STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505382	A. BUILDING _____ B. WING _____	03/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REGENCY WENATCHEE REHABILIATION & NURSING CENTER	1326 RED APPLE RD WENATCHEE, WA 98801

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that staff provided treatment as directed by the resident's provider, documented facility staff observations/descriptions of the pressure ulcers, and developed and implemented interventions for the resident's identified skin issues for one of two residents (#4) reviewed for pressure ulcers and skin condition. These failures placed the resident at risk of extended healing time, and development of additional pressure ulcers/skin issues. Findings included . Review of the revised 04/2018 facility policy titled, Skin at Risk Program Overview, included, .to ensure that residents who enter the facility without a significant wound do not develop wounds unless .unavoidable, to ensure thorough assessment is completed if a significant wound is identified, and to ensure appropriate treatment/care provided to promote healing .4. An appropriate treatment order will be obtained from the resident's physician and implemented when a wound is identified .7. Weekly measurements for pressure ulcers .will be documented on the Weekly Ulcer Evaluation .includes length, width, depth .pain, amount and type of drainage .10. Development of stage II or greater pressure ulcer will be documented on an Incident Report and investigated per protocol . Pressure ulcers defined: Stage III - Full thickness skin loss in which subcutaneous (under the skin) fat may be seen Stage II - partial thickness skin loss with exposed dermis (layer of living tissue below the top of the skin) Stage I - Area of redness that does not go away or blanch to touch Resident #4. Resident record review showed the resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the resident's 12/17/19 quarterly comprehensive assessment showed the resident needed extensive help from two staff to move and reposition in bed, to transfer, and for skin and incontinence care. The comprehensive assessment also showed the resident was at risk for pressure ulcer development and had one Stage III pressure ulcer identified on 12/04/19. The assessment documented the resident had pressure relieving devices on his bed and in his wheelchair. Review of the resident's 09/16/19 annual comprehensive assessment showed the same level of care needs as in the 12/17/19 assessment, but showed that although the resident was identified to be at risk for pressure ulcers, he had no current pressure ulcers at that time. Review of treatment orders in the resident's Medication Administration Records (MARs) and associated staff documentation showed: *December 2019 - Apply Hydraguard (medicated cream) to buttocks four times per day and as needed for chronic excoriation, started on 05/01/19, discontinued on 12/31/19 - with a new order for Remedy Moisture Barrier Cream to buttocks one time a day for excoriation, started on 12/31/19. Review of the resident's record did not show staff documentation about the size or condition of the resident's buttocks/bottom area. *January 2020 - As of 01/28/2020, the resident's physician ordered a dressing to treat a skin issue on the resident's right ankle. Review of the resident's record showed no staff documentation related to the type of wound, its size, depth, or presence of drainage. *February 2020 - As of 02/06/2020, the wound on the right ankle was resolved. Documentation as of 02/09/2020 in the MAR indicated [REDACTED]. Review of the resident's record showed no staff documentation related to the type of wound, its size, depth, or presence of drainage. *March 2020 - As of 03/12/2020, the resident's physician ordered that licensed staff was to monitor the left ankle scab daily. The MAR indicated [REDACTED]. The MAR indicated [REDACTED]. However, the record did not show staff documentation about the type of wound on the left ankle, its size, depth, or presence of drainage. Resident record review of provider/Advanced Registered Nurse Practitioner (ARNP) visit notes showed: *12/04/19 - (Visit to) .look at his bottom. His chronic pressure wounds are much worse today than last seen a couple months ago .Stage 3 pressure wound of buttock .spoke with wound clinic and they suggested a different mattress .The facility will get the pt (patient) a different mattress and see if that helps. Wound care clinic recommended low air loss mattress . *01/24/2020 - (Visit) .to look at a new outer left ankle pressure wound with slough present (dead matter on the wound surface) .Staff have been now putting his feet in foam boots after the recent ankle pressure sore .Assessment: New left ankle pressure wound (Stage II) there is some drainage . Resident record review of provider/Primary Care Physician visit notes of 03/13/2020 showed the list of [DIAGNOSES REDACTED]. Review of the resident's 12/17/19 comprehensive care plan showed a Focus issue of Potential/Alteration in Skin Integrity/Pressure Ulcers related to fragile skin, history of rash for .buttocks with chronic intermittent excoriation . and a Focus issue of Skin at risk due to decreased mobility, incontinent of bowel .history of .buttock rashes with chronic excoriation . Further review of the resident's care plan did not show documentation of a Focus issue related to the resident's Stage III, Stage II, or Stage I pressure ulcers as documented by the facility's ARNP. Review of the resident's record showed no documentation of licensed staff's assessments of the resident's wounds as they developed to show if they were avoidable or not, no documentation of thorough assessments including measurements of the wounds when identified, no documentation of weekly measurements and status of each wound, and no documentation related to why the low air loss mattress was not placed after the resident's provider/ARNP documented the facility would place one. During a 03/12/2020 interview at 12:46 PM with Staff D, Nursing Assistant (NA), and Staff E, NA, when asked if the resident had any sores/wounds, they stated that the resident had one on his bottom. Staff D stated that once the NAs began to keep the resident's incontinent brief off when he was put to bed after lunch, the skin on his bottom got better. During a 03/16/2020 interview at 2:53 PM with Staff F, Registered Nurse (RN), she stated the resident had a pressure ulcer on his bottom but it was healed. She stated she last saw the resident about three weeks ago and she stated at that time, the resident's bottom was scabbed over. During a 03/16/2020 interview at 3:05 PM with Staff G, NA, he stated that about two weeks prior when he last cared for the resident, the resident had a very small scab on the outer left ankle. During a 03/17/2020 interview at 12:22 PM with Staff H, RN, he stated that he had never seen a Stage II pressure ulcer on this resident. He stated the resident did have chronic excoriation on his bottom. He stated he did daily checks on the scab on the resident's left ankle. During observations and interviews on 03/17/2020 at 1:32 PM with Staff I, NA and Staff J, NA, Staff I stated that the resident did have a scab on his left outer ankle. Both NAs stated the ankle looked better and the scab was smaller. They both stated the scabbed area was larger at one time. Observations and interviews that same day at 1:32 PM showed the resident wore socks on his feet that extended up over his ankles; he was not wearing any type of protective boots. The NAs stated that the resident's provider had ordered several types of cream for the resident's bottom and the current one was working out the best. Observation of the resident's bottom/buttocks showed the skin was intact with no rash or other type of skin breakdown. When asked, Staff J pulled down the resident's right sock. The outer ankle/boney area showed the skin was intact with no redness or scabbing. Observation of the outer left ankle/boney area showed an area approximately one-half inch wide by approximately one inch long. The outer ankle boney area had a light brown, thin scab over it. The sock covered the ankle bone; no type of protective dressing or padding was seen on the ankle and the NAs did not place the resident's foot/ankle in a foam boot before covering him. When asked about the resident's bed mattress, Staff I lifted a corner of the sheet and stated the resident was lying on one of the regular house mattresses. During a 03/17/2020 interview at approximately 2:05 PM with Staff K, Maintenance Supervisor, he was asked about the type of mattress on the resident's bed. Observation showed Staff K walked down to the resident's room and returned about two minutes later. He stated that the resident's mattress was a standard facility mattress. Later that day at approximately 3:00 PM, when asked if this resident ever had a low air loss mattress on

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

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.

