| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505537 | A. Building<br>B. Wing | 03/17/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Montesano Health-Rehab Center | 800 N Medcalf Lane<br>Montesano, WA 98563 |

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) |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify a physician of a choking event for 1 of 3 sampled residents (Resident 1) reviewed for physician notification. This failure placed residents at risk of unmet care needs, lack of physician oversight and interventions, and a diminished quality of life.Findings included. Record Review of facility policy, titled, Guidelines for Notifying Physicians of Clinical Problems, revised February 2014, documented, The charge nurse or supervisor should contact the attending physician at any time if they feel a clinical situation requires immediate discussion and management. The policy also documented, The following symptoms, signs, and laboratory values (which are not all inclusive) should prompt immediate notification of the physician, after an appropriate nursing evaluation.Tachypnea [breathing fast] and dyspnea [shortness of breath, a subjective sensation of difficulty or discomfort in breathing] with a pulse oximetry [blood oxygen reading] below 90%. Resident 1 admitted to the facility on [DATE]. Record review of Resident 1's Quarterly Minimum Data Set, an assessment tool, dated 02/20/2026, documented the resident was severely cognitively impaired. Record review of Resident 1's facility investigation, dated 03/08/2026, documented, [Resident 1] experienced a choking incident during breakfast. CNA [Certified Nursing Assistant] had [Resident 1] sitting upright and moved him more upright prior to LN [licensed nurse] notification. Upon notification, LN responded promptly, evaluation and assist to clear food from mouth via suction. Note o2 [oxygen] saturation [pulse oximetry] at 86%; supplemental oxygen administered per PRN [as needed] orders. Record review of Resident 1's nursing progress note, dated 03/08/2026, documented, 0830 [8:30 AM] resident has distressful choking episode while eating in room. CNA at bedside. Suctioned resident for small amount of breakfast chunks, initial saturation 86%, O2 placed at 2 liters with increase to >90%, with improved color, lungs clear without evidence of aspiration [inhalation of food] at this time. Record review of Resident 1's electronic medical record failed to document notification of the physician. In an interview on 03/13/2026 at 1:06 PM, Staff C, Registered Nurse, said she was assigned to Resident 1 when she was informed that resident 1 was choking. Staff C said she went to the resident's room and applied suction to the resident's mouth. Staff C said she assessed Resident 1 after suctioning and the resident had a pulse oximeter reading of 86%. Staff C said she applied oxygen via nasal cannula to increase blood oxygen saturation. Staff C said after the incident, no notification was made to the resident's physician or family. Staff C said she did not recall when notifications should be made. In an interview on 03/17/2026 at 12:04 PM, Staff B, Director of Nursing/Registered Nurse, said anytime there was a change in condition with a patient the nurse was expected to notify the provider of what happened at that time, meaning notifications should be done immediately. Staff B said staff reported changes in conditions to providers via phone call. Staff C said staff were trained during orientation to report changes of condition to providers. Staff C stated, Based on the documentation I've seen, I would consider the breakfast event [Resident 1 choking] as a change in condition, and we should have notified the physician. Reference WAC 388-97-0320(1)(a)-(d)(2)(a)(b) . |

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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