STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505473	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agility Health and Rehabilitation	5520 Bridgeport Way West University Place, WA 98467

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on interview and record review, the facility failed to provide and accurately complete in writing the required forms of their potential liability for payment, related to Medicare services ending, for 1 of 3 sampled residents (Resident 14) reviewed for coverage notification. Failure to ensure Resident 14 was provided the Notice of Medicare Non-Coverage (NOMNC) and Skilled Nursing Facility (SNF) Advanced Beneficiary Notice (ABN: a notification that provides an estimated cost of continuing services which may no longer be covered by Medicare. Beneficiaries may choose to continue the services but may be financially liable), diminished their ability to make informed financial and care decisions related to their continued stay. Findings included . Resident 14 admitted to the facility on [DATE] with diagnoses that included pneumonia (lung infection) and weakness and was able to make needs known. Review of Resident 14's electronic health record (EHR) showed Resident 14 was their own responsible party (manages, directs, and controls funds and assets) and did not have a durable power of attorney (DPOA: legal document that allows someone else to act on their behalf when they cannot). The EHR did not show documentation that Resident 14 was provided the NOMNC or SNF ABN required forms related to Medicare services ending. Review of Resident 14's NOMNC form, dated 03/04/2024, showed Resident 14's coverage of skilled nursing services would end on 03/07/2024 and liability began on 03/08/2024. It showed that on 03/04/2024 at 11:30 AM, Staff C, Business Office Manager (BOM), had signed and dated a section on the form that they had informed Resident 14's emergency contact via phone. It showed no documentation of a signature or the date by the signature line from the resident or resident representative located on the form and no other documentation written on the form. Review of Resident 14's SNF ABN Notice of Non-coverage form, undated and unsigned, showed it was determined that the resident's Medicare/insurance would not cover room and board beginning on 03/08/2024. It had a box checked on the form that showed the resident wanted care and not to bill Medicare and that they understood that they (Resident 14) may be billed because they were responsible for payment of the care. It showed Resident 14 could not appeal because Medicare would not be billed. It showed the word Phone handwritten on the line for the signature of patient or authorized representative and no other documentation noted on the form. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505473	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agility Health and Rehabilitation	5520 Bridgeport Way West University Place, WA 98467

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/08/2024 at 1:34 PM, Staff C stated they should have documented on Resident 14's NOMNC and SNF ABN forms, additional information related to completing the forms and attempts to obtain signatures. During an interview on 05/08/2024 at 1:47 PM, after reviewing Resident 14's NOMNC and SNF ABN forms, Staff A, Administrator, stated Resident 14's documented forms did not meet expectations. Reference WAC 388-97-0300 (1)(e), (5), (6)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505473	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agility Health and Rehabilitation	5520 Bridgeport Way West University Place, WA 98467

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on interview and record review, the facility failed to accurately assess 2 of 22 sampled residents (Residents 2 and 68) when reviewed for comprehensive assessment. This failure placed residents at risk of unidentified care needs, lack of care planning, lack of needed services, and a diminished quality of life. Findings included . Resident 2 Review of Resident 2's annual minimum data set (MDS), an assessment tool, dated 03/17/2024, showed the resident did not have a pre-admission screening and resident review (PASRR) level two and did not have dental issues. Review of Resident 2's electronic health record showed a PASRR level two was completed on 05/19/2023. During an interview on 05/06/2024 at 10:00 AM, Resident 2 stated they had lost their denture since October of 2023. Review of a progress note, dated 10/10/2023, showed Resident 2 had reported they lost their denture. Review of a denture consultation, dated 01/24/2024, showed a referral for x-ray and extraction of a tooth, and recommendation for new lower partial denture. During an interview on 05/09/2024 at 1:04 PM, Staff J, MDS Coordinator/Licensed Practical Nurse (MDS-C/LPN), stated Resident 2's level two PASRR was overlooked and the MDS was coded inaccurately for PASRR. Staff J stated Resident 2 had missing teeth and partial dentures, but they were coded as having no dental issues because the resident had not complained of dental issues within the seven-day lookback period for the assessment. Resident 68 Review of Resident 68's quarterly MDS, dated [DATE], showed the resident had adequate vision without corrective lenses. During an interview on 05/06/2024 at 10:17 AM, Resident 68 stated they had two cataracts (a condition in which the lens of the eye becomes cloudy) and their vision was blurred. Review of the care plan, dated 07/22/2022, showed a focus area related to cataracts which caused impaired vision. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505473	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agility Health and Rehabilitation	5520 Bridgeport Way West University Place, WA 98467

