

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  Cedar River Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  17420 106th PI SE Renton, WA 98055	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>50511</p> <p>Based on observation, interview, and record review the facility failed to provide care and services in a manner that maintained and promoted dignity for 1 of 16 sample residents reviewed (Resident 214). This failure placed residents at risk for a diminished sense self-worth and overall well-being.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's revised February 2021 Dignity Policy each resident would be cared for in a manner that promoted or enhanced their sense of well-being. The policy showed when staff helped with care, residents should be supported and provided with a dignified dining experience.</p> <p>&lt;Resident 214&gt;</p> <p>According to the 04/10/2025 Admission Minimum Data Set (MDS - an assessment tool) Resident 214 needed substantial/maximal assistance with eating due to fractures to right and left shoulders.</p> <p>In an interview and observation on 04/15/2025 at 8:20 AM, Resident 214 stated they had to be fed because they could not move their arms due to their shoulder fractures. Staff G (Certified Nursing Assistant) assisted Resident 214 with four large bites of oatmeal and then left the room. Resident 214 stated they thought the staff were very busy with other residents. Staff G did not return to assist Resident 214 until 8:31 AM, 11 minutes later.</p> <p>In an interview on 04/15/2025 at 8:20 AM Staff G stated they would give Resident 214 only four bites of food and then would come back after they finished passing out the rest of the food trays to other residents.</p> <p>In an interview on 04/21/2025 at 11:10 AM Staff B (Director of Nursing) stated they were aware that care staff needed help with tray services and requested that leadership begin helping with meal trays.</p> <p>In an interview on 04/21/2025 at 12:41 PM Staff A (Administrator) stated their expectation was for staff to only place a tray in front of a resident when they were ready to assist that resident with eating the whole meal to help promote dignity to the resident.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>REFERENCE: WAC 388-97-0180(1-4).</p>

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>42203</p> <p>Based on observation, interview, and record review the facility failed to ensure residents' medical information was maintained in a manner to ensure privacy and confidentiality when staff failed to properly secure medical records for 3 of 16 sampled residents (Resident 59, 7, &amp; 50) reviewed for privacy and confidentiality and 7 supplemental residents (Residents 30, 66, 264, 9, 38, 56, &amp; 55). The failure to ensure residents' medical appointment and weight information were stored in a secure manner placed residents at risk for a loss of privacy and a diminished quality of life.</p> <p>&lt;Findings&gt;</p> <p>&lt;Facility Policy&gt;</p> <p>Record review of the facility's December 2016 Resident Rights policy showed facility staff were prohibited from disclosing Protected Health Information (PHI - any information that could be used to identify someone and their health care status). The policy directed staff to make reasonable efforts to protect residents' PHI.</p> <p>&lt;Resident 30&gt;</p> <p>Observations on 04/14/2025 at 10:59 AM and 04/14/2025 at 1:10 PM showed a folder placed upright on the counter at the 3rd floor nurses station. The folder, facing away from the nurse's station and viewable to anyone walking by, had an appointment arrangement form attached to it showing Resident 30's name. This form showed Resident 30 had an appointment at 3:40 PM for oncology (a branch of medicine that specializes in the diagnosis and treatment of cancer) and hematology (the study of blood and blood disorders).</p> <p>&lt;Resident 66&gt;</p> <p>Observations on 04/15/2025 at 8:27 AM showed a folder placed upright on the counter at the third-floor nurse's station. The folder, facing away from the nurse's station and viewable to anyone walking by, had an appointment arrangement form attached to it showing Resident 66's name. This form showed Resident 66 had an appointment at an orthopedic (a medical specialty clinic focused on the diagnosis, treatment, and prevention of diseases, injuries, and deformities of the musculoskeletal system) clinic.</p> <p>Observations on 04/18/2025 at 9:08 AM showed a folder sitting upright on the counter at the third-floor nurse's station. The folder, facing away from the nurse's station and viewable to anyone walking by, had an appointment arrangement form attached to it showing Resident 66's name. This form showed Resident 66 had an appointment at a urology (a medical specialty focused on diagnosing and treating disorders of the urinary system and the male reproductive organs) clinic.</p> <p>&lt;Resident 264&gt;</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observations on 04/16/2025 at 3:16 PM, 04/17/2025 8:09 AM, and 04/17/2025 at 12:38 PM showed a folder placed upright on the counter at the third-floor nurse's station. The folder, facing away from the nurse's station and viewable to anyone walking by, had an appointment arrangement form attached to it showing Resident 264's name. This form showed Resident 264 had an appointment at an orthopedic (a medical specialty clinic focused on the diagnosis, treatment, and prevention of diseases, injuries, and deformities of the musculoskeletal system) clinic.</p> <p>&lt;Resident 9&gt;</p> <p>Observation on 04/16/2025 at 1:14 PM showed an appointment sheet for Resident 9 was placed in an upright document stand on the corner of the second-floor nurse's station. The appointment sheet was easily viewed by passersby. The appointment sheet included Resident 9's name and showed the resident had an orthopedic appointment that day at 1:30 PM. The form showed Resident 9 would see an external orthopedic provider.