STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505243	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Olympia Transitional Care and Rehabilitation	430 Lilly Road Northeast Olympia, WA 98506

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(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** 46793 . Based on observation and interview, the facility failed to respect and value the residents' private space by not knocking and/or announcing themselves for 1 of 2 sampled residents (Resident 6) reviewed for resident rights for dignity. This failure placed residents at risk for being treated with lack of dignity and a diminished quality of life. Findings included . Review of policy entitled Dignity and Respect, dated April 2021, documented, Staff members shall knock before entering the Resident's room. Resident 6 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (an assessment tool), dated 12/21/2023, showed Resident 6 was cognitively intact. On 01/22/2024 at 2:33 PM, Resident 6 said aides enter the room all the time without knocking. At 2:49 PM Staff F, Certified Nursing Assistant, entered Resident 6's room without knocking or announcing himself. When asked if entering without knocking was normal practice, Staff F stated, I'm sorry and existed the room. On 01/25/2024 at 11:38 AM, Staff C, Resident Care Manager said staff are expected to knock and announce themselves before entering a resident's room. Staff C said Staff F should have knocked before entering the room. At 12:24 PM Staff B, Director of Nursing Services, said staff show dignity and respect by shutting privacy curtains, not using pet names with residents, knocking on door, and announcing themselves before entering. Staff B said she had been informed of the situation by Staff F. Staff B said Staff F should have knocked before entering the resident's room. Reference WAC 388-97-0180 (2)

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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on observation and interview, the facility failed to ensure visibly dirty/soiled bed linen was removed and clean linen provided for 1 of 4 sampled residents (Resident 18) reviewed for environment. This failure placed the resident at risk of feeling unclean, undignified, and for potential infections. Findings included . Resident 18 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (an assessment tool), dated 11/08/2023, showed Resident 18 was moderately cognitively impaired. On 01/22/2024 at 12:56 PM, Resident 18's hospital gown, bed linen sheet, and blanket was observed covered in multiple clustered yellow-orange stains, ranging from pea size to quarter size. Resident 18 said staff change the bed linens about once a week. On 01/24/2024 at 3:02 PM Resident 18's hospital gown, bed linen sheet, and blanket was observed covered in multiple clustered yellow-orange stains, ranging from pea size to quarter size. On 01/25/2024 at 11:38 AM, Staff C, Resident Care Manager, said residents bed linens should be changed on resident shower days. Staff C said Resident 18's hospital gown and bed linens should have been changed when they were observed to be soiled. At 12:24 PM, Staff B, Director of Nursing, said Resident 18's hospital gown and linens should have been changed. Reference WAC 388-97-0880(1)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on observation, interview and record review, the facility failed to ensure a resident dental assessment was correct and accurately reflected resident care needs for 1 of 3 sampled residents (Resident 55) reviewed for dental care. This failure placed residents at risk for unidentified and unmet care needs and a diminished quality of life. Findings included . Resident 55 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS, as assessment tool), dated 11/21/2023, showed Resident 55 was moderately cognitively impaired, required assistance for personal care, and had no obvious cavities or or broken natural teeth. On 01/22/2024 at 9:57 AM, Resident 55 stated, I have plenty of problems, not able to go to the dentist, unsure if there is a dentist that comes to the facility. Resident 55 pointed to his right upper teeth showing a dark and broken tooth, and stated, This has been here for long time. On 01/26/2024 at 2:42 PM, Staff B, Director of Nursing Services, said the expectation is for the MDS to match actual resident condition. Reference WAC 388-97-1000(2).