STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505123	A. BUILDING _____ B. WING _____	03/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BREMERTON CONVALESCENT & REHABILITATION CENTER	2701 CLARE AVENUE BREMERTON, WA 98310

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F 0606 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Not hire anyone with a finding of abuse, neglect, exploitation, or theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure they did not currently employ nursing assistant staff that had disqualifying findings for abuse, neglect or misappropriation of property for 24 of 31 nursing assistants (Staff AA, Staff BB, Staff CC, Staff DD, Staff EE, Staff FF, Staff GG, Staff HH, Staff II, Staff JJ, Staff KK, Staff LL, Staff MM, Staff NN, Staff OO, Staff PP, Staff QQ, Staff RR, Staff SS, Staff TT, Staff UU, Staff VV, Staff WW and Staff XX) reviewed for federal employment requirements. This had the potential to place all residents at risk for contact with staff who have findings or disciplinary actions in effect related to abuse and neglect and receive care from staff disqualified to have contact with vulnerable adults. Findings included. The Washington Nurse Aide Registry (OBRA, Omnibus Budget Reconciliation Act of 1993) maintains a database of individuals who meet federal requirements to provide caregiving to residents residing in skilled nursing facilities. Nursing homes are required to search this database to determine if an individual nursing assistant is ineligible to work in a skilled nursing home due to findings of abuse, neglect, or misappropriation of property. On [DATE] the facility reported to the department a concern regarding care for Resident #7. On [DATE] the facility reported to the department a concern regarding missing items for Resident #10. Both reports showed the facility suspended Staff TT, CNA and Staff EE, CNA pending result of investigations. On [DATE] the investigator requested OBRA Registry information from Staff H for Staff TT and Staff EE. At that time, Staff H did not have OBRA registry information for either Staff TT or Staff EE. During an interview on [DATE] at 1:30 pm Staff H, Human Resources Director (HRD) reported that he just found out he was not using the correct form to look up the OBRAs to request information from the state registry. Staff H further reported he had no idea that he was doing it incorrectly until just yesterday. Staff H described he started in November as the HR Director and has had very little training. Staff H reported now that he understood the correct procedure, he was going to do an audit and ensure all of them were up to date. Additional information provided by Staff H on [DATE] showed the following CNAs also had expired OBRAs: Staff AA, CNA OBRA expired [DATE] Staff BB, CNA OBRA expired [DATE] Staff CC, CNA OBRA expired [DATE] Staff DD, CNA OBRA expired [DATE] Staff FF, CNA OBRA expired [DATE] Staff GG, CNA OBRA expired [DATE] Staff HH, CNA OBRA expired [DATE] Staff II, CNA OBRA expired [DATE] Staff JJ, CNA OBRA expired [DATE] Staff KK, CNA OBRA expired [DATE] Staff LL, CNA OBRA expired [DATE] Staff MM, CNA OBRA expired [DATE] Staff NN, CNA OBRA expired [DATE] Staff OO, CNA OBRA expired [DATE] Staff PP, CNA OBRA expired [DATE] Staff QQ, CNA OBRA expired [DATE] Staff RR, CNA OBRA expired [DATE] Staff SS, CNA OBRA expired [DATE] Staff UU, CNA OBRA expired [DATE] Staff VV, CNA OBRA expired [DATE] Staff WW, CNA OBRA expired [DATE] Staff XX, CNA OBRA expired [DATE] Reference WAC [DATE](1)(b)(i)(ii)
