STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505522	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salmon Creek Post Acute & Rehabilitation	2811 NE 139th Street Vancouver, WA 98686

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934 Based on interview and record review, the facility failed to ensure residents received information about the risk and benefits and failed to obtain the resident's informed consent prior to the administration of psychotropic medications for 2 of 6 sampled residents (32 & 78) reviewed for right to be informed and make treatment decisions. These failures placed residents and/or their representatives at risk of not being fully informed about the care and treatment related to the risks and benefits associated with psychotropic medications and a diminished quality of life. Findings included . 1) Resident 32 was admitted to the facility on [DATE] with diagnoses including depression. The Admission Minimum Data Set (MDS) assessment, dated 09/17/2024, indicated Resident 32 was alert and oriented. Resident 32 received a physician order for Wellbutrin, an antidepressant, dated 10/24/2024. The October Medication Administration Record (MAR) showed Wellbutrin was administered on 10/25/2024, before an informed consent was presented to Resident 32. On 10/25/2024 at 8:34 AM, Staff J, Unit Manager and Licensed Practical Nurse, said consents for new psychotropic mediations were completed by the floor nurse with the resident and/or their representative. While reviewing the MAR for Resident 32, Staff J said it looked as if Resident 32 was administered the Wellbutrin earlier, but the risk and benefits were not covered and a consent was not signed with the resident and/or their representative. 2) Resident 78 was admitted to the facility on [DATE]. The Admission MDS, dated [DATE], indicated Resident 78 was alert and oriented. Resident 78 received a physician order for Prochlorperazine Maleate, an antipsychotic, dated 09/29/2024. The October 2024 MAR showed Resident 78 was to receive, Prochlorperazine Maleate Oral Tablet 5 MG [milligram] . Give 1 tablet by mouth every 24 hours as needed for Nausea related to END STAGE RENAL DISEASE . (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The October 2024 MAR showed Resident 78 was to receive, Prochlorperazine Maleate Oral Tablet 5 MG . Give 1 tablet by mouth one time only for Antipsychotic for 2 Days. Resident 78's electronic health record did not show an informed consent for the Prochlorperazine Maleate. On 10/25/2024 at 10:32 AM, Staff B, Director of Nursing Services and Registered Nurse, said any use of a psychotropic medication should have a consent form signed by the resident or their representative. Reference WAC 388-97-0260 (2)(d)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 51254 Based on observations, interviews, and record review the facility failed to accurately assess significant weight loss for 1 of 1 sampled resident (71) reviewed for assessment accuracy. This failure placed residents at risk for nutritional and functional decline in overall health status and a diminished quality of life. Findings included . The facility provided policy entitled, Weight Management Guideline, created 05/25/2023, indicated weight change of 10% is significant, greater than 10% is severe. All scheduled weights will be obtained prior to meetings . Identification of weight loss to determine accurate weight with supporting documentation to prevent, monitor, or intervene with undesirable weight. Resident 71 was admitted to facility on 05/16/2024 with diagnoses including severe malnutrition and Diabetes Mellitus. The Significant Change Minimum Data Set (MDS) assessment, dated 09/24/2024, indicated Resident 71 was moderately cognitively impaired. Resident 71's alteration in nutritional status care plan, dated 05/26/2024, documented the goal was to maintain stable weights within 3-5 pounds. Interventions in the care plan were documented, Diet as ordered, weights per protocol, supplements as ordered. Supplements consumption is to be recorded. A Nutrition/Dietary progress note, dated 09/30/2024, documented significant weight loss of 11.73% of total body weight for Resident 71. A Nutritional assessment, dated 09/30/2024, documented Resident 71's diet would be liberalized to promote oral intake. Resident will have weekly weights x four for close weight monitoring. On 10/24/2024 at 3:25 PM, after reviewing Resident 71's medical record, Staff F, Registered Nurse, said weights had not been recorded in the chart as requested by the Registered Dietician (RD). Staff F said the order was not put in correctly, so staff were not