM showed a tray of uncovered biscuits sitting on top of a table in the corner of the kitchen. Staff FF (Dietary Cook) stated the biscuits were left over from breakfast service and should not be left uncovered. On 05/01/2024 at 9:17 AM, a bag of open and undated peas, potato (tater tots), and burger patties were observed inside the standing refrigerator by the food preparation area. Observation on 05/01/2024 at 9:39 AM showed the kitchen freezer had a bag of open and undated pie crusts, and an open and undated bag of sausages that was left exposed and with obvious signs of freezer burn. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 05/01/2024 at 9:45 AM showed undated chocolate cake slices inside the standing refrigerator next to the chef's office. Staff K (Dietary Manager) stated they were probably leftovers. In an interview on 05/01/2024 at 10:18 AM, Staff K (Dietary Manager) stated the facility's policy was to label and date all food items when they were opened, .so [kitchen staff] know when they [food] go bad and avoid serving spoiled foods to our residents. Staff K stated they expected all kitchen staff not to leave food items uncovered or exposed to the environment, and to throw away leftover food items after every meal service for safety. Staff K confirmed all food items identified in the two refrigerators and freezer were unlabeled and undated, and stated the kitchen staff (who opened the food items) should have labeled and dated the food items, but they did not. <Unsanitary Food Preparation> Observation on 05/01/2024 at 9:52 AM showed Staff N (Food Service Worker) was preparing food for lunch service. Staff N put their gloves on, retrieved the baked chicken for hot holding (keeping hot foods hot before serving), and laid the tray of chicken on top of the preparation table. With the same pair of gloves, Staff N went to get frozen hotdogs from the freezer, placed them in a deep pan, touched the handles of the standing oven to open it, placed the food inside, closed the oven door, pressed the side buttons to set the time, and walked away while reaching into their pocket to check their cellphone. Still with the same gloves on, Staff N took a dirty knife and pan from the prep table, took them over to the dishwashing area, and came back to the prep area without performing HH or changing their gloves. Staff N got an oven mitt and wore them over the dirty gloves, took the pan of baked chicken from hot holding and placed it on the prep table, removed the mitt from their gloved hands, and picked up two pieces of chicken with the dirty gloves. In an interview on 05/01/2024 at 9:57 AM, when Staff N was asked about the facility's policy regarding HH and guidance for changing gloves, Staff N stated, .change them [gloves] only if food juices come in contact with my hands. Otherwise, I keep the gloves on . When asked if they should have washed their hands and/or changed their dirty gloves prior to touching the baked chicken, Staff FF stated, Oh, now I get what you are saying .yes, I should have. In an interview on 05/01/2024 at 9:59 AM, Staff K stated they expected all kitchen staff, especially those performing food preparation, to wash their hands and change their gloves between clean and dirty kitchen areas and after touching surfaces before they handle/touch the food to prevent food contamination and food-borne illness. REFERENCE: WAC 388-97-1100(3).

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	505455	A. Building B. Wing	05/09/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47836 Based on interview and record review, the facility failed to ensure resident records were complete, accurate, and readily accessible for 2 of 18 sampled residents (Resident 1& 21) whose records were reviewed. The facility failed to ensure current legal guardianship documents were accurate, accessible to staff, and in resident records. These failures placed residents at risk for unidentified and/or unmet care needs. Findings included . <Facility Policy> According to the facility policy titled, Advance Directives, revised [DATE], showed information regarding advanced directives/Legal guardianship would be displayed prominently in the resident's medical record that was retrievable by any staff. The policy showed interdisciplinary staff would review annually and be recorded in the resident's medical records. <Resident 1> According to a [DATE] Annual Minimum Data Set (MDS - an assessment tool) Resident 1 had memory impairment. The assessment showed Resident 1 admitted to the facility on [DATE]. Review of Resident 1's records on [DATE] showed responsible parties listed as Abacus Guardianship Incorporated for financial power of attorney. Resident 1's record had a copy of Abacus legal guardianship documents which had expired on [DATE]. <Resident 21> According to a [DATE] Annual MDS Resident 21 had severe memory impairment. The assessment showed Resident 21 admitted to the facility on [DATE]. Review of Resident 21's records on [DATE] showed an agent/attorney listed as responsible for healthcare & financial power of attorney. Resident 21's record had a copy of the legal guardianship documents which had expired on [DATE]. In an interview on [DATE] at 10:51 AM Staff E (Social Service Director) stated Resident 1's Guardianship expired on [DATE] but Abacus was still listed as an active legal guardian, but they should not be. Staff E stated Resident 21 had legal guardianship documents in their records which had expired on [DATE] and still listed as the resident's legal guardian, but they should not be. REFERENCE: WAC [DATE](1)(a)(i-iv).