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on interview and record review the facility staff failed to identify and immediately report to the Administrator and/or the to department State allegations of abuse or neglect for three of eight residents (#s 1, 6 and 17) reviewed for allegations related to abuse or neglect. This prevented the facility from conducting immediate investigations; take steps to protect residents from further abuse/neglect if necessary; conduct a thorough investigation; and monitor and treat residents as needed for potential harm. Findings included . Refer to F 689 for medical history and incident of choking for Resident #6 Refer to F660 for medical history and discharge information for Resident #1 and Resident #17 RESIDENT #17 Alert notes written by licensed nursing staff on 02/23/2020 showed Resident #17 continued with verbal abuse directed towards staff, yelled obscenities and had disruptive behaviors toward visitors and other residents. Notes showed other residents were disgusted and staff would follow up with management if this pattern continues. A social service note dated 0[DATE]20 showed the resident showed increased signs of agitation and had been verbally abusing staff and other residents. During telephone interview on 03/18/2020 beginning 1:07 PM, Staff D Social Services Director (SSD) stated that Resident #17 cursed at and blocked her roommate from getting out of bed. Staff D also stated after the resident discharged (0[DATE]20) he checked with residents on that residential hall and made sure they were okay and they were grateful Resident #17 discharged . The facility incident/ investigation log did not show staff reported the incident to administration; logged the incident within five days or conducted a full investigation as required. During telephone interview on 03/18/2020 beginning 1:07 PM, Staff C Director of Nursing (DON) stated that she did not recall staff informed her about Resident #17's behaviors toward others and would remember that. Staff C stated that if staff did not report the incident, it would not be investigated. Staff C also stated that the process required staff to immediately report verbal incidents and then she would interview the resident involved to determine a causal factor for the behavior. Staff C stated all residents on the hall would be immediately assessed to determine who may have heard the altercation and be monitored for potential psychological harm; and initiate a risk management report. Staff C stated that staff might have misunderstood what they needed to do. RESIDENT #1 On [DATE] the facility discharged Resident #1 to an adult family home with an inadequate supply of medications. The facility did not arrange and ensure the new medical provider received medical documents for an appointment scheduled for [DATE]. The provider could not refill prescriptions for the resident because of lack of medical information about the resident. During an interview on [DATE]20 at 9:58 PM, Anonymous Outside Agency T (AOA T) stated that the department's home and community services (HCS) contacted the facility on [DATE]. AOA T stated HCS staff informed the facility Resident #1's family was upset due to concerns with inadequate supply of medications sent by the facility; paperwork not provided for the new medical provider to be able to refill prescriptions and because the resident ran out of medication. During an interview on 03/04/2020 at 10:20 AM, Staff D Social Services Director (SSD) stated that the facility found out on [DATE] Resident #1 ran out of some medications. The facility incident and investigation log did not show staff viewed the incident as an allegation of potential neglect, notified the department or conducted an investigation to determine root cause of discharge concerns reported. RESIDENT #6 A Hospital Discharge Summary dated 10/11/19 showed Resident #6 had right upper and lower lobe aspiration pneumonitis/pneumonia. A Care Plan revised 12/16/19, included an intervention for staff to assist Resident #6 to the dining room to eat upright in his wheelchair for all meals. A facility investigation dated 0[DATE] showed Resident #6 choked on food while eating in his room. Staff delivered the meal tray to the resident's room and did not follow the care plan to take the resident to the dining room where he could receive supervision while eating. The facility incident/investigation log did not show the facility notified the department of the allegation of potential neglect. During an interview on [DATE]20 at 2:58 PM, Staff C, Director of Nursing (DON) stated the aide did not follow the care plan and the facility provided retraining. WAC 388-97-0640(5)(a) .