</p> <p>&lt;Resident 59&gt;</p> <p>Observation on 04/17/2025 at 8:20 AM showed an appointment sheet that included Resident 59's name, was placed in an upright document stand on the corner of the second-floor nurse's station. The appointment sheet was easily readable by anyone passing the station. The sheet showed the resident had an external orthopedic appointment at 10:20 that day.</p> <p>&lt;Resident 38&gt;</p> <p>Observations on 04/18/2025 at 7:57 AM showed a folder sitting upright on the counter at the third-floor nurse's station. The folder, facing away from the nurse's station and viewable to anyone walking by, had an appointment arrangement form attached to it showing Resident 38's name. This form showed Resident 38 had an appointment at a pulmonary (lung) and sleep clinic.</p> <p>&lt;Resident 56&gt;</p> <p>Observation on 04/18/2025 at 9:57 AM showed an appointment sheet including Resident 56's name for a blood draw placed in the same upright document stand on the corner of the second-floor nurse's station. The appointment sheet was easily readable.</p> <p>&lt;Resident 7&gt;</p> <p>Observations on 04/21/2025 at 7:58 AM showed a folder sitting upright on the counter at the 3rd floor nurses station. The folder, facing away from the third-floor nurse's station and viewable to anyone walking by, had an appointment arrangement form attached to it showing Resident 7's name. This form showed Resident 7 had an appointment at radiology (a medical specialty clinic that uses medical imaging to diagnose and treat diseases).</p> <p>&lt;Resident 55&gt;</p> <p>Observation on 04/21/2025 at 9:27 AM showed an appointment sheet for Resident 55 for an external urology appointment placed in the same upright document stand on the corner of the second-floor nurse's station. The appointment sheet was easily readable.</p> <p>(continued on next page)</p>

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>&lt;Resident 50&gt;</p> <p>In an interview on 04/14/2025 at 12:48 PM, Resident 50's family member stated they received an email on 04/10/2025 from the facility which included some information about insurance coverage for another resident, rather than for Resident 50. Resident 50's family member stated they notified the facility of the error.</p> <p>Review of the 04/10/2025 email showed an attached letter which included the name, admitted , pending amount of co-pay due per day, and the name of the supplemental insurance company of another resident at the facility. A follow up email was sent from the facility with the corrected information for Resident 50 on 04/11/2025.</p> <p>&lt;Resident Weight Information&gt;</p> <p>Observation on 04/16/2025 at 1:19 PM showed a list of nine resident beds with corresponding weights left on the second-floor nurse's station. The list of resident weights was easily readable by passersby and because the names of all nine residents were shown on signs placed outside the residents' rooms, passersby could determine the nine residents' weight.</p> <p>In an interview on 04/21/2025 at 11:54 AM, Staff B (Director of Nursing) stated it was their expectation staff always maintain privacy and confidentiality of a resident's information. Staff B stated staff were to ensure their computer screens were not visible to others, carts were locked, report sheets and information not be out visible in public areas and should not divulge any information to others. Staff B stated the residents were entitled to their privacy and helped maintain dignity.</p> <p>REFERENCE: WAC 388-97-0360.</p> <p>43642</p> <p>50511</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203</b></p> <p>Based on interview and record review, the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR - a mental health screening required prior to admission to a nursing home) assessments were completed as required for 2 of 5 residents (Resident 45 &amp; 50) reviewed for PASRR screening. The failure to ensure PASRR screenings were complete and accurate left residents at risk for inappropriate placement and/or not receiving timely and necessary services to meet their mental health care needs.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the undated facility PASRR policy, the facility would screen for mental disorders prior to admission by completing a Level I PASRR form. The policy showed the facility would ensure the Level I PASRR was complete and accurate prior to admission. Individuals who had or were suspected to have a mental disorder would not be admitted to the facility unless: a Level II invalidation was completed by the state-designated authority, a Level II evaluation was completed, or by hospital exemption (the resident admits directly from an acute inpatient hospitalization for an anticipated stay of fewer than 30 days in the home).</p> <p>&lt;Resident 45&gt;</p> <p>According to the 04/08/2025 Admission Minimum Data Set (MDS - an assessment tool) Resident 45 admitted to the facility on [DATE] from the hospital. The MDS did not indicate Resident 45 had any psychiatric or mood conditions.</p> <p>According to a 04/02/2025 Daily Skilled Charting progress note, Resident 45 had a diagnosis of anxiety.</p> <p>According to a 04/08/2025 Social Services progress note, the Level I PASRR received from the hospital did not include Resident 45's anxiety diagnosis and was inaccurate. The note showed a correct Level I PASRR was completed.</p> <p>Review of the corrected 04/03/2025 Level I PASRR showed an anxiety disorder was included in the Serious Mental Illness (SMI) indicators section. The form showed a Level II PASRR referral was not required.</p> <p>In an interview on 04/21/2025 at 8:48 AM Staff I (Social Services Director) stated they completed a new Level I PASRR after identifying the PASRR completed by the hospital omitted the resident's anxiety diagnosis. Staff I reviewed the 04/03/2025 Level I PASRR and stated as the PASRR included an SMI indicator, a referral for a Level II evaluation should have been, but was not made.</p> <p>43642</p> <p>&lt;Resident 50&gt;</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>According to a 04/07/2025 Admission MDS, Resident 50 admitted on [DATE] with multiple medically complex diagnoses including depression. This MDS showed Resident 50 required the use of an antidepressant medication during the assessment period.