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	505455	A. Building B. Wing	05/09/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45941 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment to prevent placing residents at risk for facility acquired infections. The facility staff failed to consistently perform Hand Hygiene (HH) before and after resident care/contact. These failures placed residents at risk for facility acquired or healthcare-associated infections and related complications. Findings included . <Hand Hygiene> <Resident 52> Observation on 05/03/2024 at 10:04 AM showed Staff T (Certified Nursing Assistant - CNA) provided peri care to Resident 52 in the bed and put clean slacks on the resident. Staff T did not change their dirty gloves before touched the clean areas. Staff EE (Licensed Practical Nurse) started changing the wound dressing for Resident 52's wound on their back and Staff T was assisting the Staff EE by holding the resident with the same contaminated gloves. After Staff EE changed the wound dressing for Resident 52, Staff T fixed the resident's shirt with the same contaminated gloves and pulled the resident up in bed. Then Staff T removed the dirty brief from the bed, moved the box of wipes from the chair to the counter, grabbed Resident 52's pillow and put on the resident's sides for repositioning and covered the resident's legs with a clean blanket with the same contaminated gloves. Then Staff T removed their gloves, washed hands, and left the room. In an interview on 05/03/2024 at 10:20 AM, Staff T stated they usually changed their gloves in between the care but they forgot to change their gloves. Staff T stated they should have changed their gloves, but they did not. In an interview on 05/03/2024 at 10:23 AM, Staff EE confirmed Staff T did not change their gloves. Staff EE stated they expected staff to wash their hands before and after resident's contact, staff should change their gloves in between the care from dirty area to clean area. In an interview on 05/03/2024 at 11:31 AM, Staff Z (Infection Preventionist) stated they expected staff to perform HH before and after every contact with residents and change gloves during providing care to residents, and in between from dirty areas to clean areas. Staff Z stated Staff T should have changed their gloves after provided peri care. <Hand Hygiene - Meals> <Resident 16> Observation on 05/01/2024 at 12:21 PM showed Staff X (CNA) was observed passing meal trays to several residents at the third floor dining room, touching residents and surfaces while passing trays. After the staff was done, Staff X sat down and started assisting Resident 16 with their meal without washing their hands. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/01/2024 at 12:39 PM, Staff X stated the staff were expected to perform HH prior to helping residents eat. Staff X stated they should have washed their hands before assisting Resident 16 but did not. <Residents 49 & 43> Observation on 05/01/2024 at 12:25 PM showed Staff Y (CNA) was observed passing meal trays to several residents at the third floor dining room, touching residents and surfaces while passing the trays. After the staff was done, Staff Y sat in between Residents 49 and 43 and started assisting both residents with their meals at the same time without doing HH. Staff Y was observed touching Resident 43's hands/skin (needed more dining assist) multiple times as the resident would attempt to reach for their juice glass and then went and gave Resident 49 a bite of their salad. In an interview on 05/01/2024 at 12:26 PM, Staff Z stated it was important for all staff to perform HH before providing dining assistance to residents to prevent infection. Staff Z stated the expected the CNAs to help residents one at time to prevent cross-contamination. REFERENCE: WAC 388-97-1320 (1)(a)(c). 46471