F 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or**

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 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) **discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to convey necessary information to an Adult Family Home (AFH) provider when they transferrred a resident; and/or ensure required physician discharge summaries were documented that included special instructions or precautions for ongoing care for three of five residents (Resident #s 1, 3 and 17) reviewed for transfer/discharge requirements. These failures prevented Resident #1 from experiencing a smooth, safe transition to an AFH and for Resident #17 to not have all immediate needs met following discharge, and had the potential for Resident #3 to experience unsafe discharge. Findings included . Refer to F660 for interviews and record reviews regarding medical history and information related to unsafe discharges for Resident #1 and Resident #17. CFR 483.15(c)(2)(iii) references required physician documentation in the resident's record for transfers and discharges when services of the nursing home were no longer needed. RESIDENT #1 An Interdisciplinary Resident Discharge Note signed [DATE] showed Resident #1 transferred to an Adult Family Home on [DATE] and had a follow up appointment with a physician scheduled for [DATE]. Resident #1's medical record did not contain evidence facility staff contacted the AFH to coordinate final details of discharge that included ensuring documents the new primary physician needed at the first appointment were sent timely, or to discuss the resident's current status with the AFH at the time of discharge. During an interview on 03/04/2020 at 10:20 AM, Staff D Social Services Director (SSD) stated that when the facility made an appointment with Resident #1's new primary care physician the office did not request copies of discharge documents. Staff D stated the resident should have been educated at the time of discharge to bring the discharge packet to the physician appointment. Staff D stated he later found out the packet did not go with the resident to the physician's appointment. No evidence in the record was found nursing or social service staff contacted the AFH and informed them of the importance to send the information in the discharge packet with Resident #1 to the physician's appointment [DATE]. When the resident got to the appointment, the physician did not have information necessary to refill prescriptions needed and had to reschedule the appointment for a later date. During a telephone interview on [DATE]20 at 9:56 AM, Anonymous Outside Agency T (AOA T) stated that Resident #1 toured the AFH on 01/20/2020 and met the provider and did not move in until [DATE] (12 days later.) AOA T also stated the facility did not send enough of all medications when transferred and the resident ran out of some of them. During a telephone interview on 0[DATE]20 at 3:42 PM, Anonymous Outside Provider O (AOP O) stated that when the resident visited the AFH before transfer, the resident could transfer with a gait belt. AOP O stated that the first day at the AFH, Resident #1 had pain in her feet, could not stand and the AFH had to contact a family member to assist with transfers. AOP O also stated the facility did not call or discuss the resident's current status just prior to the transfer to the AFH. During an earlier interview on [DATE]20 at 11:08 AM, Staff F Licensed Practical Nurse (LPN) stated that one of the nurses or the Resident Care Manager should contact the AFH and give a hand off report at the time of transfer. RESIDENT#17 Resident #17 admitted [DATE] and discharged home on[DATE]. The resident's medical [DIAGNOSES REDACTED]. Progress notes showed Resident #17 required re-hospitalization twice during facility stay. Staff sent the resident to the hospital due to respiratory decline on 02/09/2020 to 02/13/2020 and again on 0[DATE] to [DATE]. A Discharge Planning Note dated 0[DATE]20 showed the resident would discharge that day with current medications and a front wheeled walker. Resident #17's medical record did not contain a discharge summary written by the physician with minimum documentation that included special instructions or precautions for ongoing care, and other necessary information for a safe transition of care. RESIDENT #3 Resident #3 admitted to the facility on [DATE] with [MEDICAL CONDITION] of a limb; a blood disorder; protein calorie malnutrition; [MEDICAL CONDITION] and a blood clot. A Discharge Planning Note showed the resident discharged from the facility on 0[DATE]. Resident #3's medical record did not contain a provider discharge summary that showed the basis for transfer or discharge. During an interview on 03/04/2020 at 10:20 AM, Staff D SSD stated that he never saw a physician discharge summary included with discharge packets. During an interview on 03/04/2020 at 1:48 PM, Staff J Medical Records (MR) stated that physicians did not complete a summary of stay. WAC 388-97-0120 .