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/09/2024 at 1:04 PM, Staff J stated Resident 68 had not mentioned vision issues so was coded as having no vision issues. Staff J stated staff would look at medical records and previous MDS to code for vision issues. During an interview on 05/09/2024 at 1:44 PM, Staff B, Director of Nursing Services, stated the PASRR section was coded inaccurately for Resident 2's MDS. Staff B stated Resident 2 was now complaining of dental issues and would be coded as having dental problems. Staff B stated Resident 68 had no treatment or diagnosis for vision issues, but the resident would be re-assessed for vision issues. 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
	505473	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agility Health and Rehabilitation	5520 Bridgeport Way West University Place, WA 98467

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on interview and record review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASRR) assessment was accurately completed upon or prior to admission for 1 of 5 sampled residents (Resident 76) reviewed for unnecessary medications. This failure placed the resident at risk for inappropriate placement and/or not receiving timely and necessary services to meet one's mental health care needs. Findings included . Resident 76 was admitted to the facility on [DATE] with diagnoses that included depression and adjustment disorder with anxiety (emotional or behavioral problems that occur after a stressful life event). Review of the quarterly minimum data set (MDS), an assessment tool, dated 03/13/2024, showed Resident 76 was able to make their needs known. Review of the PASRR assessment, dated 11/17/2022, completed by the hospital prior to Resident 76's admission on 01/11/2023, showed no serious mental illness indicators documented on the form. This form showed, No Level II evaluation indicated. Review of Resident 76's electronic health record showed no documentation another PASRR had been completed. During an interview on 05/08/2024 at 10:35 AM, Staff D, Senior Regional Social Services Director, stated Resident 76's 11/17/2022 PASRR was missing the diagnoses of depression and adjustment disorder with anxiety, and this did not meet expectations. During an interview on 05/08/2024 at 11:22 AM, Staff B, Director of Nursing Services, stated Resident 76's 11/17/2022 PASRR did not meet expectations because of missing diagnoses and another PASRR assessment needed to be completed. Reference WAC 388-97-1975

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505473	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agility Health and Rehabilitation	5520 Bridgeport Way West University Place, WA 98467

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of practice for 2 of 25 sampled residents (Residents 214 and 39) reviewed for quality of care. The facility failed to ensure Resident 214's peripherally inserted midline catheter (PICC, a long flexible catheter [tube] placed into a vein in the upper arm and into a large vein) and Resident 39's provider order for a referral to urology (a provider that specialized in diagnosing and treating diseases of the urinary organs) was obtained. These failures placed residents at risk of medical complications, unmet needs, and a poor quality of life. Findings included . According to the Lippincott Manual of Nursing Practice, Tenth Edition ([NAME], [NAME] & [NAME], 2014, page 16), The practice of professional nursing has standards of practice setting minimum levels of acceptable performance for which its practitioners are accountable. According to [NAME], Duell & [NAME], Clinical Nursing Skills, 6th Edition, page 4, Nurse Practice Act identified skills and functions that professional nurses perform in daily practice included, in part, to administer treatments per physician's orders. The Washington State Nurse Practice Act, WAC 246-840-710(2)(d), states nurses violate standards of practice by, Willfully or repeatedly failing to administer medications and/or treatments in accordance with nursing standards. Resident 214 Resident 214 admitted to the facility on [DATE] with diagnoses to include osteomyelitis (inflammation of bone or bone marrow usually due to infection) to the left lower extremity (left foot and ankle). Review of Resident 214's electronic health record (EHR) showed they were admitted for long term intravenous (IV) antibiotic treatment and had a PICC line inserted into their right arm. Review of the April 2024 medication administration record (MAR) showed an order dated 04/27/2024 for vancomycin (an antibiotic used in the treatment of bacterial infections) one time a day and cefepime (an antibiotic used to treat bacterial infections) every eight hours via PICC. The resident's MAR had several IV protocol orders that directed licensed nurse (LN) staff to: change the IV dressing as needed, and to monitor the insertion site every shift for signs and symptoms of infection; however, no order directed the LNs to ensure proper measurements of the PICC line at the insertion site. Review of Resident 214's care plan, dated 04/26/2024, showed the resident was on IV antibiotic therapy related to left lower extremity wound infection with chronic left ankle osteomyelitis. Several interventions were documented for the LN to monitor the IV site for complications; however, no care plan documentation showed for the LNs to measure the PICC line catheter length prior to administering the IV antibiotic medication infusion. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505473	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agility Health and Rehabilitation	5520 Bridgeport Way West University Place, WA 98467

