| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505536 | A. Building<br>B. Wing | 11/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Three Rivers Care | 1305 Alexander St<br>Centralia, WA 98531 |

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|---|---|
| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete an AIMS (Abnormal Involuntary Movement Scale) test (a rating scale used to assess the severity of involuntary movements that sometimes develop as a side effect of treatment with antipsychotic medications [a class of drugs primarily used to treat mental health conditions such as hallucinations and delusions]) and/or failed to monitor for adverse side effects (ASE) of antidepressant medication (a class of drugs used to treat depression, a mental health condition characterized by persistent feelings of sadness, hopelessness, and/or loss of interest in activities) for 1 of 5 sampled residents (Resident 42) reviewed for unnecessary medications. This failure placed residents at risk for medication side effects, medical complications, and a diminished quality of life.Findings included . Resident 42 was admitted to the facility on [DATE] with multiple diagnoses to include major depressive disorder. Record review of Resident 42's physician orders, dated 09/17/2025, showed Resident 42 was prescribed Abilify (an antipsychotic medication)10 mg (milligrams) at bedtime for depression. The September 2025 Electronic Medication Administration Record (EMAR) showed Resident 42 was receiving Abilify 10 mg at bedtime. Record review of Resident 42's antipsychotic medication care plan, dated 09/17/2025, documented an intervention, Complete AIMS assessment as indicated. Review of Resident 42's Electronic Health Record (EHR) did not show documentation of an AIMS test completed for the administration of Abilify. Record review of Resident 42's physician orders, dated 09/18/2025, showed Resident 42 was prescribed Effexor (an antidepressant medication) 150 mg at bedtime for depression. The September 2025 EMAR showed Resident 42 was receiving Effexor 150 mg at bedtime. Record review of Resident 42's physician orders, dated 09/17/2025, and discontinued 09/18/2025, documented Monitor: for Antidepressant side effects.every shift Record review of Resident 42's Treatment Administration Record, showed antidepressant side effect monitoring completed on 09/17/2025 for one shift. Resident 42's EHR did not show further documentation for ASE monitoring for antidepressant medication. In an interview on 09/25/2025 at 10:40 AM, Staff D, Resident Care Manager/Infection Preventionist/Licensed Practical Nurse, said an AIMS test was completed for residents on antipsychotic medication upon admission. Staff D said an AIMS test was not done on Resident 42 and it should have been. Staff D further said if a resident was taking an antidepressant medication, they should monitor for any side effects of the medication and would check them off. Staff D said they would have a physician's order to monitor for side effects. Staff D said she did not see monitoring for ASE of an antidepressant medication. Staff D said she discontinued the physician's order to monitor for ASE, stating, I dc'd [discontinued] it, that was an accident. On 09/25/2025 at 11:46 AM, Staff C, Director of Nursing/Registered Nurse said she expected an AIMS test to be completed upon admission for residents taking an antipsychotic medication. Staff C said she expected ASE were to be monitored for residents taking an antidepressant medication. Reference WAC 388-97-1060 (3)(k)(i) |

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 |
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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a depression (a mental health condition characterized by persistent feelings of sadness, hopelessness, and/or loss of interest or pleasure in activities) baseline care plan for 1 of 5 sampled residents (Resident 42) reviewed for unnecessary medications. This failure placed residents at risk for unmet care needs and a diminished quality of life. Findings included. Resident 42 was admitted to the facility on [DATE] with multiple diagnoses to include major depressive disorder. Record review of Resident 42's level 1 Pre-admission Screening and Resident Review (PASRR), dated 09/15/2025, showed Resident 42 had a Serious Mental Illness Indicator (SMI) of Mood Disorder, depression. Record review of Resident 42's updated level 1 PASRR, dated 09/22/2025, showed Resident 42 had a SMI of Mood Disorder and Anxiety (a mental health condition characterized by persistent worry, fear, and unease) disorder. The updated level 1 PASRR further documented, Resident has a diagnosis of depression and anxiety. She takes Abilify [an antipsychotic medication often used to treat various mental health conditions and/or major depressive disorder when an antidepressant medication alone is not enough] and Effexor [an antidepressant medication] for depression. Record review of Resident 42's physician orders, dated 