prompted to obtain or record weights. Staff F said requested weights were unable to be located for RD review. At 3:15 PM, Staff C, Unit Manager and Licensed Practical Nurse, said the weights for each resident were recorded in the medical record. Staff C said she was not sure why the weights for Resident 71 were not recorded as requested by the RD. On 10/25/2024 at 8:35 AM, after reviewing the facility weight policy and process, Staff H, RD, said the RD ran a weekly weight report to evaluate nutritional status. A weekly dietary risk meeting was held with the facility team, which included the RD, nursing and management. The facility interdisciplinary team discussed weight gain or loss and initiated a team approach to interventions. Staff H said the RD would follow up with nursing about missing weights. Nursing was to ensure the weights were obtained and recorded. Staff H said the RD would send out a weekly weight report which included missing weights. Staff H was unable to provide missing weights for Resident 71. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 3:36 PM, after reviewing Resident 71's medical record to locate weights for Resident 71, Staff B, Director of Nursing Services and Registered Nurse, indicated she was unable to find any weights recorded after 10/04/2024. Reference WAC 388-97-1000 (1)(b)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 51254 Based on interview and record review, the facility failed to ensure the recommendations of the Preadmission Screen and Resident Review (PASARR) Level II were followed for 1 of 1 sampled resident (23) reviewed for PASARR. This failure placed residents at risk of not receiving the necessary mental health services and a diminished quality of care. Findings included . Resident 23 was admitted to facility on 11/09/2022 with a diagnoses including Alzheimer dementia and Major depression. The Quarterly Minimum Data Set assessment, dated 10/04/2024, indicated Resident 23's cognition was not assessed. Resident 23's PASARR 1, dated 06/03/2024, indicated the need for a level II assessment by a licensed mental health professional or mental health agency for individual services. PASARR level II recommendations were not found in Resident 23's medical record. On 10/24/2024 at 9:05 AM, when asked about the PASARR Level 1, dated 06/03/2024 for Resident 23, and if a Level 2 evaluation had occurred, Staff A, Administrator, said it likely was not done. At 3:15 PM, Staff A said the facility had a fax confirmation for a PASARR level II request having been sent to the evaluator, but the facility did not follow up with the evaluator to ensure services were started. Reference WAC 388-97-1060 (1)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50416 Based on observation, interview and record review, the facility failed to a baseline care plan was not developed to address falls and communication for 2 of 8 sampled residents (66 & 82) reviewed for baseline care plans. This failure placed residents at risk for unmet care needs and a diminished quality of life. Findings included . <Fall Risk > Resident 66 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS) assessment, dated 10/05/2024, documented Resident 66 was severely cognitively impaired, and had diagnoses including Cognitive Communication Deficit and Cerebrovascular Accident (a condition when blood flow to a section in the brain is suddenly cut off). Resident 66's progress note, dated 09/29/2024, noted, Resident had a fall (unwitnessed) and was found on floor next to the bed . Resident 66's electronic health record (EHR) showed a care plan initiated on 10/02/2024, and noted, The resident is at risk for fall r/t [related to] stroke. The resident has had an actual fall with no injury r/t Poor Balance, Poor communication/comprehension, Unsteady gait . On 10/24/2024 at 2:16 PM, Staff B, Director of Nursing Services and Registered Nurse, said Resident 66 had three falls since admission; on 09/11/2024, on 09/28/2024 and on 10/17/2024. After reviewing Resident 66's EHR, Staff B said Resident 66's fall risk care plan was initiated on 10/02/2024, after two of the three falls. Staff B said residents were assessed for falls on admission and staff would develop baseline care plans within 48 hours of admission. Staff B said her expectation was Resident 66's fall risk care plan was initiated on admission. <Communication Needs> Resident 82 was admitted to the facility on [DATE]. The Admission MDS, dated [DATE], documented Resident 82 was alert and oriented. Resident 82's care plan, initiated 10/21/2024, documented, The resident has an interpretation need, but speaks English enough to navigate basic staff encounters . On 10/22/2024 at 9:21 AM, Resident 82 was observed laying in bed. Resident 82 interacted with state surveyor speaking limited English but stated, Phone, phone, bring phone. No English. On 10/23/2024 at 11:39 AM, Staff K, Unit Manager and Licensed Practical Nurse, said staff used a facility translator service to communicate in detail with Resident 82. Staff K said Resident 82 spoke enough English to have her needs met. Staff K said Resident 66's communication care plan was initiated on 10/21/2024. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/2024 at 2:00 PM, Staff B, Director of Nursing Services and Registered Nurse, said the expectation was Resident 82 should have had a communication needs care plan initiated on admission. Reference WAC 388-97-1020 (3)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46751 Based on interview and record review, the facility failed to ensure ongoing neurological assessments (assess the nervous system and identify any abnormalities that affect function and activities of daily living) were performed after an unwitnessed fall for 1 of 2 sampled residents (66); failed to ensure daily weights were obtained for 2 of 9 sampled residents (75 & 288) reviewed for weight management; failed to ensure the bowel protocol was initiated for 2 of 7 sampled residents (24 & 73) and failed to ensure dental services were obtained for 1 of 1 sampled resident (53) reviewed for quality of care related to neurological assessments, weight management, bowel management, and dental services. These failures placed residents at risk for worsening conditions, health complications and diminished quality of life. Findings included . <Neurological Assessments> Resident 66 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS) assessment, dated 10/05/2024, documented Resident 66 was severely cognitively impaired, had diagnoses including Cognitive Communication Deficit and Cerebrovascular Accident (a condition when blood flow to the brain is suddenly cut off). The electronic health record (EHR) showed Resident 66 had an unwitnessed fall on 09/28/2024. The 72-hour neurological assessment, entitled Neuro Checks V.2 - V 2, initiated 09/28/2024, was incomplete. On 10/24/2024 at 2:36 PM, after reviewing Resident 66's neurological assessments for an unwitnessed fall on 09/28/2024, Staff B, Director of Nursing Services and Registered Nurse, said the neuro checks for Resident 66's 09/28/2024 fall were incomplete. Staff B said it was the expectation of the nurses to complete neurological assessments after every unwitnessed fall. <Weight Management> 1) Resident 75 was admitted to the facility on [DATE] with diagnoses including Congestive Heart Failure (CHF). The Admission 5-Day MDS, dated [DATE], showed Resident 1 was alert and oriented. Physician order, dated 09/04/2024, documented, Weigh on admission, weekly X 3, then monthly. One time only for 1 Day AND one time a day every [Tuesday]. Resident 75's electronic health record (EHR) for October 2024 showed one weight on 09/03/2024 at 8:03 PM, 290 Lbs (pounds) by Mechanical Lift (Manual). Resident 75's EHR was missing weights on 09/10/2024, 09/17/2024, 09/24/2024, 10/01/2024, 10/08/2024, and 10/15/2024. 2) Resident 288 was admitted to the facility on [DATE]. The Admission MDS assessment, dated 10/10/2024, showed Resident 288 was alert and oriented and had diagnoses including CHF. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician order, dated 10/05/2024, documented, Daily weights one time a day for heart failure Notify physician if patient gains 2 pounds in 2 days or 5 or more pounds in a week. Resident 288's EHR for October 2024 showed the following weights: --10/24/2024 at 12:13 PM - 217.4 Lbs Mechanical Lift (Manual) --10/20/2024 at 5:44 PM - 222.4 Lbs Wheelchair (Manual) --10/10/2024 at 8:02 PM - 220.2 Lbs Wheelchair (Manual) --10/09/2024 at 7:59 PM - 223.6 Lbs Wheelchair (Manual) Resident 288's EHR was missing weights on the following dates: 10/04/2024, 10/05/2024, 10/06/2024, 10/07/2024, 10/08/2024, 10/11/2024, 10/12/2024, 10/13/2024, 10/14/2024, 10/15/2024, 10/16/2024, 10/17/2024, 10/18/2024, 10/19/2024, 10/21/2024, 10/22/2024, and 10/23/2024. On 10/24/2024 at 10:47 AM, Staff K, Unit Manager and Licensed Practical Nurse, said Resident 288 had a diagnosis of CHF and had an order to obtain daily weights. After reviewing Resident 288's weights in the EHR, Staff K stated, CNAs [Certified Nurse Assistant] are not getting them [weights]. At 2:09 PM, after reviewing Resident 288's weights in the EHR, Staff B, Director of Nursing Services and Registered Nurse (RN), said there were only a few weights documented. Staff B said