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 5/09/2024 at 7:54 AM, Resident 214 laid in bed within their room. The resident stated they had been admitted for antibiotic therapy for an infection and that the nurses administered the antibiotic every day into their PICC line; however, the resident was unaware of whether LN staff measured the PICC catheter prior to administering the IV antibiotic. During an interview on 05/09/2024 at 8:01 AM, Staff G, Licensed Practical Nurse (LPN), stated the PICC line insertion site was assessed for infection and monitored for possible infiltration every day; however, they were unaware and/or did not ensure the correct measurements were in place or recorded prior to infusion of the resident's IV antibiotics. During an interview on 05/09/2024 at 9:45 AM, Staff B, Director of Nursing Services (DNS), stated the facility did not receive the measurement of the PICC line insertion site from the hospital documentation; however, they would change the order to reflect the actual measurements at the insertion site so that LNs would ensure the correct placement of the PICC line catheter prior the administration or infusion of the antibiotic medications. Resident 39 Resident 39 admitted to the facility on [DATE] with diagnoses to include heart disease, diabetes, urinary tract infection (UTI), and depression. Review of Resident 39's focus care plan, dated 04/04/2024, showed the resident had bladder incontinence (lack of voluntary control over urination). Review of Resident 39's clinical progress notes showed that the resident complained of dysuria (painful or difficult urination) on the following dates: 04/30/2024 and 05/06/2024. Review of Resident 39's EHR showed a provider had ordered the resident to be referred to a urologist on 04/08/2024 due to a mass (an abnormal growth of cells, a cyst, hormonal changes, or an immune reaction which may be benign [not cancer] or malignant [cancer]) on Resident 39's left kidney. On 05/08/2024 no documentation was found within the resident's EHR of the urologist consultation results or whether the consultation was obtained. During an interview on 05/08/2024 at 1:48 PM, Staff K, Certified Nurse Aide (CNA), stated they were the transportation coordinator for the facility and were tasked to schedule any provider's orders that required a referral; however, they had just received the communication document and would now send the urology referral today. During an interview on 05/08/2024 at 1:50 PM, Staff F, Assistant Director of Nursing Services (ADNS), stated their expectation would be for the providers urology referral for Resident 39, dated 04/08/2024, be sent when it was ordered rather than 30 days later. Reference WAC 388-97-160(2)(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505473	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agility Health and Rehabilitation	5520 Bridgeport Way West University Place, WA 98467