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) his bed, Staff K stated, No. He stated that there was only one low air loss mattress currently in use in the facility and it was not on Resident #4's bed. During a 03/17/2020 interview at approximately 3:41 PM with Staff B, Director of Nursing (DON), she stated that the skin on the resident's bottom had problems with excoriation, and that the resident had developed scabbed areas to the outer boney areas on both ankles. When asked about the lack of staff documentation regarding the skin conditions on the resident's bottom/buttocks and both ankles, she stated there was no documentation completed in the resident's record. When asked about the resident not having a low air loss mattress on his bed as designated by the ARNP, the DON stated that because staff did not think the skin on the resident's bottom was a Stage III pressure ulcer, they did not place the mattress. Resident record review did not show documentation of an assessment or communication with the attending physician or medical director for clarification direction since they did not agree with the current assessment. During that same interview, when asked if staff completed incident report(s) and investigations when the skin on the resident's bottom broke down, or for the wounds that developed on both of the resident's outer ankle bones, the DON stated, I don't have any incident reports. Reference: WAC 388-97-1060 (3)(b)
F 0756 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure, for three of six residents reviewed for unnecessary [MEDICAL CONDITION] and/or opioid medications (#239, 5, 6), that the residents' physician responded in a timely manner to pharmacy recommendations about the [MEDICAL CONDITION] and/or opioid medications prescribed. These failures placed the residents at risk of receiving unnecessary medications, adverse side effects, and a decreased quality of life. Findings included . Resident #239. Review of the resident's record showed she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the resident's medical record showed physician orders, dated 01/20/2020, for [MEDICAL CONDITION] medications of [MEDICATION NAME] (antipsychotic) 25 mg (milligrams) two times a day, and [MEDICATION NAME] (antianxiety) 1 mg every 4 hours as needed (PRN). Review of the resident's record showed a 01/28/2020 Pharmacy Consultation Report wherein the facility pharmacist noted that the [MEDICATION NAME] was not appropriate for the resident particularly in light of the resident's history of stroke. The pharmacist documented a recommendation for a gradual dose reduction (GDR) for the [MEDICATION NAME] to 12.5 mg daily for 14 days, then to stop the medication. The rationale for the recommendation was antipsychotics are associated with increased risk for stroke and mortality. Additionally, the facility's pharmacist also recommended, to the resident's physician, that the [MEDICAL CONDITION] PRN ([MEDICATION NAME]) had been in place more than 14 days without a stop date. Review of the resident's record showed on 03/13/2020 (45 days later), the physician reevaluated the recommendations from the pharmacist and tapered the [MEDICATION NAME] as the pharmacist indicated from 25 mg daily to 12.5 mg daily, and stop in 14 days. During an interview on 03/17/2020 at 10:55 AM, Staff Q, Social Services Director (SSD), stated, The [MEDICATION NAME] was not justified . She stated that the facility had identified the need for process improvement of the [MEDICAL CONDITION] medication reviews which included pharmacy recommendations because we're not getting it where it is needed in a timely manner. Resident #5. Review of the resident's record showed his admission to the facility on [DATE]. The resident's [DIAGNOSES REDACTED]. Review of the resident's physician orders [REDACTED]. The resident's physician also prescribed an antidepressant ([MEDICATION NAME]) twice daily for depression in November 2013. Review of a 10/24/19 Pharmacy Consultation Report in the resident's record showed the pharmacist documented, (Resident) has received an antidepressant .twice daily for management of depressive symptoms since November 2013, he also receives [MEDICATION NAME] 5 mg daily for severe depression. Both agents are due to be reviewed for an attempt at a GDR. Please attempt a gradual dose reduction (GDR) to [MEDICATION NAME] 2 mg by mouth daily and documenting a GDR of ([MEDICATION NAME]) would be clinically contraindicated due to GDR of [MEDICATION NAME]. Review of the resident's record showed the resident's provider/Advanced Registered Nurse Practioner (ARNP) responded twice to the pharmacist's 10/24/19 recommendation. In the ARNP's first documented response, she chose to decline the GDR for the antidepressant [MEDICATION NAME] and gave her rationale. However, her response to the recommendation was dated 12/10/19, about one and one-half months