</p> <p>Record review showed Resident 50 was admitted from the hospital with a 04/02/2025 Level I PASRR. Section 1 of this Level I PASRR showed the resident was marked as having no SMI indicators, but in a subsection underneath, the SMI indicator for a mood disorder of depression was selected. The last section of the form showed Resident 50 did not require a Level II evaluation as they did not show indicators of an SMI, even though Resident 50 was identified with depression in the SMI indicators of Section 1.</p> <p>In an interview on 04/21/2025 at 10:10 AM, Staff I stated it was their expectation a Level I PASRR was accurate, and Level II evaluations obtained as required so residents could be evaluated for any needed services. Staff I reviewed Resident 50's records and confirmed the resident was identified with an SMI and did not receive a Level II PASRR prior to admission to the facility.</p> <p>REFERENCE: WAC 388-97-1915 (1)(2)(a-c).</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>50511</p> <p>Based on observation, interview, and record review the facility to ensure comprehensive Care Plans (CPs) were developed to address all identified resident care needs for 4 (Residents 58, 214, 14, &amp; 45) of 16 residents whose CPs were reviewed. This failure placed residents at risk for unmet care needs and frustration.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's December 2016 Care Plans, Comprehensive Person-Centered policy, facility staff would develop and implement a comprehensive CP in conjunction with the resident and/or their representative. The policy showed CPs should include measurable goals and describe the care and services the resident should be provided.</p> <p>&lt;Resident 58&gt;</p> <p>According to the 03/27/2025 Admission Minimum Data Set (MDS - an assessment tool) Resident 58 medical conditions including spinal cord dysfunction, spinal stenosis (a narrowing of spinal cord space that compressed nerves of spine) and muscle weakness. The MDS showed Resident 58 had frequent pain.</p> <p>Review of history and physical admission paperwork dated December 2024 showed Resident 58 had a total knee replacement in December 2024</p> <p>Review of Resident 58's revised 03/28/2025 Pain Management CP showed Resident 58 was at risk for pain or discomfort due to lower back disorders and other complications. The CP showed staff were to assess pain every shift and showed Resident 58 preferred to lie on their side due to pain in their lower back. The CP did not show Resident 58 had pain in their right knee.</p> <p>Review of 03/28/2025 Musculoskeletal Disorder CP showed Resident 58 was at risk for pain or fracture related to a pinched nerve in the resident's lower back area and spinal stenosis. The CP showed staff were to encourage mobility and handle the resident gently when turning/repositioning. The CP did not show Resident 58 had a right knee total replacement in December 2024 which caused them to have pain and limited mobility.</p> <p>In an interview on 04/15/2025 at 8:45 AM, Resident 58 stated they had pain in their back and their knee because of their prior surgery.</p> <p>In an interview on 04/18/2025 at 8:28 AM Resident 58 stated they were always in pain and their medications helped somewhat but because of their spinal stenosis and knee surgery, they had ongoing chronic pain. Resident 58 stated they could reposition themselves and staff did not help them with this, but they had to be careful with repositioning because of their knee surgery as their doctor told them their knee should be kept straight for better healing.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/18/2025 at 11:00 AM Staff E (Resident Care Manager - RCM) stated nurses should have captured Resident 58's knee pain and included it on the CP but did not. Staff E stated the pain from the knee replacement should have been put on the CP for Resident 58's quality of life and for appropriate pain interventions and therapy.</p> <p>&lt;Resident 214&gt;</p> <p>According to the 04/10/2025 Admission MDS, Resident 214 had conditions including osteoporosis, hypertension (high blood pressure), reduced mobility, impairment to both shoulders, and a right shoulder fracture.</p> <p>Review of the 04/05/2025 Musculoskeletal Disorder CP, showed Resident 214 had a potential risk for pain due to a right shoulder fracture. The CP did not show Resident 214 had a fracture on the left shoulder.</p> <p>Review of interdisciplinary team care conference notes dated 04/05/2025 showed Resident 214 had both right and left fractures to their shoulders.</p> <p>Review of admission paperwork Hospital discharge problem list dated 4/1/2025 showed Resident 214 had fractures to both left and right shoulders.</p> <p>In an interview on 04/15/2025 at 8:11 AM Resident 214 stated they would have surgery in two days' time to fix the fracture on their left shoulder first because they were left-handed. Resident 214 stated their right shoulder would be addressed after two weeks recovery from left shoulder surgery. Resident 214 stated they had to wear slings on both shoulders, and sometimes when they received a shower, the staff got their slings wet.</p> <p>In an observation on 04/16/2025 at 9:41 AM, Resident 214 told the two care staff who were helping them to transfer to the shower chair to exercise caution with both shoulders when they transferred them.</p> <p>In an interview on 04/18/2025 at 10:56 AM Staff E confirmed Resident 214 had fractures to both shoulders. Staff E reviewed Resident 214's CP and confirmed that the CP showed only the right shoulder fracture was identified. Staff E stated both shoulder fractures should be on the CP because Resident 214 had pain in both shoulders and the same precautions should be employed on both shoulders, but the left shoulder was not.