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46827 Based on interview, observation, and record review, the facility failed to ensure transfer pole and bed mobility bar (safety devices used for residents to assist in transfers and/or positioning) provider orders were obtained, assessments were completed, and care plan was updated for 1 of 3 sampled residents (Resident 11) reviewed for accident hazards. This failure placed residents at risk of improper transfer pole and bed mobility bar use, decreased freedom of movement, and a decreased quality of life. Findings included . Resident 11 admitted to the facility on [DATE], with a recent readmission on 03/30/2024, with multiple diagnoses to include hemiplegia unspecified affecting left nondominant side (paralysis of left side of body). Multiple observations on 05/06/2024, 05/07/2024, 05/08/2024, and 05/09/2024 showed a transfer pole next to Resident 11's left side of the bed and a bed mobility bar to the right side of the bed. There were no observed markings on the floor or the wall to indicate the appropriate position that the bed should be placed in relation to the transfer pole to ensure safe placement for transfers. During an interview on 05/06/2024 at 11:46 AM, Resident 11 said they used the transfer pole with the assistance of staff to transfer into and out of bed and used the bed mobility bar to assist in repositioning in their bed. Review of Resident 11's electronic health record (EHR) showed no provider orders for the use of a transfer pole or bed mobility bar, no safety device assessments or consents for transfer pole or bed mobility bar, and no care plan intervention related to the use of the bed mobility bar to the right side of the bed. On 05/09/2024 at 10:09 AM, Staff N, Registered Nurse/Manager, said there should be a physician order, assessment/consent, and the care plan updated for all safety devices. At 10:10 AM, Staff B, Director of Nursing Services, said upon admission if safety devices were needed there should be an order from the provider, an assessment/consent, and a care plan. Reference WAC 388-87-1060 (3)(g)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505473	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agility Health and Rehabilitation	5520 Bridgeport Way West University Place, WA 98467

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on interview and record review, the facility failed to ensure enteral nutrition (the delivery of nutrients through a feeding tube directly into the stomach or small intestine) was administered in accordance with provider's orders and professional standards of practice for 1 of 1 sampled resident (Resident 15) reviewed for enteral nutrition. The facility failed to have a system in place which ensured the amount of enteral formula (liquid food products) a resident received was reconciled with the amount they were ordered to receive. This failure placed the residents at risk for inadequate nutrition, dehydration, and other adverse outcomes. Findings included . Resident 15 was admitted to the facility on [DATE] with diagnoses including stroke, hemiplegia (paralysis of one side of the body), and dysphagia (difficulty swallowing). Review of the admission minimum data set (MDS), an assessment tool, dated 04/21/2023, showed Resident 15 had malnutrition and received their nutrition through a feeding tube. Review of a focused care plan, revised on 04/18/2024, showed the resident required a tube feed related to dysphagia. The goal for Resident 15 was to maintain adequate nutritional and hydration status as evidence by a stable weight and no signs or symptoms of malnutrition or dehydration. Interventions included staff to monitor caloric intake and follow current providers orders for (tube) feeding. An additional care plan focus showed the resident had nutritional problem related to dysphagia and stroke and the resident would maintain adequate nutritional status as evidence by maintaining weight. Interventions included licensed nurses (LN) to monitor acceptance of diet and to report to the provider weight loss of 3 pounds (lbs.) in a week. Review of a provider order, dated 04/17/2024, showed orders for enteral feeding one time a day of Osmolite 1.5 to infuse at 50 milliliters (mls.) per hour for a total of 1000 ml via feeding tube. The order instructed the LN to record the total volume infused at disconnect and to notify the provider if the volume was less than or greater than 200 ml of the goal (1000ml). Review of April 2024 and May 2024 medication administration records (MAR), from 04/18/2024 - 04/30/2024 and 05/01/2024 to 05/06/2024, showed scheduled enteral feeding time to end at 1200 (noon) daily and to restart every day at 4:00 PM. The MAR showed an area in which the LNs were to document the amount of enteral formula provided. The MARs showed multiple documented X, that was documented rather than the total amount infused. Review of Resident 15's electronic health record (EHR) showed a weight of 135.2 pounds was recorded on 05/02/2024. The next documented weight was 125.4 pounds on 05/07/2024, a 9.8 lbs. weight loss. During an interview on 05/08/2024 at 11:26 AM, Staff H, Licensed Practical Nurse/Resident Care Manager (LPN/RCM), stated Resident 15's recent weight loss should have been placed into the weight loss binder to inform the registered dietician, but it appeared that did not happen. Staff H stated they discussed any resident weight loss every Tuesday afternoon; however, the resident was weighed late that evening, so it was not addressed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505473	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agility Health and Rehabilitation	5520 Bridgeport Way West University Place, WA 98467