09/17/2025, showed Resident 42 was prescribed Abilify 10 mg (milligrams) at bedtime for depression. The September 2025 Electronic Medication Administration Record (EMAR) showed Resident 42 was receiving Abilify 10 mg at bedtime. Record review of Resident 42's physician orders, dated 09/18/2025, showed Resident 42 was prescribed Effexor 150 mg at bedtime for depression. The September 2025 EMAR showed Resident 42 was receiving Effexor 150 mg at bedtime. Record review of Resident 42's Electronic Health Record care plans did not show a Focus area related to depression, and/or antidepressant medication use. In an interview on 09/25/2025 at 10:40 AM, Staff D, Resident Care Manager/Infection Preventionist/Licensed Practical Nurse, said if a resident had a diagnosis of depression or taking antidepressant medication, they should have a care plan in place. Staff D said she could not find a depression or antidepressant medication use care plan, and there should have been. In an interview on 09/25/2025 at 11:46 AM, Staff C, Director of Nursing/Registered Nurse, said she expected depression and antidepressant medication use care plans were in place for residents with a diagnosis of depression and/or taking antidepressant medication. Reference WAC 388-97-1020 (3) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow physicians' orders to assess resident's pulse (heart rate) prior to medication administration for 1 of 5 residents (Resident 30) and to administer pain medication per physician's ordered parameters for 1 of 6 residents (Resident 17), reviewed for quality of care. These failures placed residents at risk of unmet care needs, medical complications and diminished quality of life.Findings included .<br><br>Resident 30 was admitted to the facility on [DATE], with multiple diagnoses including Essential Hypertension (high blood pressure). The Quarterly Minimum Data Set (MDS, an assessment tool), dated 08/22/2025, documented Resident 30 was alert and oriented.<br><br>Record review of Resident 30's physician's order, revised on 06/12/2025, documented hydrALAZINE HCl [hydrochloride - medication to treat high blood pressure] Oral Tablet 10 MG [milligram] (Hydralazine HCl) Give 1 tablet by mouth two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) [diagnosis code] Hold for SBP [systolic blood pressure which is the top number] < [less than]100 pulse less than 60.<br><br>Record review of Resident 30's medication administration records (MAR) from 11/13/2024 to 06/12/2025 showed Hydralazine was administered but no pulse was recorded.<br><br>In an interview and record review on 09/24/2025 at 2:33 PM, Staff D, Infection Preventionist/Licensed Practical Nurse, reviewed Resident 30's hydralazine orders and said Resident 30's pulse should have been assessed and recorded before the nurse administered Hydralazine.<br><br>In an interview on 09/25/2025 at 10:14 AM, Staff C, Director of Nursing/Registered Nurse, said it was the expectation that Resident 30's pulse should have been assessed and recorded prior to Hydralazine being administered.<br><br>Resident 17 was admitted to the facility on [DATE] with multiple diagnoses including chronic pain syndrome. Resident 17's admission MDS, dated [DATE], indicated Resident 17 was alert and orientated.<br><br>Review of Resident 17's MAR, dated 09/01/2025 – 09/30/2025, indicated, Hydrocodone-Acetaminophen Tablet [a narcotic to treat pain] 5-325 MG (milligrams) Give 1 tablet by mouth every 6 hours as needed for for (sp) pain level 1-5 .<br><br>Review of Resident 17's MAR, dated 09/01/2025 – 09/30/2025, indicated, Hydrocodone-Acetaminophen Tablet 5-325 MG (milligrams) Give 2 tablet by mouth every 6 hours as needed for for (sp) pain level 6-10. The MAR documented Resident 17 received two tablets of the Hydrocodone-Acetaminophen on 09/14/2025, 09/20/2025, and on 09/21/2025 for pain levels of four.<br><br>In an interview and record review on 09/24/2025 at 1:50 PM, Staff C, said nurses should follow the order when administering pain medication. While reviewing the MAR, Staff C said Resident 17 got one tablet of Hydrocodone-Acetaminophen for pain levels 1-5. Staff C said Resident 17 should get two tablets if the pain level was 6-10. Staff C said Resident should have received only one Hydrocodone-Acetaminophen on 09/14/2025, 09/20/2025, and 09/21/2025.