STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505206	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Timberline	400 East 33rd Street Vancouver, WA 98663

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50416 Based on interview and record review, the facility failed to ensure residents were treated with respect and dignity to enhance their quality of life when a resident called out for help and a licensed nurse told the resident they could not help for 1 of 2 sampled residents (38) reviewed for resident rights. This failure placed residents at risk of not meeting their highest practical psychosocial well being, unmet care needs, and a diminished quality of life. Findings included . Resident 38 was admitted to the facility on [DATE] with diagnoses including depression and anxiety. The Quarterly Minimum Data Set assessment, dated 08/05/2024, indicated Resident 38 was moderately cognitively impaired. The care plan interventions/task, dated 09/06/2024, documented, [Resident 38] has increased anxiety when other people are angry or aggressive. Staff to speak calmly to her when communicating with her. Resident 38's care plan, dated 09/06/2024 and revised 01/08/2025, documented, Focus:[Resident 38] is at risk for depression/low mood r/t [related to] diagnosis of Depression. Review of Resident 38's progress notes, dated 01/18/2025 at 1:55 PM, documented Resident on alert r/t [related to] psychological distress. Resident displayed mild distress first thing this morning when I went in to see her to check blood sugar. She asked what I was doing here, and I told her I worked here. She seemed a little upset and requested to check her own blood sugar and I let her. I also explained to her that I wanted to get her pain meds on board before her shower. I went back in to talk with her about being upset and asking why I was here. She spoke with me a little bit. Then I went about the morning routine as usual and she was pleasant and cooperative with me the rest of my shift without any issue. A progress note, dated 01/19/2025 at 2:54 PM, documented LN [License Nurse] followed up with resident. She states that she is feeling much better today. Resident states that she received the care that she needed and denies any harm. However, she prefers to not have specific nurse [Staff G, Licensed Practical Nurse-LPN] tend to her. LN asked resident if she feels safe. Resident states that she feels safe and enjoys the nurse on shift today, and is not in any distress at this time. Care plan reviewed and updated. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/21/2025 at 11:40 AM, Resident 38 said she had an incident with a nurse (Staff G, LPN), approximately a week ago. Resident 38 said she almost fell out of her bed and yelled out for help. Resident 38 said Staff G responded to Resident 38's call for help saying she was giving out medication. Resident 38 said Staff H, Certified Nursing Assistant (CNA), came into her room to help her and then another CNA (Staff J, CNA) came into the room to assist. On 01/24/2025 at 11:07 AM, Resident 38 stated, I lost my balance trying to sit up on the side of the bed. I just know that I said help help, I am falling. I have fallen many times before, but I have never called out that frantic before. I didn't know what else to do. I know I was going to land on the floor. Resident 38 stated, It made me feel like crap. I am already planning on stopping dialysis and slowly die. Having that happen made me feel like its okay for me to leave. I didn't feel like that before. Resident 38 said Staff G was in another section in the building the next day. When asked how Resident 38 knew Staff G was in another section of the building, Resident 38 stated, I asked one of the CNAs and they told me she was on another cart. In my mind I was nervous that she was going to be here that day. Resident 38 stated, After that incident, [Staff G] worked with me. I didn't like that she was here. It was uncomfortable. [Staff G] came in the room and asked is there was a problem that she should know about. I asked why are you here. I asked if you had a patient in distress would you help, and [Staff G] said she would. I didn't like the way I was feeling and I just stopped. Resident 38 stated, I told [Staff I, Infection Preventionist and Staff Development Coordinator] about what I had said to [Staff G]. I told [Staff I] if I was not able to get out of bed, if the building was burning, I don't think she [Staff G] would help. I told [Staff I] I don't feel comfortable with her [Staff G's] care. [Staff G] could have put the medication in a basket and come in to help [when Resident 38 was falling and called out for help]. At 3:04 PM, Staff I said on 01/16/2025, Staff H reported a concern saying she was not sure how to address it. Staff H told Staff I she heard Resident 38 yelling for help and Staff G yelled at Resident 38 that she could not help. Staff I stated, [Staff H and I] said that was abuse and needed to report it to [Staff A, Administrator]. Staff I said it was the expectation that Staff G should have locked the medication she had in the cart and went to assist Resident 38. On 01/27/2025 at 10:20 AM, Staff A said she was immediately made aware of the incident that occurred on 01/16/2025 in relation to Resident 38's interaction with Staff G. Staff A stated, The investigation completed was unsubstantiated. Staff A said Staff G had narcotics on the cart and called Staff H to assist Resident 38. At 10:49 AM, Staff H stated, On the 16th [01/16/2025] around 1:00 PM we were doing lunch. I pushed the cart down the hallway. I grabbed one tray and heard the nurse screaming a little bit. She had yelled a little bit. [The nurse] said I am busy. I have meds right now. My [Staff H's] plan was to deliver the tray I had. Then I heard another yell, and they [the person yelling] had yelled help me please two or three times. I walked into the room [room [ROOM NUMBER]] and Resident 38 was tangled in her oxygen tubing and a little bit frantic. The resident said I don't feel safe here with this nurse [Staff G]. I [Staff H] immediately went to report to a manger. When asked if Staff G had asked Staff H to go into Resident 38's room and assist her, Staff H stated, The nurse [Staff G] did not ask me to come and help the resident [Resident 38]. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:11 PM, Staff J stated, I heard the nurse [Staff G] say to Resident 38, I can't come. I have narcotics out. [Staff G] asked me to assist Resident 38. I went into room [ROOM NUMBER] and saw [Staff H] trying to assist Resident 38 get untangled. Staff J said she did not recall seeing Staff H going into Resident 38's room and she found Staff H in the room already assisting Resident 38. Additional documentation provided by the facility on 01/29/2025 included SSD (Social Services Director) follow up note, dated 01/28/2025, documented Resident 38's recount of her interaction with Staff G. Per the follow-up note, Resident 38 stated, After yelling for help several times, [Staff G] screamed at me that she couldn't help me right now because she was holding medications . Per SSD follow-up note, Resident 38 indicated she did not trust Staff G with her care and seeing Staff G on the day SSD followed up, triggered Resident 38's PTSD (Post-traumatic Stress Disorder) and anxiety. Additional documentation provided by the facility on 01/29/2025 included a Primary physician progress note, undated, with a print date of 01/29/2025, documented a conversation between the provider and Resident 38. The progress notes highlighted Resident 38's past medical and psychosocial history and documented, Unfortunately, [Resident 38] feels that she was inappropriately treated by the nurse who noted she was busy at the time, and subsequently feels that she cannot trust this nurse to have her care as a top priority in her day to day operations . The progress note documented Resident 38's personal history of abuse and panic attacks and the event that occurred on 01/16/2025 triggered her response. On 01/30/2025 at 10:56 AM, Staff G said she was standing at her medication cart and had liquid medication and narcotics belonging to the resident in room [ROOM NUMBER] in her hand. Staff G stated, Resident 38 was calling my name as she usually does, and I had a CNA go check on her. When asked which CNA she asked to check on Resident 38, Staff G stated, I asked [Staff H] to go check on Resident 38. When asked if Resident 38 was calling out saying help, Staff G stated, Resident 38 did not call out for help. Reference WAC 388-97-0180 (1-4)