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/08/2024 at 11:29 AM, Staff G, LPN, stated Resident 15's recent weight loss was documented in the evening on 05/07/2024 at 6:16 PM. Staff G stated if the weight loss was significant then the resident should have been re-weighed, and/or documented the correct weight and to notify the provider of any significant change in weight. Staff G also stated they were to clear out the total and record the amount of enteral feed infused on the MAR; however, it appeared that the total had not been recorded in MAR and should have been. During an interview on 05/08/2024 at 1:11 PM, Staff F, Assistant Director of Nursing Services (ADNS), stated their expectations would have been for Resident 15 to be re-weighed, documented, and informed the provider/registered dietician if there was a significant weight loss. During an interview on 05/08/2204 at 12:20 PM, Staff E, Registered Dietician, stated they were surprised that there was no area within the EHR MAR where the LNs could input the total volume of enteral feed infused but there should have been. Staff E stated the resident was just re-weighed and had a documented weight of 132.2 pounds. Staff E stated they started the resident on additional nutrition intake of liquid protein twice a day. During an interview on 05/08/2024 at 12:34 PM, Staff B, Director of Nursing Services, stated Resident 15 should have had enteral feed totals of fluids provided, monitored, and documented for nutritional intake per provider orders. Staff B stated, in response to Resident 15's significant weight decline, LNs should have either re-weighed the resident and/or notified the provider if there was a decline in weight and this did not meet their expectations. Reference WAC 388-97-1060 (3)(f) .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505473	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agility Health and Rehabilitation	5520 Bridgeport Way West University Place, WA 98467

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 40817 Based on interview and record review, the facility failed to provide timely dental assistance to residents for 2 of 3 sampled residents (Residents 2 and 53) when reviewed for dental services. This failure placed residents at risk of dental pain, difficulty eating, avoidable weight loss, and a diminished quality of life. Findings included . Resident 2 During an interview on 05/06/2024 at 10:00 AM, Resident 2 stated they had been missing their denture since October of 2023. Review of a progress note, dated 10/10/2023, showed Resident 2 had reported a missing denture. Review of a denture consultation, dated 01/24/2024, showed referral for x-ray and extraction of a tooth, and recommendation for new lower partial denture. During an interview on 05/09/2024 at 12:22 PM, Staff L, License Practical Nurse Supervisor, stated Resident 2 had been referred for an extraction and new dentures on 01/24/2024, but this had not occurred. Resident 53 During an interview on 05/07/2024 at 8:25 AM, Resident 53 stated they had four teeth. Review of Resident 53's care plan, initiated 12/25/2023, showed a focus area for the resident having four teeth with an intervention for referral to the dentist/hygienist. During an interview on 05/09/2024 at 11:20 AM, Staff L stated Resident 53 had not been seen by the dentist/hygienist and they should have been seen as soon as possible given their dental status. During an interview on 05/09/2024 at 1:19 PM, Staff B, Director of Nursing Services, stated dental referrals should be done as soon as possible. Reference WAC 388-97-1060 (1), (3)(j)(vii)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505473	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agility Health and Rehabilitation	5520 Bridgeport Way West University Place, WA 98467

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40817 Based on observation and interview, the facility failed to maintain resident refrigerators in sanitary conditions for 1 of 1 resident refrigerator when reviewed for kitchen. This failure placed residents at risk of consuming contaminated foods, foodborne illness, and a diminished quality of life. Findings included . Observation on 05/07/2024 at 12:38 PM of the resident refrigerator's freezer showed a severely freezer burnt hotdog in a plastic container without a date label and a box of yogurt sticks with a best by date of November 2023. Review of the refrigerator section showed a brown paper bag dated 04/26/2024 with artichoke dip and antipasto salad with sell through dates of 04/29/2024, an original cardboard pizza box with a date of 04/26/2024 with dried, curled slices of pizza, a small cake without name or date, a plastic bag with a hamburger wrapped in paper with no name or date, and a bag with cut fruit with a sell through date of 04/22/2024. During an interview on 05/07/2024 at 12:52 PM, Staff M, Dietary Supervisor, stated the resident refrigerator did not meet expectation for sanitary food storage. During an interview on 05/07/2024 at 1:04 PM, Staff A, Administrator, stated resident food should be marked with a name and date label and thrown out after three days. Staff A stated that the resident refrigerator did not meet expectation. Reference WAC 388-97-1100 (3), -2980