it was her expectation the licensed nurses let the CNAs weigh residents as ordered and record the weights in the EHR. On 10/25/2024 at 9:52 AM, Staff E, RN, stated, I see no weights were taken [for Resident 288]. <Bowel Management> 1) Resident 24 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented the resident was alert and oriented. Physician orders, dated 11/15/2022, documented to administer, Senna Laxative Oral Tablet 8.6 MG [Sennosides]. Give 1 tablet by mouth as needed for no BM [bowel movement] x 48 hr BID [twice daily], and Bisac-Evac Suppository 10 MG [Bisacodyl] Insert 1 suppository [laxative] rectally as needed for no BM x 72 hr QD [once a day]. The Bowel and Bladder Elimination task sheet showed Resident 24 had a Bowel Movement (BM) on 10/02/2024 at 9:48 PM, and did not show another BM until 10/09/2024 at 9:36 AM, almost six and a half days (over 155 hours between BMs). Review of Resident 24's October 2024 Medication Administration Record (MAR) showed no bowel protocol or bowel interventions were initiated. 2) Resident 73 was admitted to the facility on [DATE]. The Admission 5-Day MDS, dated [DATE], documented the resident was alert and oriented. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician orders, dated 09/02/2024, documented to administer, Senna Laxative Oral Tablet 8.6 MG [Sennosides]. Give 1 tablet by mouth as needed for no BM x 48 hr BID, and Bisac-Evac Suppository 10 MG [Bisacodyl] Insert 1 suppository [laxative] rectally as needed for no BM x 72 hr QD. The Bowel and Bladder Elimination task sheet documented Resident 73 had a BM on 10/07/2024 at 2:19 PM, and did not have another BM until 10/14/2024 at 9:33 AM, over six and a half days (over 162 hours between BMs). Review of Resident 73's October 2024 MAR showed no bowel protocol or interventions were initiated. On 10/25/2024 at 9:52 AM, Staff E, RN, said residents with no BM in three days were administered MiraLAX (laxative), or lactulose (laxative) first. Staff E was unable to provide documentation the BM protocol was initiated for Resident 24 and for Resident 73. Staff E stated, Lactulose should have been given on the 5th [third full day], I think. It was not, for Resident 24. Staff E stated, It doesn't look like anything was given to both. At 10:13 AM, Staff B said it was the expectation of staff to initiate the Bowel Protocol as ordered. Staff B said agency staff had been inconsistent with documentation. Staff B was unable to provide further documentation. 50416 51254 <Dental Services> Resident 53 was admitted to facility on 06/27/2023 with diagnoses including fracture to the tibia/fibula. The Significant Change MDS, dated ,d+[DATE] /2024, noted Resident 53 was alert and oriented. The Care Plan and Kardex (an individualized care plan directive), dated 09/02/2024, indicated staff were to assist Resident 53 to brush teeth, rinse dentures, clean gums with toothette, and rinse mouth. On 10/21/2024 at 10:07 AM, Resident 53 said she was hoping to get some upper dentures. Resident 53 said no one had talked with her about her missing teeth or possibility for dentures. On 10/23/2024 at 11:20 AM, Staff G, CNA, said the care directive indicated for staff to rinse dentures, and brush teeth. Staff G was unsure if Resident 53 had dentures. At 11:23 AM, Staff G said she was not sure about Resident 53's denture status. Staff F, RN, and Staff G said they would go look and ask Resident 53 about her dentures. Resident 53 said she does not have dentures but would like them, pointing to her upper gums. On 10/24/2024 at 8:15 AM, Staff A, Administrator, said she had asked for dental records to be faxed over from the outside dentist Resident 53 visited. Staff A was unsure if the facility had made coordination attempts for dental services, or what type of insurance Resident 53 had. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 10:35 AM, Resident 53's Power of Attorney (POA) said she went to an outside dental appointment with Resident 53 in April 2024 to have an infected tooth pulled. The POA said Resident 53 did not qualify for Medicaid and the family was unable to pay for dentures. The POA said no one from the facility had talked to her about dental care options. At 10:45 AM, Staff A said the facility was unable to locate documentation concerning Resident 53's dental care needs or correspondence regarding care provided by outside dentist. Reference WAC 388-97-1060 (1) (2)(b) (3)(c) (3)(j)(vii) .