after the pharmacist's 10/24/19 recommendation. Review of the resident's record showed the GDR for the resident's antidepressant was done in 2018, over a year prior. In the second response by the provider/ARNP to the same 10/24/19 pharmacy recommendation, the ARNP declined the GDR for the antipsychotic, [MEDICATION NAME], and documented her clinical rationale. Neither the ARNP nor the resident's physician responded to the 10/24/19 recommendation until 01/27/2020, three months later. During a 03/18/2020 interview at 1:24 PM with Staff Q, Social Services Director (SSD), she agreed a GDR could have been done on the antipsychotic medication, [MEDICATION NAME]. Review of the resident's record showed no documentation by the resident's physician or ARNP of an assessment with a documented clinical rationale about why the resident continued on the antipsychotic medication and/or why a GDR was clinically contraindicated for the antipsychotic medication and had not been completed. Resident #6. Resident record review showed the resident was admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Review of the resident's annual 09/23/19 comprehensive assessment showed she received routine antidepressant medication. Review of the resident's current physician orders [REDACTED]. Further record review showed the resident's physician prescribed [MEDICATION NAME] 15 mg, a second antidepressant medication, on 07/03/18 for a [DIAGNOSES REDACTED]. Review of a 09/30/19 Pharmacy Consultation Report in the resident's record showed the pharmacist documented the resident received two antidepressants, [MEDICATION NAME] 125 mg daily for management of anxiety/depressive symptoms, and [MEDICATION NAME] 15 mg daily for anxiety/depression. The pharmacist documented that both agents are due to be reviewed for an attempt at a GDR. The pharmacist included information that the resident's last screen for depression showed she scored a 2 (minimal depression) in September 2019. The pharmacist requested the resident's physician please consider if a GDR for the [MEDICATION NAME] to 100 mg daily was appropriate for the resident. The resident's physician agreed to follow the pharmacy recommendation. However, the physician did not respond to the recommendation until 10/30/19, one month later. During a 03/17/2020 interview at 1:26 PM with Staff B, Director Of Nursing (DON), she stated that the process with pharmacy recommendations was to print them and give to the residents' physician who was routinely in the facility twice a week. The DON stated that the ideal outcome would then be that the physician got back to staff about the recommendations within seven days. The DON stated that if staff did not hear from the physician in seven days, the physician would be approached again. The DON stated this process was not happening consistently. Reference: WAC 388-97-1300 (4)(c)
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure three of six residents (5, 6, 239), reviewed for unnecessary [MEDICAL CONDITION] and/or opioid medications, were assessed/reassessed for the continued use of medications, received medications for appropriate [DIAGNOSES REDACTED]. These failures placed the residents at risk of adverse medication side effects, oversedation, and/or receiving medications not needed to treat their medical conditions. Findings included . Review of the facility's revised 7/2018 policy/procedure titled, Behavior Monitoring/[MEDICAL CONDITION] Medication Policy, showed it included, To define how .[MEDICAL CONDITION] medication use will be managed. It is the policy of this facility to routinely review residents' use of [MEDICAL CONDITION] medications to ensure appropriate use, monitor effectiveness .4 .Target behaviors should relate to the [DIAGNOSES REDACTED]. The eMAR (electronic Medication Administration Record [REDACTED]. Review of the facility's undated guide titled, Psychoactive GDR (Gradual Dose Reduction) Guidelines, showed it included, * 'Clinical rationale' must include physician documentation as to why any attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder . Resident #5. Resident record review showed the resident admitted to the

