STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505522	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salmon Creek Post Acute & Rehabilitation	2811 NE 139th Street Vancouver, WA 98686

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48392 Based on interview and record review, the facility failed to ensure a comprehensive individualized care plan was developed with specific information for that resident for 6 of 6 sampled residents (1, 2, 3, 4, 5, and 6) reviewed for care plans. This failure placed residents at risk for unmet care needs and a diminished quality of life. Findings included . 1) Resident 1 was admitted to the facility on [DATE] with diagnosis including Congestive Heart Failure, Hypothyroid, Hyperlipidemia (HLD - high cholesterol). The admission Minimum Data Set (MDS) assessment, dated 07/19/2024, showed Resident 1 had moderate cognitive impairment and utilized a walker to assist with ambulation. Review of Resident 1's Care Plan, initiated 07/14/2024, showed the following segments were incomplete and/or not individualized: --Focus: The resident has an ADL [activities of daily living] self-care performance deficit AEB [as evidenced by] Intervention: physical assist as needed with Intervention: provide supervision and cueing as needed with Intervention: Oral Care Routine: Specify Intervention: Eating: The resident requires (specify what assistance) by (X) staff to eat. Intervention: Toileting: The resident requires (specify what assistance) by (X) staff for toileting. (Areas to fill in were left blank.) --Focus: The resident has limited physical mobility AEB Intervention: Ambulation: the resident requires (specify assistance) by (X) staff to walk. (specify frequency) and as necessary. (Areas to fill in were left blank.) (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
	505522	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salmon Creek Post Acute & Rehabilitation	2811 NE 139th Street Vancouver, WA 98686

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Focus: The resident has impaired cognitive function/dementia or impaired thought processes AEB (Areas to fill in were left blank.) --Focus: The resident has (specify urge, stress, functional, mixed) bladder incontinence r/t [related to] Intervention: Brief Use: The resident uses (specify size) disposable briefs. Change (specify frequency) and PRN [as needed]. (Areas to fill in were left blank.) --Focus: The resident has (specify acute/chronic) pain r/t (Areas to fill in were left blank.) --Focus: The resident wishes to (specify return/be discharged) to (specify home, another facility) Intervention: Evaluate/record .Address gaps by (community referral to specify, pre-discharge PT/OT [physical therapy/occupational therapy], internal referral to specify) Intervention: Make arrangements (specify home care, PT, OT, MD, wound nurse) Intervention: The resident needs (specify assistance/supervision) with (specify communicate/describe needs, book appointments .) on discharge to community. (Areas to fill in were left blank.) --Focus: The resident has bowel incontinence r/t (Areas to fill in were left blank.) 2) Resident 2 was admitted to the facility on [DATE] with diagnoses including Type 1 Diabetes Mellitus, Acute Kidney Failure, and Hypertension (high blood pressure). The admission MDS assessment, dated 08/03/2024, showed Resident 2 had severe cognitive impairment and ambulated independently. Review of Resident 2's Care Plan showed the following segments were incomplete and/or not individualized: --Focus: The resident has (specify acute/chronic) pain r/t Intervention: Administer analgesia (specify medication) as per orders. (Areas to fill in were left blank.) --Focus: The resident wishes to discharge home. Intervention: Make arrangements (specify home care, PT, OT, MD, wound nurse) (Areas to fill in were left blank.) 3) Resident 3 was admitted to the facility on [DATE] with diagnosis including aortic valve stenosis, muscle weakness, hypertension, and sarcopenia (loss of muscle tissue as part of aging). The MDS assessment, dated 08/11/2024, showed Resident 3 had moderate cognitive impairment and required moderate assistance with ambulation. Review of Resident 3's Care Plan showed the following segments were incomplete and/or not individualized: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505522	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salmon Creek Post Acute & Rehabilitation	2811 NE 139th Street Vancouver, WA 98686

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Focus: The resident has an ADL self-care performance deficit AEB Goal: The resident will maintain current level of function in (specify) through the review date. Intervention: physical assist as needed with Intervention: provide supervision and cueing as needed with Intervention: Oral Care Routine: Specify (Areas to fill in were left blank.) --Focus: the resident has a communication problem r/t Goal: the resident will be able to make needs known by (specify) on a daily basis . (Areas to fill in were left blank.) --Focus: The resident has a behavior problem (specify) r/t Goal: The resident will have no evidence of behavior problems (specify) by review date. (Areas to fill in were left blank.) --Focus: The resident is on IV [intravenous] medications (specify medications) r/t Intervention: IV dressing: (specify location and type), observe dressing (specify frequency), change dressing and record observations of site (specify frequency). (Areas to fill in were left blank.) --Focus: The resident has (specify acute/chronic) pain r/t Intervention: Administer analgesia (specify medication) as per orders. (Areas to fill in were left blank.) --Focus: The resident wishes to (specify return/be discharged) to (specify home, another facility) Intervention: Evaluate/record . Address gaps by (community referral to specify, pre-discharge PT/OT, internal referral to specify) Intervention: Make arrangements . (specify home care, PT, OT, MD, wound nurse) Intervention: The resident needs (specify assistance/supervision) with (specify communicate/describe needs, book appointments .) on discharge to community. (Areas to fill in were left blank.) --Focus: The resident has altered respiratory status/difficulty breathing AEB (Areas to fill in were left blank.) 4) Resident 4 was admitted to the facility on [DATE] with diagnoses including Urinary Tract Infection, Hematuria (blood in urine), and Hypertension. The admission MDS assessment, dated 08/17/2024, showed Resident 4 had severe cognitive impairment and ambulates with use of a wheelchair. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505522	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salmon Creek Post Acute & Rehabilitation	2811 NE 139th Street Vancouver, WA 98686