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49452 Based on observation, interview, and record review, the facility failed to implement Enhanced Barrier Precautions (EBP) when providing medical device care and wound care for 4 of 5 sampled residents (62, 240, 241 & 339) reviewed for infection prevention and control. These failures placed residents, staff, and visitors at risk for contracting infectious diseases and a decreased quality of life. Findings included . Record review of the facility's policy entitled, Enhanced Barrier Precautions Policy, dated 03/28/2024, showed the requirement for facility staff were to use gown and gloves during high contact resident care activities for residents with certain Centers for Disease Control (CDC) targeted infections and for residents with wounds or indwelling medical devices. 1) Resident 62 was admitted to the facility on [DATE]. The Admission Minimum Data Set (MDS) assessment, dated 10/03/2024, documented Resident 62 was alert and oriented and had an indwelling urinary catheter. On 10/21/2024 at 12:26 PM, Resident 62 was observed with a urinary catheter bag hanging on the frame of the wheelchair they were sitting in while in their room. No EBP signage was observed at Resident 62's door or entrance to the room. No PPE (personal protective equipment) was observed at the entrance of their room. When asked if staff wore gowns when they assisted with direct care or emptying their foley, Resident 62 said they only wore gloves. On 10/22/2024 at 9:00 AM, Resident 62 was observed sitting up in bed with a urinary catheter bag hanging on the right side bed frame. No EBP signage was observed at Resident 62's door or entrance to the room. No PPE was observed at the entrance of their room. On 10/23/2024 at 9:20 AM, Resident 62 was observed with a urinary catheter bag hanging on the frame of the wheelchair they were sitting in while in their room. No EBP signage was observed at Resident 62's door or entrance to the room. No PPE was observed at the entrance of their room. 2) Resident 240 was admitted to the facility on [DATE]. The Admission MDS, dated [DATE], documented Resident 240 was alert and oriented and had an abdominal drain (removes fluid from the abdominal cavity). Review of Resident 240's Order Summary Report, showed an order, dated 10/11/2024, Abdominal Drain: Please flush with 20 cubic centimeters [cc] saline through the 3-way [stopcock valve] once per shift. Do not disconnect drain. On 10/22/2024 at 9:37 AM, when asked if staff wore gowns when they assisted with direct care or caring for the abdominal drain, Resident 240 said the staff only used gloves. No EBP signage was observed at Resident 240's door or entrance to the room. No PPE was observed at the entrance of their room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/2024 at 9:20 AM, no EBP signage was observed at Resident 240's door or entrance to the room. No PPE was observed at the entrance of their room. 3) Resident 241 was admitted to the facility on [DATE]. The Admission MDS, dated [DATE], documented Resident 241 was alert and oriented and had a peripherally inserted central catheter (PICC line--a long intravenous tube that's inserted through a vein in your arm and passed through to the larger veins near your heart). Review of Resident 241's Order Summary Report, showed an order, dated 10/13/2024, PICC LINE to [left upper extremity] LUE. Change dressing weekly and PRN [as needed] if wet, dirty, not intact, or compromised in any way. On 10/21/2024 at 2:58 PM, when asked if staff wore gowns when they assisted with direct care or caring for their PICC line, Resident 241 said staff only used gloves. No EBP signage was observed at Resident 241's door or entrance to the room. No PPE was observed at the entrance of their room. On 10/22/2024 at 9:00 AM, no EBP signage was observed at Resident 241's door or entrance to the room. No PPE was observed at the entrance of their room. On 10/23/2024 at 9:20 AM, no EBP signage was observed at Resident 241's door or entrance to the room. No PPE was observed at the entrance of their room. On 10/21/2024 at 10:40 AM, when asked if any residents on the B Hall were on Enhanced Barrier or Contact Precautions, Staff J, Unit Manager and Licensed Practical Nurse (LPN), said no and that everyone in the hall that was on COVID Precautions was no longer on precautions. On 10/23/2024 at 9:05 AM, when asked if any residents on B Hall were on Enhanced Barrier or Contact Precautions, Staff L, LPN, said no. Staff L said if someone were on a precaution, a sign would be outside their door and PPEs would be at the door. 51254 4) Resident 339 was admitted to the facility on [DATE] with diagnoses including spinal injury resulting in paraplegia (a condition which causes loss of motor function and sensation below the area of spinal cord injury) and used a suprapubic catheter (a tube that drains urine from the bladder) due to paraplegia. On 10/21/2024 at 9:45 AM, no EBP signage or PPE was observed outside of Resident 339 room. On 10/22/2024 at 9:25 AM, no EBP signage or PPE was observed outside of Resident 339 room. Staff were observed entering and exiting room without applying PPE. On 10/23/2024 at 11:20 AM, when asked about the use of EBP, Staff G, Certified Nursing Assistant (CNA), said it was the same as standard precautions. When asked what PPE would be worn for a resident with an open wound or indwelling device, Staff G stated, We would wear gloves. We don't wear gowns for catheter care, just gloves. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505522	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salmon Creek Post Acute & Rehabilitation	2811 NE 139th Street Vancouver, WA 98686

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 1:50 PM, Staff D, Infection Control Nurse and Registered Nurse (RN), stated, Staff should wear a gown and gloves when providing direct care to a resident with an open wound or indwelling device. Staff D said EBP were initiated by the admission nurse. Staff D said the nurse manager should follow up the next day to verify the precautions that were needed were in place. Staff D said ultimately the Infection Prevention Nurse was responsible to make sure the appropriate EBP signage and PPE were being utilized. Staff D said all staff were educated regarding EBP upon hire and annually. At 2:08 PM, Resident 339 was observed being pushed by facility staff in a shower chair into the community shower room. The staff was not wearing PPE when providing care to Resident 339, when they entered the shower room, or when assisting Resident 339 back into bed. At 2:30 PM, Staff F, RN, was observed entering Resident 339's room to provide wound care. Staff F did not wear a protective gown during wound care. When asked about precautions for residents with open wounds or indwelling devices, Staff F said we just use gloves since there is no infection in the wound or bladder. Staff F said EBP are for use when infections are present. On 10/24/2024 at 10:05 AM, Staff B, Director of Nursing Services and RN, said she would expect staff to wear gloves and gown when providing care to a resident with a wound, catheter or indwelling device. Reference WAC 388-97-1320 (1)(a)(2)(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Report COVID19 data to residents and families. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50416 Based on interview and record review, the facility failed to notify a resident's family and/or representative of a positive COVID-19 (Coronavirus - a contagious disease) results for 1 of 5 sampled residents (75) reviewed for infection prevention and control. This failure placed residents and/or resident's representative at risk of not being knowledgeable to make decisions about their care in relation to the facility's COVID-19 management plan and a diminished quality of care. Findings included . The facility's policy, entitled Reporting to: Residents, Representatives, and Families During COVID-19 Pandemic, dated 05/15/2020, documented, The facility will inform residents, resident representatives, and families by 5:00 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. Resident 75 was admitted to the facility on [DATE]. The Admission 5-Day Minimum Data Set (MDS) assessment, dated 07/09/2024, documented the resident was alert and oriented. Review of Resident 75's September 2024 Treatment Administration Record (TAR), documented a positive COVID-19 test on 09/27/2024. Resident 75's Electronic Health Record (EHR) did not document the resident or their representative were informed of the above mentioned positive result. On 10/21/2024 at 11:15 AM, Resident 75 said she was not notified of her positive COVID-19 test, until about three days later. Resident 75 said the doctor told her, by the way, you had COVID. On 10/24/2024 at 2:48 PM, Staff D, Infection Preventionist and Registered Nurse (RN), said the facility notified residents and their representatives of a positive COVID-19 test as soon as possible after the test. Staff D stated, We would put them on alerts as soon as identified and notify family within 24 hours of the test. Staff D said the facility was aware of not notifying Resident 75, and the staff responsible had been educated on the facility's reporting process. On 10/25/2024 at 10:18 AM, Staff B, Director of Nursing Services and RN, said residents and/or their representatives were notified of a positive COVID-19 test per facility policy, but Resident 75 was not. Staff B stated, We missed one there. No associated WAC.