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) facility on [DATE] and readmitted after a surgery on 01/07/2020. The resident's [DIAGNOSES REDACTED]. Documentation in a 07/06/12 hospital note showed the resident received antipsychotic medication, [MEDICATION NAME] 1 milligram (mg) in the evening and a half mg in the morning, and antidepressant medication, [MEDICATION NAME] 40 mg daily, for [DIAGNOSES REDACTED]. Review of a 06/28/17 documentation in the resident's record of a visit by a behavioral health Advanced Registered Nurse Practitioner (ARNP) showed a [DIAGNOSES REDACTED]. The ARNP prescribed [MEDICATION NAME] (antipsychotic) 5 mg every morning and [MEDICATION NAME] (antidepressant) 60 mg twice a day. Review of another visit by the behavioral health ARNP on 08/01/18 showed she documented, .his [MEDICATION NAME] had been decreased as part of a GDR .I have not had any report of hallucinations or delusions (signs/symptoms of [MEDICAL CONDITION]) in some time. He continues to take [MEDICATION NAME] for [MEDICAL CONDITION] as well as an adjunct for his depression. The ARNPs documentation showed the antipsychotic continued at 5 mg daily and the antidepressant at 40 mg twice a day. Resident record review of current physician orders [REDACTED]. The [DIAGNOSES REDACTED]. Review of the resident's November 2019 through March 2020 MARs showed the resident's target behavior symptoms for the use of the antidepressant and antipsychotic medications were the same. Documentation listed them as verbal - swearing, restlessness, irritability, sleeplessness, feeling overwhelmed, and shortness of breath (anxiety), inappropriate sexual remarks/gestures, and tearfulness, sadness, statements of not wanting to live, social isolation, and self-neglect (depression). Review of 09/21/19 and 12/21/19 facility [MEDICAL CONDITION] Medication Reviews in the resident's record showed the last dose change in the antipsychotic medication ([MEDICATION NAME]) was documented in both as 04/19/17. During a 03/13/2020 interview at 12:16 PM with Staff D and Staff J about the resident and his care, both NAs stated that the resident did not have any type of behaviors. Staff D stated, He is easy to work with and he says what he wants. The NAs stated that the resident got out of bed when he wanted; some days he preferred to stay in bed. Staff J stated, He does the same with eating. Staff D stated that when the resident was hungry, he would eat. Staff D stated that before the resident had his surgery (in January 2020), Sometimes he was irritable because he was in a lot of pain. Since he's come back, he is like a normal person now. During a 03/18/2020 interview at 1:06 PM with Staff I, NA, she stated that the resident liked to joke and be friendly in a good way with staff, acting like he's part of the family. Staff I stated that before the surgery, the resident did not act like himself as much because he was in a lot of pain. During a 03/18/2020 interview at 1:24 PM with Staff Q, Social Services Director (SSD), she agreed that a GDR could have been done on the antipsychotic medication, [MEDICATION NAME]. Review of the resident's record showed no documentation by the resident's physician or ARNP of assessments with documented clinical rationale for the continued use of the antipsychotic [MEDICATION NAME] at 5 mg daily and without a GDR, given the signs/symptoms staff were monitoring (signs/symptoms usually related to dementia). Resident #6. Review of the resident's record showed her admission to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Review of the resident's quarterly 12/24/19 comprehensive assessment showed she received antidepressant medication on seven of seven assessment days. The resident's annual 09/23/19 comprehensive assessment also showed she received routine antidepressant medication. Review of the resident's physician orders [REDACTED]. Further resident record review showed the resident's physician ordered a second antidepressant medication, [MEDICATION NAME] 15 mg daily with a current [DIAGNOSES REDACTED]. Review of the resident's MARs for September 2019 and monthly from December 2019 through March 2020 showed they listed the resident's target behaviors/symptoms of depression. Review of the documentation in the MARs by licensed staff for the five months reviewed showed no signs/symptoms of depression were documented. Documentation, dated 12/16/2020, from the resident's provider/ARNP did not show that the ARNP documented a risk versus benefit for the continued use of the [MEDICATION NAME] at 15 mg daily, nor did the ARNP document a clinical rationale related to the continued use of two antidepressant medications at the same time. During a 03/17/2020 interview at 10:45 AM with Staff Q, SSD, she stated the facility needed a process improvement on their [MEDICAL CONDITION] medication reviews and [MEDICAL CONDITION] documentation for the use of two antidepressant medications for this resident. During a 03/17/2020 interview at 3:00 PM with Staff B, DON, she stated she agreed that the resident's provider/ARNP needed to document a clinical rationale/reason for not doing a GDR on the [MEDICATION NAME], not documenting she completed a risk versus benefit with the resident/representative for the [MEDICATION NAME], nor documented a clinical rationale for maintaining the orders for the resident to receive two antidepressant medications at the same time, especially when the resident showed no signs/symptoms of depression. Resident #239. Review of the medical record showed she was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the11/21/19 comprehensive