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 . Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of practice for 5 of 24 sampled residents (Residents 23, 177, 276, 128 and 129) reviewed. The failure to follow, obtain, and/or clarify incomplete or conflicting physicians' orders when indicated, placed residents at risk for medication errors and other potential negative outcomes. Findings included . <Resident 23> Resident 23 admitted to the facility on [DATE]. Review of their current physician's orders showed: a) 09/19/2023 order for clonidine (blood pressure medication) with instruction to hold all blood pressure medications for a systolic blood pressure (SBP) less than or equal to 100. b) 10/05/2023 order for lisinopril/hydrochlorothiazide (a combination blood pressure and diuretic medication) with instruction to hold all blood pressure medications if the resident's SBP was less than or equal to 110. Review of Resident 23's January 2024 Medication Administration Records (MARs), showed facility nurses administered the resident's lisinopril/hydrochlorothiazide with a SBP less than or equal to 110 and clonidine with a SBP less than or equal to 100, when the medications should have been held: <lisinopril/hydrochlorothiazide> 01/18/2024 with a SBP of 109 01/21/2024 with a SBP of 110 <clonidine > 01/20/2204 7:00 PM dose with a SBP of 100 01/22/2024 7:00 AM dose with a SBP of 100 On 01/26/2024 at 11:26 AM, Staff B, Director of Nursing (Director of Nursing Services/DNS/RN), said on the above referenced occasions facility nurses administered Resident 23 their clonidine and lisinopril/hydrochlorothiazide outside of the physician ordered parameters, when the medications should have been held. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 23's clonidine and lisinopril /hydrochlorothiazide orders showed they directly conflicted with each other. The lisinopril /hydrochlorothiazide instructed that all blood pressure medications be held if the resident's systolic SBP was less than or equal to 110. Which would include holding the clonidine, but the clonidine order directed it to be held if SBP is less than or equal to 100. On 01/26/2024 at 11:26 AM, Staff B said facility nurses should have identified the conflicting order and clarified them, but they had failed to do so. <Resident 129> Resident 129 admitted to the facility on [DATE]. Review of the resident's electronic health record (EHR) showed the resident had a Peripherally Inserted Central Catheters (PICC/ a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near the heart) to their right upper arm. Review of Resident 129's physician's orders showed the following 01/19/2024 PICC orders: a) Change catheter securement device on night shift every seven days. b) Change needleless connector with weekly dressing change. c) Observe site for signs and symptoms of phlebitis (inflammation of a vein), redness, warmth, infiltration every shift The orders failed to identify the type and location of Resident 129's venous access device (e.g. PICC to the right upper arm.) <Resident 128> Resident 128 admitted to the facility on [DATE]. Review of the residents EHR showed the resident had a PICC to their right upper arm. Review of Resident 128's physician's orders showed the following 01/08/2024 PICC orders: a) Change catheter securement device on night shift every seven days. b) Change needleless connector with weekly dressing change. c) Observe site for signs and symptoms of phlebitis (inflammation of a vein), redness, warmth, infiltration every shift The orders failed to identify the type and location of Resident 128's venous access device (e.g. PICC to the right upper arm.) <Resident 276> Resident 276 admitted to the facility on [DATE]. Review of the residents EHR showed the resident had a PICC to their right upper arm. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 276's physician's orders showed the following 01/16/2024 PICC orders: a) Change catheter securement device on night shift every seven days. b) Change needleless connector with weekly dressing change. c) Observe site for signs and symptoms of phlebitis (inflammation of a vein), redness, warmth, infiltration every shift The orders failed to identify the type and location of Resident 276's venous access device (e.g. PICC to the right upper arm.) On 01/26/2024 at 12:06 PM, Staff B said residents' intravenous access orders should have included the type and location of the venous access device, but acknowledged for the above referenced residents they did not. 42960 <Resident 177> Resident 177 admitted to the facility on [DATE] with an order for metoprolol (a blood pressure medication) twice daily, with instruction to hold the medication if the SBP was less than or equal to 110. Review of Resident 177's January 2024 MAR showed on 01/12/2024 staff administered the 8:00 AM and 8:00 PM doses of metoprolol instead of holding the medication as ordered for a SBP of less than 110. On 01/25/2024 at 11:57 AM, Staff J, Licensed Practical Nurse Supervisor, confirmed the nurse administered both the morning and evening dose of metoprolol for Resident 177 on 01/12/2024. Staff J said it should not have been given and nurses should check the order parameters before giving a medication. At 1:17 PM, Staff B said the nurse administered Resident 177's metoprolol outside of the ordered parameters on 01/12/2024, when the medication should have been held. Reference WAC 388-97-1620 (2) .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on observation and interview, the facility failed to ensure an environment free of accident hazards for 1 of 2 sampled residents (Resident 29) reviewed for accidents. The facility's failure to identify and enclose free hanging electrical wires, placed residents at risk for avoidable falls, other injuries, and a diminished quality of life. Findings included . Resident 29 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS, an assessment tool), dated 11/07/2023, showed Resident 29 was cognitively intact. On 01/22/2024 at 1:44 PM, Resident 29 said she was concerned about the two electrical cords hanging down from the back of TV to the electrical sockets. Resident 29 said she and her roommate have repeatedly hooked the arms of their wheelchair and or walker on the cords as they had passed by the electrical cords. Resident 29 said she had asked the facility twice to place the cords in an encasement to prevent equipment from getting hooked. The electrical cords were observed to be hanging from behind the TV and no encasement observed. The end of the cord was observed to be tied in a knot at the plug-in socket. On 01/24/2024 at 9:51 AM, a long plastic encasement (3-foot tube) was mounted to the wall, but the electrical cords were observed to be hanging from behind the TV, outside the encasement. The end of the cord was observed to be tied in a knot at the plug-in socket. At 3:14 PM the long plastic encasement (3-foot tube) was mounted to the wall, but the electrical cords were observed to be hanging from behind the TV outside the encasement. The end of the cord was observed to be tied in a knot at the plug-in socket. At 03:29 PM, Staff D, Maintenance Director, said that his employee had mounted the plastic encasing yesterday (01/23/2024). When asked why the wires were located outside of the encasing, Staff D stated he did not know why the wires had not been placed in the encasing. Staff D observed the wires, then said the wires had not been placed inside the encasing due to the encasing requiring a notch for the wires to be set inside of the encasing correctly. When asked if the adjustments should have been made when the encasing was mounted, Staff D said the adjustments should have been completed the day prior. On 01/25/2024 at 12:24 PM, Staff B, Director of Nursing Services, said the electrical wires should have been encased when the concern was identified. Reference WAC 388-97-3320 .

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview and record review, the facility failed to ensure the external catheter length of Peripherally Inserted Central Catheters (PICC/ a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near the heart) were measured upon admission and at least weekly thereafter, for 3 of 3 residents (Resident 128, 129 & 276) reviewed for intravenous (IV) therapy. These failures detracted from staffs' ability to determine if the PICC was in the same position or had migrated and placed residents at risk for loss of vascular access, infection, and other potential negative outcomes. Findings included . Review of the facility's Central Venous Access Device (CVAD) Dressing Change policy, revised 06/01/2021, showed upon admission the external catheter length of a residents PICC must be measured as part of the initial assessment and then measured at least weekly. 