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 4's Care Plan showed the following segments were incomplete and/or not individualized: --Focus: The resident has an ADL self-care performance deficit AEB Intervention: physical assist as needed with (Areas to fill in were left blank.) --Focus: The resident has limited physical mobility AEB Intervention: The resident requires (specify assistance___by (x) staff to walk (specify frequency) and as necessary. (Areas to fill in were left blank.) --Focus: The resident has impaired cognitive function/dementia or impaired thought processes AEB Goal: The resident will remain orient to (specify person, place, sit, time) through the review date. (Areas to fill in were left blank.) --Focus: The resident wishes to (specify return/be discharged) to (specify home, another facility) Intervention: Evaluate/record . Address gaps by (community referral to specify, pre-discharge PT/OT, internal referral to specify) Intervention: Make arrangements . (specify home care, PT, OT, MD, wound nurse) Intervention: The resident needs (specify assistance/supervision) with (Specify communicate/ describe needs, book appointments .) on discharge to community. (Areas to fill in were left blank.) 5) Resident 5 was admitted to the facility on [DATE] with diagnoses including multiple sclerosis, muscle weakness, and paraplegia. The admission MDS assessment, dated 08/05/2024, showed Resident 5 was cognitively intact and ambulated with assistance of a wheelchair. Review of Resident 5's Care Plan showed the following segments were incomplete and/or not individualized: ==Focus: The resident has an ADL self-care performance deficit. Goal: The resident will maintain current level of function in (specify) through the review date. Intervention: Provide supervision and cueing as needed with (Areas to fill in were left blank.) ==Focus: The resident has occasional bladder incontinence. Intervention: Incontinent: Check (specify frequency) and as required for incontinence. (Areas to fill in were left 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
	505522	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salmon Creek Post Acute & Rehabilitation	2811 NE 139th Street Vancouver, WA 98686

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6) Resident 6 was admitted to the facility on [DATE] with diagnoses including Congestive Heart Failure and class III Obesity (morbid obesity). The admission MDS assessment, dated 08/01/2024, showed Resident 6 was cognitively intact and ambulated with assistance of a wheelchair. Review of Resident 6's Care Plan showed the following segments were incomplete and/or not individualized: --Focus: The resident has an ADL self-care performance deficit AEB Goal: The resident will improve current level of function in (specify ADLs) resident will be able to (specify). Interventions: Physical assist as needed with Interventions: Provide supervision and cuing as needed with Intervention: Oral Care Routine: Specify Intervention: Eating: The resident requires (Specify what assistance) by (X) staff to eat. Intervention: Toileting: The resident requires (Specify what assistance) by (X) staff for toileting. (Areas to fill in were left blank.) --Focus: The resident has (specify urge, stress, functional, mixed) bladder incontinence r/t Intervention: Brief Use: The resident uses (specify size) disposable briefs. Change (specify frequency) and PRN. (Areas to fill in were left blank.) --Focus: [Resident 6] has a mood problem r/t Goal: The resident will have improved mood state (specify happier, calmer .) through review date. (Areas to fill in were left blank.) --Focus: The resident is at risk of fall r/t (Areas to fill in were left blank.) --Focus: The resident has a swallowing problem r/t (Areas to fill in were left blank.) --Focus: The resident has (specify acute/chronic) pain r/t (Areas to fill in were left blank.) --Focus: The resident has bowel incontinence r/t (Areas to fill in were left blank.) On 08/23/2024 at 1:40 PM, Staff B, Director of Nursing Services and Registered Nurse, said the Resident Care Managers (RCMs) are tasked with writing the comprehensive care plans. Staff B said the incomplete segments of the care plans should have been completed with person-centered information, and she would be providing education to the RCMs regarding the incomplete segments. Reference WAC 388-97-1020 (1), (2)(a)(c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505522	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salmon Creek Post Acute & Rehabilitation	2811 NE 139th Street Vancouver, WA 98686