assessment showed the resident had a mood disorder (depression). The assessment showed the resident did not exhibit hallucinations or delusions. Review of the medical record showed that on 01/22/2020 the [DIAGNOSES REDACTED]. Review of December 2019 and January 2020 care plan and progress notes showed the resident did not exhibit hallucinations or behaviors. During an interview on 03/13/2020 at 9:46 AM, Staff Q, SSD, stated that the resident had admitted with depression and she received antidepressant medication for treatment. She stated that in January 2020, a family member reported to the facility's ARNP that the resident had some restlessness, repetitive movements, and hallucinations. Review of a 01/31/2020 Physician Visit showed, Patient has been having some agitation with hallucinations, for example this morning she believes she had hair in her face and tried removing .over an hour . of repetition of moving the hand over the face. The ARNP ordered [MEDICATION NAME] (antipsychotic) 25 mg twice daily for agitation with hallucinations. Review of a 02/26/2020 social services progress note showed the facility scheduled a care conference with the family and communicated their concerns about the family going directly to the ARNP requesting [MEDICAL CONDITION] RX (medication) changes or increases without communicating with the resident's care manager. During an interview on 03/16/2020 at 2:12 PM, Staff B, DON, stated that the ARNP added the [MEDICATION NAME] for hallucinations because the family had reported their concerns directly to the ARNP. The DON stated that she recognized the medication was not justified and should have been reviewed and addressed. During an interview on 03/17/2020 at 10:55 AM, Staff Q, SSD, stated, We recognize the [MEDICATION NAME] was not justified. Reference: WAC 388-97-1060 (3)(k)(i)
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.** Based on observation and interview, three of four kitchen staff (N, O, M), observed in the kitchen, failed to properly handle food and dishes in a manner to prevent potential cross-contamination. Failure to prevent cross-contamination of food and dishes placed residents at risk for preventable food borne illnesses. Findings included . On 02/11/2020 at 1:00 PM, Staff N, Kitchen Helper (KH), was observed, with gloved hands, to be prepping salads for the dinner meal. She was observed to be cutting lettuce on a cutting board. She was also wearing an apron, and on several occasions her apron was observed to touch the cutting board area where she was cutting the lettuce. She grabbed a cloth from the sanitizer bucket and cleaned the surface area she had been working on. She then proceeded to take the cutting board to the soiled side of the kitchen (opposite wall of the dish machine) and placed the used cutting board there. She then removed her soiled gloves, and without washing her hands, placed a new set of gloves on, and walked into the dry storage to obtain a new cutting board. One glove had torn, so she grabbed another glove and replaced it, and then proceeded to cut the tomatoes for the salad on the new cutting board. After the lunch meal on 03/11/2020 at 1:05 PM, Staff O, Cook, was observed washing dishes. He placed the soiled dish rack into the dish machine to sanitize the dishes, and while the dishes were being sanitized he would prepare another rack of soiled dishes to go in next. Once the dishes were sanitized, with his soiled hands, he grabbed the sanitized rack and move it to the clean side, and then proceeded to place a new rack of soiled dishes into the machine. He repeated the process, each time without washing his hands prior to touching the clean rack of dishes. During interview with Staff P, Dietary Service Manager (DSM), right after the observation on 03/11/2020 at 1:05 PM, the DSM stated she expected staff to wash their hands between soiled and clean tasks. On 03/12/2020 at 10:22 AM, Staff M, KH, was observed washing dishes. He placed soiled dishes into the dish machine while he loaded another rack of soiled dishes to go in next. He was observed to move the clean rack of dishes out of the dish machine and place another rack of soiled dishes in, without washing his hands in between tasks. Reference: WAC 388-97-1100 (3)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the facility's Infection Prevention and Control Program (IPCP) was reviewed on an annual basis, and failed to ensure infection control standards were maintained by