1) Resident 128 admitted to the facility on [DATE]. Review of Resident 128's antibiotic therapy care plan, dated 01/08/2024, showed they had a PICC to their right upper arm for IV antibiotic therapy. On 01/25/2024 at 11:26 AM, Resident 128 was observed with a double lumen, valved PICC, with an external length of three centimeters, to the right upper arm. Resident 128's PICC maintenance and monitoring orders did not include direction to staff to measure the external catheter length of the PICC. Review of Resident 128's electronic health record (EHR) showed no PICC insertion report, documentation of the initial external catheter length upon admission or weekly thereafter was present. 2) Resident 276 admitted to the facility on [DATE]. Review of the comprehensive care plan showed the resident had a PICC to the right upper arm for administration of IV antibiotics. Resident 276's PICC maintenance and monitoring orders showed there was no order that directed staff to measure the PICC external length. Review of Resident 276's EHR showed no PICC insertion report, documentation of the external catheter length upon admission or weekly thereafter was present. 3) Resident 129 admitted to the facility on [DATE]. Review of Resident 129's IV care plan, dated 01/22/2024, showed they had a PICC to the right upper arm for administration of IV antibiotics. Resident 129's PICC maintenance and monitoring orders showed there was no order that directed staff to measure the PICC external length weekly as directed in the facility policy. On 01/25/2024 at 3:22 PM, Staff B, Director of Nursing, said nursing staff should have measured the external catheter length upon admission and at least weekly therafter for Residents 128's, 129's and 276's, but failed to do so. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference WAC 388-97-1060 (3)(j)(ii)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 37044 Based on observation, interview, and record review the facility failed to ensure a medication error rate of less than five percent when 2 of 2 nurses (Staff H & Staff G) did not correctly administer 3 of 31 medications in accordance with physician orders and/or manufacturer's guidelines for 2 of 3 residents (Residents 23 & 17) observed during medication pass. This resulted in a medication error rate of 9.68% percent. These failures placed residents at risk for ineffective treatment of underlying medical conditions and/or adverse side effects. Findings included . <Resident 23> On 01/24/2024 at 8:03 AM, Staff G, Registered Nurse (RN), took Resident 23's blood pressure and pulse. The systolic blood pressure (SBP) was 110 and pulse was 62. Staff G then administered the resident's lisinopril/hydrochlorothiazide (a combination blood pressure and diuretic medication) and clonidine (a blood pressure medication.) Review of Resident 23's January 2024 Medication Administration Record (MAR) showed the 10/25/2023 lisinopril/hydrochlorothiazide order instructed nursing to hold all blood pressure medications if the SBP was less than or equal to 110. On 01/26/2024 at 8:19 AM, Staff G, RN, indicated the order was to hold all blood pressure medications for a SBP less than 110, not less than or equal to 110. After reviewing the order, Staff G confirmed the order was to hold for a SBP less than or equal to 100 and said Resident 23's lisinopril/hydrochlorothiazide and clonidine should have been held. <Resident 17> On 01/24/2024 at 7:03 PM, Staff H, RN, administered one drop of Latanoprost ophthalmic solution (lowers pressure in the eye) into each of Resident 17's eyes. Staff H did not hold pressure on the inner canthus (inner corner) after administration. On 01/26/2024 at 11:38 AM, when asked if pressure should be held on the inner canthus of the eye for 1-2 minutes after administering Latanoprost eye drops to allow the medication to be absorbed by the eye Staff B, Director of Nursing, stated, Yes. Reference WAC 388-97-1060 (3)(k)(ii)