<br><br>Reference WAC 388-97-1060(1)(3)(k)(i) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure oxygen tubing was changed for 1 of 1 sampled resident (Resident 7) reviewed for respiratory care. This failure placed residents at risk of respiratory infections and a decreased quality of life. Findings Included. Record review of the facility's policy titled, Oxygen Management, revised 08/2023, documented .6. Change oxygen tubing weekly or when soiled, impaired integrity or as needed. Resident 7 was admitted to the facility on [DATE] with multiple diagnosis to include chronic obstructive pulmonary disease (COPD, a group of lung diseases that cause long-term breathing problems) and emphysema (a chronic lung disease that causes progressive damage to the air sacs in the lungs). The admission Minimum Data Set (MDS, an assessment tool), dated 08/23/2025, showed resident 7 was cognitively intact and had COPD or chronic lung disease. Record review of Resident 7's physician orders, dated 08/16/2025, documented, O2 [oxygen] @ [at] 1 Liter via nasal cannula Continuously for end of life care, Chronic Resp [respiratory] Failure every shift. The August 2025 and September 2025 Electronic Treatment Administration Record (ETAR) showed Resident 7 was receiving oxygen daily. Record Review of Resident 7's physician orders, dated 08/15/2025, start date 08/17/2025, documented, Change O2 tubing, label and date every night shift every Sun [Sunday]. Record Review of Resident 7's September 2025 ETAR (Electronic Treatment Record) showed the O2 tubing was scheduled to be changed on Sunday 09/07/2025, 09/14/2025, and 09/21/2025. The ETAR further showed a check mark on 09/07/2025, 09/14/2025, and 09/21/2025, indicating the check mark Follow Up Codes as Administered. In an observation on 09/22/2025 at 11:47 AM, Resident 7 was lying in bed with oxygen on running at 1 liter per minute (lpm) per nasal cannula. The oxygen tubing was observed with white tape on it dated 9/8, 14 days ago. In an interview on 09/22/2025 at 11:57 AM, Staff H, Registered Nurse (RN), said oxygen tubing was replaced once a week usually by the night shift nurse. In a joint observation and interview on 09/22/2025 at 12:01 PM with Staff H, Resident 7's oxygen tubing was observed with white tape on it dated 9/8. Staff H observed the white tape on Resident 7's oxygen tubing and stated, It says September 8th, it needs to be changed.it should have been changed. In an interview on 09/22/2025 at 3:01 PM, Staff D, Resident Care Manager/Infection Preventionist/Licensed Practical Nurse, said Oxygen tubing was to be changed weekly by the night shift nurse. In an interview on 09/23/2025 at 2:32 PM, Staff C, Director of Nursing/RN, said it was her expectation oxygen tubing was changed weekly per physician orders. Staff C said if staff signed the ETAR a physician's order was completed, she expected it was being done. Reference WAC 388-97-1060 (1)(3)(vi) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation and interview, the facility failed to ensure a vial of purified protein derivative (PPD) solution (used in the skin test to diagnose tuberculosis, a lung infection), was dated with the date opened according to accepted professional standards of practice for 1 of 2 medication rooms (East Hall) reviewed for medication storage and labeling. This failure placed residents at risk of receiving expired medications and negative health outcomes.Findings included .During an observation of the East Hall medication room refrigerator with Staff E, Licensed Practical Nurse (LPN), on 09/22/2025 at 10:53 AM, the refrigerator was observed to have an open unlabeled vial of PPD solution that was almost empty. Staff E said it was the expectation that the PPD solution vial was labeled with the date it was first accessed.In an interview on 09/22/2025 at 11:00 AM, Staff D, Resident Care Manager/LPN, said the PPD solution vial in the East Hall medication room refrigerator should have been labeled with the date it was opened.In an interview on 09/25/2025 at 9:53 AM, Staff C, Director of Nursing/Registered Nurse, said it was her expectation that all medications were labeled with the date they were first opened.Reference WAC 388-97-1300 (2) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure opened resident food items were labeled and dated in 1 of 2 nourishment refrigerators (West Hall) reviewed for food storage. This failure placed residents at risk for food borne illness, and a diminished quality of life. Finding included .Review of the facility's policy titled, Food: Safe Handling for Foods from Visitors, revised dated 01/2023, documented, When food items are intended for later consumption, the responsible facility staff will: a. Ensure that the food is stored separate or easily distinguishable from the facility food. b. Ensure that foods are in a sealed container to prevent cross contamination. c. Label foods with the resident's name and current date.During an observation on 09/25/2025 at 10:15 AM, in the [NAME] Hall nourishment refrigerator/freezer, two opened Tillamook ice cream containers, one with Chocolate Peanut Butter and another with Tillamook Mudslide, were not sealed and appeared to have several scoops of the ice cream missing from both. The nourishment refrigerator had an unlabeled, opened container of Tapatio Salsa [NAME] Mild with no date opened or a resident's name. In an interview on 09/25/2025 at 10:22 AM, Staff I, Dietary Manager, said opened resident personal food items should have the resident's name and have the open date written on them. Staff I said opened foods should not stay in the nourishment refrigerator for more than 7-10 days after they had been opened. Reference WAC 388-97-1100(3) & 