</p> <p>In an interview on 04/21/2025 at 12:38 PM Staff A (Administrator) stated it was important for assessments to be accurate and if there was a significant change to a resident's conditions, the MDS, assessments, and CPs were to be updated using our tools and hospital notes for accuracy. Staff A stated this was important for accuracy of residents' care.</p> <p>42203</p> <p>&lt;Resident 14&gt;</p> <p>According to the 03/18/2025 Admission MDS, Resident 14 had intact memory and experienced pain that frequently affected their sleep. The MDS showed Resident 14 had medically complex conditions.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review showed Resident 14 had a 03/13/2025 physician's order for a medication to treat gout (a form of arthritis characterized by sudden, severe attacks of pain, swelling, redness, and tenderness in one or more joints - most often in the big toe).</p> <p>Record review did not show a CP was developed by facility staff to address Resident 14's gout. There were no directions for nursing staff such as what signs and symptoms to watch for, what interventions, if any, were appropriate if Resident 14 had an acute episode of gout-related pain, etc.</p> <p>In an interview on 04/21/2025 at 12:30 PM Staff C (RCM) stated there should be a CP developed for each diagnosis or condition for which a resident received treatment. Staff C reviewed Resident 14's comprehensive CP and determined there was not but should be a gout CP.</p> <p>&lt;Resident 45&gt;</p> <p>According to the 04/03/2025 Admission MDS, Resident 45 had medically complex diagnoses including Gastroesophageal Reflux Disease (GERD).</p> <p>Record review showed a 04/03/2025 physician's order for a proton-pump inhibitor (PPI - a medicine that decreases the amount of acid produced in the stomach). This medication was ordered to treat Resident 45's GERD condition.</p> <p>Record review did not show that a CP was developed to address Resident 45's GERD and PPI medication use.</p> <p>In an interview on 04/21/25 at 12:24 PM Staff C reviewed Resident 45's chart. Staff C stated they could not find a GERD CP but there should be one for Residents 45.</p> <p>REFERENCE: WAC 388-97-1020(1),(2)(a).</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>42203</p> <p>Based on interview and record review, the facility failed to ensure physician's orders were followed for 1 of 5 (Resident 45) residents whose medication regimens were reviewed. The failure to ensure orders were followed placed residents for unneeded treatment, and other negative health outcomes</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>Review of the facility's July 2016 Administration Orders policy showed facility staff should administer medications in accordance with the physician's orders.</p> <p>Review of the facility's undated Weight Assessment and Intervention policy showed facility staff should monitor residents for undesirable or unintended weight loss or gain.</p> <p>&lt;Resident 45&gt;</p> <p>According to the 04/08/2025 Admission Minimum Data Set (MDS - an assessment tool) Resident 45 had medically complex diagnoses including heart disease and heart failure. The MDS showed Resident 45 had high blood pressure.</p> <p>Record review showed Resident 45's physician's orders included the following:</p> <ul style="list-style-type: none"> <li>- a 04/03/2025 order to weigh Resident 45 daily and notify the physician for a weight gain of more than two Pounds (lbs) in a day or five lbs in a week.</li> <li>- a 04/03/2025 order for a medication to treat high blood pressure. The order included directions to hold the medication if Resident 45's pulse was less than 60 Beats Per Minute (BPM).</li> </ul> <p>Review of the April 2025 Medication Administration Record (MAR) showed on 04/04/2025 Resident 45's weight was measured at 152.6 lbs and 156.8 lbs on 04/05/2025, an increase of 4.2 lbs in one day. Resident 45's weight was measured again on 04/06/2025 and their weight remained at 152.5 lbs, and again on 04/07/2025 for a weight of 156.6 lbs. The 04/06/2025 and 04/07/2025 weights indicated the 04/05/2025 4.2 lbs weight gain was not the result of an inaccurate measurement.</p> <p>Record review showed no indication the physician was informed of the 4.2 lbs weight gain.</p> <p>Review of the April 2025 MAR showed on 04/15/2025 Resident 45's pulse was measured at 57 BPM. The nurse gave Resident 45 their blood pressure medication instead of holding the medication as ordered (which placed the resident at risk of a further lowering of their pulse).</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/21/2025 at 12:24 PM Staff C (Resident Care Manager) reviewed Resident 45's record and stated they did not see any evidence the physician was notified as the order directed. Staff C stated because Resident 45's pulse was measured at 57 on 04/15/2024 their blood pressure medication should have been, but was not held that day (to ensure the resident's pulse stayed within a desirable range). Staff C stated it was important to follow the physician's orders.</p> <p>REFERENCE: WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i).</p> <p>43642</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>50511</p> <p>Based on observation, interview, and record review the facility failed to provide assistance with Activities of Daily Living (ADLs - daily hygiene and other self-care tasks) for 2 (Residents 13 &amp; 7) of 6 sample residents reviewed for ADLs. The failure to provide ADL assistance residents were assessed to require placed residents at risk for poor hygiene, diminished feelings of self-worth, and other negative health outcomes.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>Review of the facility's revised March 2018 Activities of Daily Living, Supporting policy, showed residents who were unable to carry out ADLs independently would receive the services necessary to maintain good nutrition, grooming, personal hygiene, and oral hygiene.</p> <p>&lt;Resident 13&gt;</p> <p>Review of the 03/07/2025 Admission Minimum Data Set (MDS - an assessment tool) showed Resident 13 needed moderate assistance with showering/bathing and had a compression fracture in their spine.