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F 0761 Level of Harm - Minimal harm or potential for actual harm 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. 37044 Based on observation and interview, the facility failed to ensure drugs and biologicals were labeled and/or dated when opened, in accordance with accepted professional standards of practice for 2 of 2 carts (400 & 500 Hall medication carts) and 2 of 2 medication rooms (300 & 500 Hall medication rooms) reviewed. These failures placed residents at risk to receive expired medications and negative health outcomes. Findings included . <300 Hall Medication Room> Observation of the 300 Hall medication room on 01/24/2024 at 7:27 AM, with Staff B, Director of Nursing (DON), revealed the following: 1) A multiuse vial of Tubersol (used for Tuberculosis testing) purified protein derivative (PPD), opened and undated. Per the Tubersol package insert, an opened vial should be discarded 30 days after opening. 2) A bottle of liquid lorazepam for Resident 8 was opened and undated. Review of the medication box showed instruction to discard the bottle of lorazepam 90 days after opening. 3) A bottle of liquid lorazepam for Resident 4 was opened and undated. Review of the medication box showed instruction to discard the bottle of lorazepam 90 days after opening. <500 Hall Medication Room> Observation of the 500 Hall medication room on 01/24/2024 at 7:36 AM, with Staff B, DON, showed: 1) An opened and undated multiuse vial of Tubersol PPD. In an interview on 01/24/2024 at 7:37 AM, Staff B, DON, said the vial of Tubersol PPD should have been dated when opened. <500 Hall Medication Cart> Observation of the 500 Hall medication cart on 01/24/2024 at 7:41 AM, with Staff B, DON, revealed: 1) Resident 178's Lantus insulin pen was opened and undated. Review of the Lantus package insert showed instruction to discard the insulin pen 28 days after opening. In an interview on 01/24/2024 at 7:41 AM, Staff B, DON, said Resident 178's Lantus insulin pen should have been dated when opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<400 Hall Medication Cart> Observation of the 400 Hall medication cart on 01/24/2024 at 7:55 AM, with Staff B, DON, revealed: 1) Resident 15's Lispro insulin pen was opened and undated. Review of the Lispro package insert showed instruction to discard the insulin pen 28 days after opening. In an interview on 01/24/2024 at 7:55 AM, Staff B, DON, said Resident 15's Lispro insulin pen should have been dated when opened. Reference WAC 388-97-1300(1)(b)(ii), (c)(ii-v), (2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 . Based on observation, interviews, and record review, the facility failed to maintain and document refrigerator temperatures for 2 of 3 facility refrigerators (Reach In & 500 Hall) reviewed for food service; failed to document dishwasher temperatures, and failed to discard expired beverages for 1 out of 1 beverage carts observed. These failures placed residents at risk of food-borne illness, unsanitary conditions, and a diminished quality of life. Findings included . <Refrigerator temperatures> On [DATE] at 10:03 AM, review of the facility's refrigerator temperature logs, documented the Reach In and 500 Hallway refrigerators had multiple missing entries and documented temperatures outside the acceptable parameters for cold food holding: Dates over/missing temperatures for Reach In Refrig: degrees Fahrenheit (F) [DATE]: 4th-42F; 19th-46F, 20th-45F. [DATE]: 7th-46F, 8th-44F, 12th-46F, 13th-46, 15th-44F, 16th-44F, 26th-42F, 30th-46F. [DATE]: 2nd-46F, 11th-44F, 23rd-42F, missing 30th. [DATE]: 2nd-42F, 3rd-42F, 4th-43F, 5th-44F, 7th-48F, missing the 10th PM, 24th-42F, missing the 29th AM. Dates over/missing temperatures for 500 Hall Refrig: degrees Fahrenheit (F) [DATE]: missing the 2nd PM, 3rd-42F, missing 10th PM, missing 11th PM, 17th-42F, missing the 18th AM, [DATE]: 6th-42F, 18th-42F, 30th-42F. [DATE]: 14th-42F, 19th-42F, missing the 20th PM. [DATE]: missing the 2nd PM, 5th-45F, 28th-42F, 29th-42F, 30th-43F, 31st-43F. At 10:20 AM, Staff E, Dietary Manager, said the temperatures outside of acceptable parameters for cold food holding were not acceptable and the facility should have a process for rechecking the temperatures to ensure all food items were within required ranges. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505243	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Olympia Transitional Care and Rehabilitation	430 Lilly Road Northeast Olympia, WA 98506