2980 |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer the pneumococcal vaccine (a vaccination used to help prevent certain bacterial infections such as pneumonia, an infection of the lungs), and/or provide information and education regarding risks, benefits, and potential side effects associated with the vaccine, for 1 of 5 sampled residents (Resident 42) reviewed for unnecessary medications. This failure placed residents at risk for developing pneumonia, related complications, and a diminished quality of life. Findings included. Record review of the facility's policy titled, Vaccination of Residents Policy and Procedure, revised 12/2022, documented, All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated or the resident has already been vaccinated.Prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations.All new residents shall be assessed for current vaccination status upon admission. Record review of the facility's policy titled, Pneumococcal Vaccine Policy and Procedure, Revised 12/2022, documented, All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections.Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission. Resident 42 was admitted to the facility on [DATE]. Review of Resident 42's Electronic Health Record (EHR) did not show documentation of information and/or education provided, nor record of a pneumococcal vaccination offered and/or declined, or medically contraindicated. In a joint interview on 09/25/2025 at 10:19 AM with Staff D, Infection Preventionist/Resident Care Manager/Licensed Practical Nurse, and Staff F, Director of Infection Prevention and Registered Nurse (RN), Staff D said they offered immunizations such as Covid-19 (Coronavirus Disease 2019, a respiratory infection) and pneumonia vaccinations to residents the same day or the day after admission. Staff D said she thought she offered the Covid-19 and pneumonia vaccination to Resident 42 upon admission. Staff D said she could not find documentation the Covid-19 or the pneumonia vaccination was offered and/or declined for Resident 42. Staff F said she could not find documentation in Resident 42's EHR the Covid-19 or pneumonia vaccination was offered and/or declined, or education provided, and indicated it should have been. In an interview on 09/25/2025 at 11:46 AM, Staff C, Director of Nursing/RN, said she expected vaccinations were offered, and education was provided, to residents upon admission and documented in the EHR. Reference WAC 388-97-1340 (2) |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer the Covid-19 (Coronavirus disease 2019, an infectious respiratory illness caused by a virus) vaccine and/or provide information and education regarding risks, benefits, and potential side effects associated with the vaccine, for 1 of 5 sampled residents (Resident 42) reviewed for unnecessary medications. This failure placed residents at risk for contracting Covid-19 infections, related complications, and a diminished quality of life.Findings included. Record review of the facility's policy titled, Vaccination of Residents Policy and Procedure, revised 12/2022, documented, All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated or the resident has already been vaccinated.Prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations.All new residents shall be assessed for current vaccination status upon admission. Record review of the facility's policy titled, COVID-19 Facility Policy and Procedure, revised 4/2025, documented, .People aged 65 years and older should receive two doses, of the current vaccination six months apart. Resident 42 was admitted to the facility on [DATE]. Record review of Resident 42's Electronic Health Record (EHR) showed Resident 42 was [AGE] years old. Review of Resident 42's EHR Immunizations showed a historical Covid-19 vaccination date of 11/04/2024. Review of Resident 42's EHR did not show documentation of information and/or education provided, nor record of a Covid-19 vaccination offered and/or declined, or medically contraindicated. In a joint interview on 09/25/2025 at 10:19 AM with Staff D, Infection Preventionist/Resident Care Manager/Licensed Practical Nurse, and Staff F, Director of Infection Prevention and Registered Nurse (RN), Staff D said they offered immunizations such as Covid-19 and pneumonia vaccinations to residents the same day or the day after admission. Staff D said she thought she offered the Covid-19 and pneumonia vaccinations to Resident 42 upon admission. Staff D said she could not find documentation the Covid-19 or the pneumonia vaccination was offered or declined for Resident 42. Staff F said she could not find documentation in Resident 42's EHR the Covid-19 or pneumonia vaccination was offered and/or declined, or education provided, and indicated it should have been. In an interview on 09/25/2025 at 11:46 AM, Staff C, Director of Nursing/RN, said she expected vaccinations were offered, and education was provided, to residents upon admission and documented in the EHR. No Reference WAC |