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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** - Many	(continued... from page 3) keeping the urinary catheter drainage bag off of the floor for one of two residents (#4) reviewed for urinary catheter drainage bags. This failure placed Resident #4 at risk of urinary tract infection. In addition, failure to annually review the IPCP placed facility staff at risk for not having the most up-to-date standards and guidelines for the prevention of infection for residents and staff. Findings included . On 03/14/2020 at 3:14 PM, the facility IPCP was reviewed with Staff B, Director of Nurses (DON). The binder which contained the IPCP showed a date of 02/01/19. The DON stated that was the last date the program was reviewed (over a year prior). The DON stated that there was a recent change in the staffing of the Infection Preventionist position and the DON had recently assumed the role until another staff person could be hired. She also stated the facility had just signed a contract with a new Medical Director, and that was part of the reason the program was not reviewed as scheduled in February 2020. Review of the facility's policy and procedure, revised 04/2018, titled Indwelling Urinary Catheters, included, To define how indwelling urinary catheters will be managed .PROCEDURE .7. Residents with long term indwelling catheter use will have care plan interventions developed to prevent complications including urinary tract infections .9. Update Care Plan and Kardex - care plan for Nursing Assistants (NAs) to appropriately reflect resident status and catheter needs/care. Resident #4. Review of the resident's record showed his admission to the facility on [DATE]. His [DIAGNOSES REDACTED]. Observations of the urinary drainage bag, between 03/11/2020 and 03/18/2020, showed the bottom of the drainage bag lying directly on the floor without a barrier, seven of nine times rather than suspended under the wheelchair on or in a designated barrier (several methods they could use - suspended under w/c or bedframe, basin on a floor, or cloth barrier between bed and floor) so it would not touch the floor (considered dirty). Observations of the resident showed the drainage bag touching the floor while seated in his wheelchair on 03/11/2020 at 4:15 PM, 03/12/2020 at 3:57 PM, 03/13/2020 at 9:20 AM, and on 03/17/2020 at 12:05 PM, and while lying in bed on 03/12/2020 at 10:30 AM and 12:51 PM, 03/17/2020 at 1:30 PM, and on 03/18/2020 at 9:44 AM. During a 03/17/2020 interview at 12:16 PM with Staff I, Nursing Assistant (NA), she stated she knew that the catheter bag should not be touching the floor. She stated for this resident it was hard to keep the bag from touching the floor because the bag needed to be below the level of the bladder. She stated in order to get the drainage bag where it needed to be to drain properly, the only place to hang it was underneath the wheelchair where it would touch the floor. During a 03/17/2020 interview at 12:25 PM with Staff D, NA, he stated the catheter bag should not be on the floor. He stated for this resident, His (wheel) chair is so low and to get the tubing where it needed to be, the drainage bag had to sit on the floor. He stated, We can't help it. Review of the resident's 12/17/19 comprehensive care plan included a Focus that showed, The resident has suprapubic catheter. The goal included the resident would show no signs/ symptoms of a urinary infection, and interventions included that the catheter bag should be covered at all times to maintain the resident's dignity. The resident's record included a second Focus that the resident was at risk for a urinary tract infection; it had the same goal. However, review of the two Focus issues in the resident's comprehensive care plan, related to the resident's need and use of a suprapubic catheter and drainage bag, showed no documentation that directed staff to keep the drainage bag off the floor to help prevent infection. Additionally, review of the Kardex care plan for NAs in the resident's record showed no documentation that directed NA staff to keep the urinary drainage bag up off the floor when the resident was in his bed or his wheelchair. Reference: WAC 388-97-1320 (1)(a)
F 0883 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five residents (#35) reviewed for influenza and pneumococcal immunizations, failed to give the necessary education regarding the benefits and potential side effects of the influenza immunization, failed to offer the influenza immunization, and failed to also give the resident the opportunity to refuse the influenza immunization. Findings included . Resident #35. Review of the resident's record noted the resident was admitted on [DATE] and discharged to home on 03/13/2020. A review of the record showed the resident was given the required pneumococcal immunizations prior to admission. However, a review of the immunization record for the resident did not show any documentation with regard to the influenza immunization. During an interview with the Staff B, Director of Nurses (DON), on two separate occasions on 03/17/2020 at 11:00 AM and again at 3:00 PM, she stated she could not locate the documentation for the influenza immunization in Resident #35's record. Reference: WAC 388-97-1340 (1)(2)