</p> <p>Review of 03/01/2025 ADL/Mobility Care Plan (CP) showed Resident 13's bathing/showering was to be done per the shower schedule.</p> <p>Review of second floor shower schedule binder located at the nurse's station showed Resident 13 was scheduled for showers every Monday and Friday.</p> <p>In an observation and interview on 04/16/2025 at 9:22 AM, Resident 13 stated staff frequently told them they would get a shower tomorrow when they ask for one. Resident 13's nails were observed to extend one quarter inch past their nail beds. At that time Staff K (Certified Nursing Assistant) entered the room from the bathroom and Resident told Staff K that they needed a shower. Staff K stated they thought the resident's shower was scheduled for the following day. Resident 13 stated they really needed to be cleaned up.</p> <p>In an interview on 04/17/2025 at 10:55 AM, Resident 13 stated they missed their shower on Monday 4/14/2025 and stated they did not understand why. Resident 13 stated they hoped they would get a shower the following day.</p> <p>In an interview on 04/18/2025 at 10:43 AM Resident 13 stated they did not get a shower that day and was told they would receive a shower the following day.</p> <p>Review of caregiver task sheets showed from 04/11/2025 through 04/18/2025 showed Resident 13 did not receive a shower over that period.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/18/2025 at 11:08 AM Staff E (Resident Care Manager) stated staff should approach the approach residents on their shower days and should document if Resident 13 refused. Staff E stated if staff were not able to get to the resident on the day the shower was scheduled, then a shower should be provided the next day. Staff E said it was important for residents to look presentable for their dignity.</p> <p>In an interview on 04/21/2025 at 11:00 AM Staff B stated staff should have offered showers twice per week and for resident refusals, should try again the next day. Staff B stated fingernails should be trimmed on shower days and stated the provision of showers was important so residents would feel presentable.</p> <p>43642</p> <p>&lt;Resident 7&gt;</p> <p>According to a 03/31/2025 Admission MDS, Resident 7 had multiple medically complex diagnoses including diabetes, had clear speech, was understood, and able to understand others. This MDS showed Resident 7 was assessed to be dependent on staff for rolling from side to side in bed, upper and lower dressing, and had no rejection of care during the assessment period.</p> <p>Review of a revised 03/25/2025 ADL/Mobility CP showed a goal that staff would anticipate and meet Resident 7's needs with interventions identified for a nurse to provide diabetic nail care.</p> <p>Review of Resident 7's physician's orders showed a 03/25/2025 order for diabetic nail care to be done weekly on Tuesdays by a licensed nurse.</p> <p>Observations on 04/14/2025 at 9:43 AM showed Resident 7 with long toenails to both feet that extended past the nailbed with some of the nails cracked and curling towards the skin. In an interview at this time, Resident 7 stated they had asked staff to clip their toenails, but it was not done.</p> <p>Review of April 2025 Treatment Administration Record showed staff signed nail care was provided to Resident 7 on 04/01/2025, 04/08/2025, and 04/15/2025.</p> <p>In an interview on 04/21/2025 at 8:23 AM, Staff O (Licensed Practical Nurse) stated nail care was important because it helped decrease the risk of infections, made residents feel better, and lessened the risk of a nail to get snagged on something. In an observation at this time, Staff O confirmed Resident 7's toenails were too long, still curled over, and needed to be cut. Staff O asked Resident 7 if they had reported their nails needed to be clipped to a nurse, Resident 7 stated they had, but they still were not clipped yet.</p> <p>REFERENCE: WAC 388-97-1060 (2)(c).</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>43642</p> <p>Based on observation, interview, and record review the facility failed to ensure fall interventions were removed timely when assessed to be unbeneficial for 1 of 3 residents (Resident 50) reviewed for accident hazards and failed to ensure resident mattresses fit the bedframe for 1 of 5 residents (Resident 31) reviewed for positioning. These failures placed residents at risk for falls, injury, and discomfort.</p> <p>Findings included .</p> <p>&lt;Falls&gt;</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's undated Falls policy, facility staff would assess each resident's risk for falls. Facility staff would evaluate and document falls that occurred in the facility, and identify and implement pertinent interventions.</p> <p>&lt;Resident 50&gt;</p> <p>According to a 04/07/2025 Admission Minimum Data Set (MDS - an assessment tool) Resident 50 had multiple medically complex diagnoses including cancer, heart failure, kidney disease, muscle weakness, and Parkinson's disease (a progressive neurological disorder that affects movement). This MDS showed Resident 50 had a fall since admission, in the last month prior to admission, and in the last 2-6 months prior to admission.</p> <p>Review of a 4/17/2025 fall Care Area Assessment (CAA) showed staff documented Resident 50 was a high-risk for falls due to an unsteady gait, reduced mobility, and acute illness, and had a history of recent and remote falls.</p> <p>Review of a 04/07/2025 progress note showed staff documented Resident 50 had a fall and interventions for floor mats would be initiated.</p> <p>According to a 04/07/2025 physician order, a floor mattress to both sides of the bed was ordered as a fall intervention for Resident 50.</p> <p>Review of a 04/08/2025 progress note showed staff reviewed the ordered interventions for floor mats put in place by staff after Resident 50's fall on 04/07/2025 and determined they were not an appropriate intervention and were to be discontinued. An intervention to offer toileting every 2-3 hours to prevent falling was initiated instead.