STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505517	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Veteran Home-Retsil	1141 Beach Drive PT Orchard, WA 98366

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45203 Based on observation, interview, and record review, the facility failed to ensure activities of daily living (ADLs) were consistently provided for residents dependent on staff to perform oral care for 1 of 3 residents (1) reviewed for ADL care for dependent residents. This failure placed residents at risk of unmet care needs, poor oral hygiene, and a diminished quality of life. Findings included . Review of the facility policy/procedure titled Mouth Care, revised 02/2018, showed oral care was to be provided to clean and freshen the mouth and to prevent oral infection. The procedure spelled out the steps to perform oral care and directed staff to document the care provided and if the resident refused. If the resident refused, staff were to document interventions provided and report to their supervisor. Resident 1 was admitted to the facility on [DATE]. The Annual Minimum Data Set (MDS), an assessment tool, dated 03/21/2024, documented Resident 1 had severe cognitive impairment with non-traumatic brain dysfunction, and was dependent on staff for all ADLs. The care plan, initiated 03/17/2023, included ADL self-care deficit and staff interventions included to provide oral care twice daily and as needed using a moistened toothette and tongue scraper. Review of Resident 1's task record for oral care for April 2024 showed no documented oral care on 9 of 30 day shifts with no documented refusals, no documented oral care on 8 of 30 evening shifts with no documented refusals, and no oral care on 12 of 30 night shifts with two documented refusals. Review of Resident 1's task record for oral care for May 2024 showed Resident 1 was not provide oral care as directed for 6 of the 12 days she was admitted in the facility. A Dental Hygienist provider note, dated 05/21/2024, documented, heavy mucus dried to gums and roof of mouth, please swab her mouth, very dry, very sticky mucus dried to roof of mouth and very dry mouth-mucus dried and stuck all over mouth, needs oral swab to moisten. Observation of photos taken on 06/02/2024 at 11:26 PM, showed Resident 1's oral cavity with dried brown and yellow matter stuck to the entirety of the roof of the mouth, dried brown and yellow matter stuck to teeth, dried white and yellow matter stuck to entirety of tongue. (continued on next page)

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
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/05/2024 Collateral Contact 1, resident representative, said Resident 1 was not getting the oral care that she needed, her tongue looked like it was painted with a yellow, goopy coating. They said there either was not enough staff to provide adequate care or the staff were not instructed how to perform the oral care. On 06/26/2024 at 3:10 PM, Staff E, Nursing Assistant, said oral care was provided to Resident 1 every day, but sometimes she was unable to get to it and she would provide oral care every other day. When asked if she was able to provide oral care to all residents who require assistance, Staff F said, most of the time, but some staff, don't do it at all. At 4:53 PM, Staff C, Registered Nurse (RN), Unit Care Coordinator, said she monitored that residents were receiving oral care via observations and documentation in the record. Staff C said Resident 1 was supposed to have her teeth brushed by the licensed nurse twice a day in addition to the oral care provided by the nursing assistants. Staff C said Resident 1 was resistant to having oral care provided. On 07/12/2024 at 12:58 PM, Staff D, Licensed Practical Nurse, said Resident 1 should receive oral care twice a day, and that Resident 1 was ok with the swabs but did not like to have her teeth brushed. When asked if they felt staff had enough time to provide oral care as directed, Staff D said, No, if we had a treatment nurse we could, but this is a heavy care unit, and it is hardly doable. At 1:33 PM, Staff B, Director of Nursing, RN, said oral care for a resident with a NPO (nothing by mouth) status should be every shift and as needed. Staff B said they were unaware of any concerns regarding resident refusals of oral care or staff challenges in completing oral care as directed. Reference WAC 388-97-1060 (2)(c)