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 4:00 PM, Staff A, Administrator, said the required cold holding temperature was 41 degrees Fahrenheit. Staff A said the missing entries and temperatures above the requiring holding were not acceptable. <Dishwasher temperatures> On [DATE] at 10:03 AM, review of the facility's dishwasher temperature logs showed the dishwasher temperatures were not being documented, only documenting if the dishwasher passed or failed the twice daily inspection. At 10:20 AM, Staff E, Dietary Manager, said she had not documented the dishwasher temperatures, only the pass fail testing results. On [DATE] at 4:00 PM, Staff A, Administrator, said the dishwasher temperatures should have been obtained. 37044 <Beverage Cart> Observation of the 400 Hall beverage cart on [DATE] at 6:57 AM, showed it contained the following: 1) A pitcher of 2% milk with a use by date of [DATE]. 2) A pitcher of whole milk with a use by date of [DATE]. 3) A carafe of skim with use by date of [DATE]. 4) A second carafe (unknown contents) with a use by date of [DATE]. In an interview on [DATE] at 6:58 AM, Staff G, Registered Nurse, confirmed the two pitchers and two carafes on the beverage cart were labeled with use by dates of [DATE] and had the cart removed from the floor. Reference WAC [DATE] (1)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 37044 Based on interview and record review, the facility failed to ensure resident medical records were complete and accurate for 6 of 6 residents (Residents 177, 20, 51, 18, 54, & 277) reviewed for bowel management. The failure to accurately record resident bowel movements placed residents at risk for unidentified and/or unmet bowel care needs. Findings included . 1) Review of Resident 177's point of care charting (a charting software program) showed two separate areas were provided for staff to document resident bowel movements, one titled Bowel Movements (BM) and the other titled, Bowel Continence. Review of Resident 177's January 2024 BM flowsheet showed staff documented the resident had no BM on: 01/05/2024, 01/06/2024, 01/07/2024, 01/08/2024, 01/10/2024, 01/13/2024, 01/16/2024, 01/17/2024, 01/18/2024, 01/20/2024, 01/21/2024, 01/22/2024 and 01/24/2024. Review of Resident 177's January 2024 Bowel Continence flowsheet showed the resident had a BM daily with exception of 01/08/2024, 01/13/2024, 01/18/2024 and 01/242024. 2) Review of Resident 20's point of care charting showed two separate areas were provided for staff to document resident bowel movements, one titled Bowel Movements and the other Bowel Continence. Review of Resident 20's January 2024 BM flowsheet showed staffed documented the resident had no BM on: 01/02/2024, 01/05/2024, 01/07/2024, 01/10/2024, 01/12/2024, 01/14/2024, 01/21/2024 and 01/22/2024. Review of Resident 20's January 2024 Bowel Continence flowsheet showed the resident had no BM on: 01/02/2024, 01/05/2024, 01/14/2024 and 01/22/2024. 3) Review of Resident 51's point of care charting showed two separate areas were provided for staff to document resident bowel movements, one titled Bowel Movements and the other Bowel Continence. Review of Resident 51's January 2024 BM flowsheet showed staffed documented the resident had no BM on: 01/01/2024, 01/02/2024, 01/03/2024, 01/04/2024, 01/07/2024, 01/08/2024, 01/09/2024, 01/12/2024. 01/14/2024, 01/15/2024, 01/17/2024, 01/018/2024, 01/19/2024, 01/21/2024, 01/22/2024 and 01/23/2024. Review of Resident 51's January 2024 Bowel Continence flowsheet showed the resident had no BM on: 01/01/2024, 01/02/2024, 01/03/2024, 01/08/2024, 01/09/2024, and 01/14/2024. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the BM and Bowel Continence flowsheets for Resident 18, Resident 54 and Resident 277 revealed similar findings, in which their BM and Bowel Continence flowsheets did not match. On 01/25/2024 at 1:33 PM, Staff I, Clinical Resources, explained in October 2023 an update of the point of care charting occurred to have it match section GG of the Minimum Data Set (MDS, an assessment tool). Per Staff I, management had not identified that the update broke the bowel charting into two different flowsheets Bowel Movement and Bowel Continence. Prior to the update they were documented on the same flowsheet. Staff I said that the change resulted in some staff charting a resident BMs on the Bowel Movement flowsheet, some on the Bowel Continence flowsheet, and others were charting on both. Staff I stated that they (management) contacted the vendor as soon as the issue was identified on survey, to have it corrected. Reference WAC 388-97-1720 (1)(a)(i-iv)(b)