</p> <p>Observations on 04/14/2025 at 12:07 PM and 04/15/2025 at 9:12 AM showed floor mats at both sides of Resident 50's bed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/21/2025 at 11:54 AM, Staff B (Director of Nursing) stated it was their expectation once fall interventions were evaluated as not appropriate, they would be removed for safety. Staff B stated staff should have, but did not implement the changes and remove the floor mats for Resident 50.</p> <p>42203</p> <p>&lt;Mattress/Bedframe fit&gt;</p> <p>&lt;Resident 31&gt;</p> <p>According to the 02/13/2025 Admission MDS Resident 31 had medically complex diagnoses including a progressive neurological/movement disorder, and a wasting condition. The MDS showed Resident 31 had a history of falls prior to admission and moderate memory impairment.</p> <p>According to the 02/08/2025 Fall Risk Assessment Resident 31 was assessed to be at high risk for falls. The assessment showed Resident 31 had risk factors including a history of falls and diagnoses that created a risk for falls.</p> <p>According to the 02/13/2025 Falls CAA, Resident 31 had risk factors for falling including delirium, impaired cognition, the resident's progressive neurological/movement disorder, and a visual impairment.</p> <p>According to the 02/19/2025 skin breakdown care plan Resident 31 required a low air loss mattress (an inflated mattress that assists to offload pressure for residents at risk for skin breakdown).</p> <p>Observation on 04/18/2025 at 8:24 AM showed Resident 31 in their bed, lying on their back, with support on both sides with pillows. Resident 31's low air loss mattress was observed to extend wider than the bedframe by one inch on the resident's right side and by over four inches on the resident's left.</p> <p>On 04/18/2025 at 1:48 PM Staff B and Staff D (Maintenance Assistant) arrived at Resident 31's room to observe the bedframe and mattress. Staff B and Staff D observed the overhang of the mattress from the bedframe and determined it needed correcting. Staff D stated the bedframe required adjustment with extender bars that would allow the mattress to fit the bedframe appropriately.</p> <p>In an interview on 04/18/2025 at 1:54 PM Staff D stated the extender bars were necessary to prevent the mattress from moving. Staff D stated the mattress should be secured for safety.</p> <p>REFERENCE: WAC 388-97-1060 (3)(g).</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>50511</p> <p>Based on interview and record review, the facility failed to ensure 1 of 4 residents (Resident 27), reviewed for nutrition, received timely evaluation of weights, and implementation of effective interventions, to maintain adequate nutrition. This failure placed the residents at risk for ongoing weight loss and poor nutrition and potential harm.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's revised March 2022 Weight Assessment and Intervention policy, residents' weights were to be monitored for undesirable or unintended weight loss. The policy showed any weight changes of five Percent (%) or more since the last weight assessment required nursing staff to immediately notify the dietitian in writing.</p> <p>&lt;Resident 27&gt;</p> <p>According to the 03/24/2025 Admission Minimum Data Set (MDS- an assessment tool) Resident 27 had diagnoses including congestive heart failure, dementia, gastric ulcer, and weakness to one side of the body. Resident 27 needed supervision or touching assistance with eating and it was important for them to have snacks.</p> <p>Review of the 03/20/2025 Malnutrition Care Plan (CP) showed staff were to obtain weights as ordered, and report changes to the physician and registered dietician.</p> <p>Review of physician's orders dated 03/19/2025 showed staff were to monitor Resident 27's weight daily and to notify the provider of more than two pounds (lbs) of weight gain or loss in one day or five lbs weight gain or loss compared to the weight in the last seven days.</p> <p>Review of April 2025 Medication Administration Record (MAR) showed Resident 27 weighed: 04/14/2025 - 111.3 lbs, 04/15/2025 - 109 lbs, 04/16/2025 - 108 lbs, 04/17/2025 - 108 lbs, 04/18/2025 - 109 lbs, 04/19/2025 - 101.2 lbs, 04/20/2025 - 100.8 lbs, and 04/21/2025 - 100.6 lbs. Weights taken between 4/16/2025 and 4/21/2025 represented a -6.85 % weight loss.</p> <p>Review of the 04/16/2025 nutritional risk assessment included a recommendation to add snacks daily due to resident's frequent activity and to continue to monitor for significant weight changes.</p> <p>Review of progress notes from 04/15/2025 through 04/21/2025 did not show documentation the provider was notified of the two lbs difference in weights per the physician's orders. Progress notes did not show written documentation was provided to the registered dietician immediately as stated in the facility's policy, about a greater than five % weight loss from 04/16/2025 through 04/20/2025. Progress notes showed snacks were implemented on 04/21/2025, five days after the nutritional risk assessment plan.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/18/2025 at 10:54 AM, Staff E (Resident Care Manager) reviewed the March 2025 physician orders and the April 2025 MAR that included orders the two lbs weight loss should have been called into the provider according to the physician orders. Staff E stated staff should have notified the provider of the two lbs weight loss and should check Resident 27's weight daily and review the previous day's weights to determine if there was a pattern. Staff E stated this was important as the doctor needed to review what caused the change in weight, whether it was food intake or medications/supplements. Staff E stated the provider could then determine what interventions were needed.</p> <p>In an interview on 04/21/2025 at 10:43 AM, Staff B (Director of Nursing) stated the weekend staff on 04/19/2025 and 04/20/2025 did not document notification of the weight loss to the provider. Staff B stated because they did not know the provider needed to be notified immediately. Staff B stated nurses should follow the providers orders but was unsure if the orders of weight loss needed to be reported, only weight gain.