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48392 Based on interview and record review, the facility failed to ensure residents were free from significant medication errors when medications were not administered in accordance with provider orders for 4 of 6 sampled residents (Residents 1, 2, 5, & 6) reviewed for significant medication errors. This failure placed residents at risk of adverse medical conditions, a change in health condition and a diminished quality of life. Findings included . Review of the facility policy Medication Error Reporting, undated, noted, Medication error/variance shall be defined as any preventable event that may cause or lead to inappropriate medication use or resident harm while the medication is in the control of the health care professional . 1) Resident 1 was admitted to the facility on [DATE] with diagnoses including Congestive Heart Failure, Hypothyroid, Hyperlipidemia (HLD - high cholesterol). The admission Minimum Data Set (MDS) Assessment, dated 07/19/2024, showed Resident 1 had moderate cognitive impairment and utilized a walker to assist with ambulation. Review of Resident 1's July 2024 Medication Administration Record (MAR), a comprehensive record of physicians' orders and the medications administered to a resident, showed the following medications were omitted/not administered: -07/22/2024 at 8:00 PM- Atorvastatin Calcium 40 mg, ordered to address HLD. -07/23/2024 at 5:00 AM- Levo-T 125 MCG, ordered to address hypothyroid. 2) Resident 2 was admitted to the facility on [DATE] with diagnoses including Type 1 Diabetes Mellitus, Acute Kidney Failure, and Hypertension (high blood pressure). The admission MDS assessment, dated 08/03/2024, showed Resident 2 had severe cognitive impairment and ambulated independently. Review of provider communication within the Progress Notes, showed on 08/10/2024 at approximately 2:00 AM, Resident 2 was sent to the hospital and returned at approximately 5:00 AM. Review of the facility's Incident Audit Report, dated 08/19/2024, showed Resident 2's medications were placed on hold when Resident 2 went to the hospital and had not been restarted and noted, Resident did not receive medications for this day until noted by nurse at approximately 18:25 [6:25 PM] today. Review of Resident 2's August 2024 MAR showed the following were not administered/completed per physicians orders: -08/10/2024 at 8:00 AM- Losartan Potassium 25 MG, ordered to address HTN. -08/10/2024 at 8:00 AM- Namenda 5 MG, ordered to address Dementia/Alzheimer's. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505522	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salmon Creek Post Acute & Rehabilitation	2811 NE 139th Street Vancouver, WA 98686

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-08/07/2024 at 6:00 PM- Nutritional shake 4 ounces, no sugar added. -08/10/2024 at 6:00 PM- Nutritional shake 4 ounces, no sugar added. -08/10/2024 at 8:00 AM- Basaglar KwikPen 10 U, ordered to address type 1 Diabetes Mellitus. -08/10/2024 at 8:00 AM- Polyethylene Glycol 17 grams, ordered to address constipation. -08/10/2024 at 8:00 AM- Senna 8.6 MG, ordered to address constipation. -08/10/2024 at 8:00 AM- Timolol Maleate 0.5%, ordered to address glaucoma. -08/10/2024 at 8:00 AM- Humalog 6 U, ordered to address type 1 Diabetes Mellitus. -08/10/2024 at 12:00 PM- Humalog 6 U, ordered to address type 1 Diabetes Mellitus. -08/10/2024 at 5:00 PM- Humalog 6 U, ordered to address type 1 Diabetes Mellitus. -08/10/2024 at 7:00 AM- CBG (capillary blood glucose test), ordered to address type 1 Diabetes Mellitus. 3) Resident 5 was admitted to the facility on [DATE] with diagnoses including multiple sclerosis, muscle weakness, and paraplegia. The admission MDS assessment, dated 08/05/2024, showed Resident 2 was cognitively intact and ambulated with assistance of a wheelchair. Review of Resident 2's August 2024 MAR showed the following was not administered/completed per physicians' orders: -08/08/2024 at 2:00 PM- Hydrocortisone External Cream 2.5%, ordered for facial rash. 4) Resident 6 was admitted to the facility on [DATE] with diagnoses including Congestive Heart Failure (CHF) and class III Obesity (morbid obesity). The admission MDS assessment, dated 08/01/2024, showed Resident 2 was cognitively intact and ambulated with assistance of a wheelchair. Review of Resident 2's August 2024 MAR showed the following was not completed per physicians' orders: -08/07/2024 at 6:15 AM- Daily weight every dayshift, ordered for CHF (a sudden increase in weight can indicate retention of water and salt and can be a sign of worsening heart failure). On 08/23/2024 at 1:40 PM, Staff B, Director of Nursing Services and Registered Nurse, said if there was a valid reason a resident had not been administered their medication, the MAR would indicate such with use of a letter in the administration box; the letters utilized have a key describing the valid reason the medication was not administered (example H indicates the medication was Held). Staff B said they intend to educate nursing staff regarding medication omissions. Reference WAC 388-97-1260 (3)(k)(iii)