</p> <p>In an interview on 04/21/2025 at 12:43 PM, Staff A (Administrator) stated they expected staff to document weight loss and discuss the weight loss in the interdisciplinary team meeting for nutritional needs. Staff A stated they expected the provider would be notified of significant weight loss immediately.</p> <p>REFERENCE: WAC 388-97-1060(3)(h).</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>42203</p> <p>Based on observation, record review, and interview the facility failed to ensure residents were provided the artificial nutrition they were assessed to require for 1 of 1 residents (Resident 114) reviewed for tube feeding. The failure to ensure the full volume of artificial nutrition ordered was provided daily placed Resident 114 at risk for weight loss and other negative health outcomes.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's November 2018 . Tube Feeding via Continuous Pump policy, when a resident required their nutrition be provided through a feeding tube, facility staff would document the amount and type of feeding provided. The policy showed the facility would document the average fluid intake.</p> <p>&lt;Resident 114&gt;</p> <p>According to the 04/11/2025 Nursing Admission Evaluation, Resident 114 admitted to the facility for treatment of conditions including for care after a stroke, for acute respiratory failure, and a swallowing difficulty. This evaluation showed Resident 114 received their dietary intake through a feeding tube.</p> <p>Record review showed a 04/11/2025 order for an artificial liquid nutrition formula to be provided at 80 Cubic Centimeters (CC) per Hour (HR) for 18 hours daily. The order gave a start time of 4:00 PM to continue through 10:00 AM for a total of 1440 CC of formula. The order included the amount of liquid nutrition to be provided each shift: 320 CC on day shift, 480 CC on evening shift, and 640 CC on night shift.</p> <p>Review of the April 2025 Medication Administration Record (MAR) showed on 04/12/2025 nurses documented they provided 333 CC of liquid nutrition on day shift rather than the 320 CC per the order, only 226 CC on evening shift instead of the 480 CC ordered, and 640 CC on night shift for a total 1199 CC for the day, rather than the 1440 CC ordered, 241 CC less than the order. The MAR did not include anywhere to document either the daily total provided (rather than the total per shift) or anywhere to document how much liquid nutrition remained at the end of the feeding.</p> <p>According to the April 2025 MAR on 04/13/2025 Resident 114 was provided only 375 CC of liquid nutrition on afternoon shift for a daily total of 1335 CC instead of the 1440 CC ordered, 105 CC less than ordered</p> <p>According to the April 2025 MAR on 04/14/2025 Resident 114 was provided only 320 CC of liquid nutrition on afternoon shift for a daily total of 1280 CC instead of the 1440 CC ordered, 160 CC less than ordered</p> <p>(continued on next page)</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 04/14/2025 at 10:33 AM showed Resident 114 in bed with a pole next to the bed with a tube feeding pump attached. Hung from the pole were two bags, one containing water with 175 CC of water remaining. The second bag contained 400 CC of liquid nutrition and indicated a full bag contained 1500 CC. Neither bag was connected to the pump and the pump was not running.</p> <p>Observation on 04/17/2025 at 8:17 AM showed the liquid nutrition bag had 500 CC remaining. The pump setting corresponded to the ordered rate of 80 CC/HR, meaning when the feeding was due to stop at 10 AM (one-and-three-quarter hours later) there would be 360 CC left, rather than the 60 CC if Resident 114 received the ordered amount.</p> <p>Observation on 04/18/2025 at 9:26 AM showed Resident 114's feeding tube bag had 450 CC of the liquid nutrition remaining with 34 minutes of scheduled feeding remaining. The pump was set to 80 CC/HR meaning only another 46 CC would be provided before the feeding was scheduled to end.</p> <p>Observation on 04/18/2025 at 10:06 AM showed Staff N (Registered Nurse) gowning up to enter Resident 114's room. Staff N stated they were going to finish the tube feeding cycle for Resident 114. Staff N stated each day at 4 PM when the feeding started nurses hung a new 1500 CC bag and when the feeding ended at 10 AM the next day, any remainder was discarded.</p> <p>In an interview on 04/21/2025 at 10:10 AM, Staff E (Resident Care Manager) stated it was important for residents that required tube feeding to receive the nutrition they were ordered. Staff E stated Resident 114 required tube feeding because of swallowing difficulties after a stroke. Staff E stated Resident 114 was ordered 1440 CC of liquid nutrition daily. Staff E stated Resident 114 did receive some medications during their feeding (which required pausing the feeding and disconnecting the pump temporarily) but did not think this affected the amount of liquid nutrition the resident received. Staff E stated they were not sure if a daily total for Resident 114's liquid nutrition was monitored anywhere in the chart or if the amount of remaining liquid nutrition was documented somewhere. Staff E stated they would clarify if these totals were documented. No further information was provided.</p> <p>REFERENCE: WAC 388-97-1060(3)(f).</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>42203</p> <p>Based on interview and record review the facility failed to ensure medically-related social services were provided for 1 of 4 residents (Residents 29) reviewed for nutrition. The failure to involve facility social workers for residents demonstrating behaviors of rejection of care placed residents at risk for unmet health needs and other negative health outcomes.</p> <p>Findings included .</p> <p>&lt;Resident 29&gt;</p> <p>According to the 03/02/2025 Admission Minimum Data Set (MDS - an assessment tool) Resident 29 had intact memory. The MDS showed Resident 29 had diagnoses including respiratory failure and reduced mobility. The MDS showed Resident 29 was totally dependent on staff to transfer in and out of bed. The MDS showed Resident 29 admitted to the facility with a Stage 2 Pressure Ulcer (PU) and a Deep Tissue Injury (DTI). The MDS showed Resident 29 did not demonstrate behaviors of rejection of care. The MDS showed Resident 29 received a diuretic (urination causing) medication.</p> <p>Record review showed Resident 29 had 02/24/2025 physician's order to weigh the resident daily.</p> <p>Record review showed that on 18 occasions out of 41 occasions between 03/05/2025 and 04/14/2025, Resident 29 refused their daily weight.</p> <p>According to the 04/11/2025 Psychosocial - Refusal of Care . Care Plan (CP) Resident 29 had a goal to have no negative outcomes related to their refusal of needed treatments and cares. The CP included goals to determine Resident 29's experiences and preferences to eliminate/mitigate triggers to the extent possible, encourage active participation in care, and to inform Resident 29 of the risks and ramifications of continued noncompliance. The CP identified the Social Services staff among those responsible to implement these interventions.</p> <p>According to a 03/20/2025 Medication Administration progress note, Resident 29 refused a constipation treatment that day.</p> <p>According to a 03/24/2025 progress note Resident 29 refused their weekly skin assessment. The note showed staff approached Resident 29 multiple times and Resident 29 asked staff if they had anything better to do.</p> <p>According to a 03/28/2025 nurse's progress note, the nurse discussed refusals of care with Resident 29. This note showed the nurse asked Resident 29 to sign a Risks vs. Benefits form to indicate they understood the consequences of their rejection of care. Resident 29 refused to sign the form and stated they wanted their spouse to sign it.</p> <p>Record review showed Resident 29's spouse signed a Risks vs. Benefits form related to Resident 29's diuretic use and refusals of care on 03/29/2025.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  Cedar River Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  17420 106th PI SE Renton, WA 98055	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/17/2025 at 1:35 PM Staff I (Social Services Director) stated assisting with behavioral health needs was among the responsibilities of the social services department. Staff I stated this included problem solving with residents with patterns of refusing cares and treatments.</p> <p>In an interview on 04/18/2025 at 10:35 AM Staff E (Resident Care Manager) stated when residents demonstrated refusals of care they tried to reason with the resident, talk to them and if it continues discuss risks and benefits. Staff E stated Resident 29 required daily weights due to their diuretic medication use. Staff E stated pain was a factor in Resident 29's refusals. Staff E stated they were unsure if the social services department was notified of Resident 29's refusals of care.</p> <p>In an interview on 04/18/2025 at 1:21 PM Staff J (Social Services Coordinator) stated they provided social services on Resident 29's unit. Staff J stated they heard Resident 29 did not want to get up occasionally. Staff J stated they were unaware Resident 29 frequently refused to be weighed. Staff J stated they wished they were informed of the refusals and stated I could have problem-solved . with Resident 29.</p> <p>REFERENCE: WAC 388-97-0960 (1).</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>43642</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on interview and record review, the facility failed to maintain a Quality Assessment and Assurance (QAA) committee that included the required participants. This failure put residents at risk for unmet care needs due to ongoing non-compliance with federal regulations and detracted from the interdisciplinary effectiveness of the team.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to a December 2024 facility Quality Assurance and Performance Improvement [QAPI] Committee policy, the committee would meet monthly and listed the staff to serve on the committee which included the: Administrator; Director of Nursing Services; Medical Director, and infection control representative.</p> <p>Review of the 07/11/2024 QAPI committee meeting sign-in sheet showed the Medical Director did not attend.</p> <p>Review of the 08/29/2024 QAPI committee meeting sign-in sheet showed the Medical Director, Director of Nursing, and Infection Preventionist did not attend.</p> <p>Review of the 09/26/2024 QAPI committee meeting sign-in sheet showed the Medical Director and Infection Preventionist did not attend.</p> <p>Review of the 10/10/2204 QAPI committee meeting sign-in sheet showed the Infection Preventionist did not attend.</p> <p>Review of the 11/14/2024 QAPI committee meeting sign-in sheet showed the Infection Preventionist did not attend.</p> <p>Review of the December 2024 tab of the binder showed no QAPI paperwork or sign-in sheet.</p> <p>Review of the 01/16/2025 QAPI committee meeting sign-in sheet showed the Administrator, Director of Nursing, and Medical Director did not attend.</p> <p>Review of the 02/27/2025 QAPI committee meeting sign-in sheet showed the Administrator and Medical Director did not attend.</p> <p>Review the March 2025 tab of the binder showed no QAPI paperwork or sign-in sheet.</p> <p>(continued on next page)</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>In an interview on 04/21/2025 at 11:24 AM, Staff A (Administrator) stated it was their expectation that QAPI meetings be held monthly per their policy and indicated the last one they could find in the binder was from 02/27/2025, almost two months prior. Staff A stated they were recently hired as the administrator of the facility and were unsure why the QAPI meetings were not held in December 2024 or March 2025 as directed in their policy. Staff A stated it was their expectation the required committee members attend the monthly QAPI meetings to ensure the key players are a part of the data review and the planning process which can affect resident outcomes and care.</p> <p>REFERENCE: WAC 388-97-1760(1)(2).</p>		