F 0660 **Level of harm** - Actual harm **Residents Affected** - Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement an effective discharge planning process that included all preparation needed for safe discharge for two of five residents (Resident #1 and 17) reviewed for discharge. Pre and post discharge care plans were not individualized, comprehensive, documented or updated, with identified specific measurable goals and interventions to address all resident needs. These failures resulted in harm to Resident #17, when the resident did not have all medical equipment available after discharge and the resident required re-hospitalization when home [MED]gen supplies depleted, and to Resident #1 when the resident was discharged without adequate medication supplies, and the facility did not send required medical information to the provider, to be able to refill prescriptions. Findings included . Facility procedure titled Discharge Planning Manual directed staff to formulate a projected discharge plan within 24 to 72 hours of admission based on the resident level of care. The manual showed for the unit, manager or designee would compare medications taken at home to discharge medications and reconcile them with the primary provider with a call and/or fax. RESIDENT #1 Admission Minimum Data Set assessment dated [DATE] (MDS, required assessment tool) showed Resident #1 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On [DATE], the facility discharged Resident #1 to an adult family home (AFH). Prior to the current admission to the facility, MDS assessments dated between 03/14/2014 and [DATE] showed Resident #1 previously resided in multiple nursing homes. The resident admitted to nursing homes following hospitalization s and discharged back to the community five separate times. A Discharge Planning note dated 01/22/2020 showed Resident #1 needed home health orders for physical and occupational therapy, and to advise when the referral was made and accepted. No further documentation was found in the record to show the facility sent a referral to the home health agency and, if or when the home health agency would provide services after discharge. Resident #1's current record did not include a discharge plan of care to identify individualized interventions necessary to provide for a safe discharge that included measurable long and short-term goals, to maximize opportunity for a successful community discharge. MEDICATIONS RAN OUT A physician order [REDACTED].#1 to discharge with current medications. During an interview on 03/04/2020 at 10:20 AM, Staff D Social Services Director (SSD) stated there was a snafu regarding Resident #1's medications and did not have enough medications when discharged from the facility to last until her physician appointment. Staff D stated the facility faxed a prescription to the pharmacy after discharge. During a telephone interview on 03/02/2020 at 12:40 PM, Anonymous Adult Family Home Provider O (AAFHP O) stated that the nursing home did not send enough medications for Resident #1 to last until the resident saw the physician on 02/12/20. During an interview on 0[DATE]20 at 2:15 PM, Anonymous Pharmacy Staff P (AP Staff P) stated that on [DATE], the facility sent a list of Resident #1's medications to the pharmacy without a physician signature and could not fill prescriptions for the AFH, the day the resident discharged . APS Staff P stated that the pharmacy immediately contacted the facility and requested signed medication physician orders, and did not receive them until 02/04/2020 (four days later). AFH medication records showed Resident #1 did not receive [MEDICATION NAME] (anti-anxiety) for 15 days starting 8:00 PM on 02/11/2020 until 8:00 PM until [DATE]20. The record also showed the resident received two doses of [MEDICATION NAME] (narcotic pain medication) one to two times daily and did not receive any beginning 02/21/2020. During an interview on 0[DATE]20 at 3:42 PM, AAFHP O stated that Resident #17 ran out of [MEDICATION NAME] on 02/11/2020 and [MEDICATION NAME] (narcotic pain medication) on 02/20/2020. AAFHP O also stated when Resident #17 ran out of medication she demonstrated increased anxiety by increase in body shaking and verbalized being anxious. NO RECORDS PROVIDED FOR PHYSICIAN APPOINTMENT An Interdisciplinary Resident Discharge Note signed [DATE], showed Resident #1 had an appointment with a provider to obtain prescription refills on [DATE] following discharge. During an interview on [DATE]20 at 11:08 AM, Staff F Licensed Practical Nurse (LPN) stated that Resident #1 was given a packet of discharge paperwork that should have included medications, course of treatment and recapitulation of stay. Staff F stated that he gave the packet for Resident #1 to the facility van driver who drove the resident to the adult family home. Staff F also stated he did not know how the AFH provider would know what to do with the packet and would think nursing staff would call them to discuss it. On 03/04/2020 at 10:20 AM, Staff D Social Services Director (SSD) stated that the facility put together a packet of information to send to the AFH for Resident #1. Staff D stated the packet included the Transfer/Discharge report that listed all medications and orders for the resident along with other discharge information. Staff D also stated that Resident #17 should have been educated at the time of discharge to bring the discharge packet to the physician appointment. Staff D also stated the AFH should be responsible to make sure the resident took the packet to the

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F 0660 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) appointment. During an interview on 03/04/2020 at 10:20 AM, Staff D SSD stated that when the facility made an appointment with Resident #1's new primary care physician, the office did not request copies of the discharge documents. During an interview on 0[DATE]20 at 2:59 PM, Anonymous Outside Agency Registered Nurse Q (AORN Q) stated that when Resident #1 arrived at the physician appointment, the physician could not refill prescriptions for the resident because the nursing home did not send medical information in advance. AORN Q stated that the facility did not inform the AFH the packet sent with the resident to the AFH should go to the physician appointment. AORN Q also stated that the nursing home made the appointment with the physician and it was standard practice the person who made the appointment should fax documents to the physician. During an interview on 03/04/2020 at 10:20 AM, Staff D SSD stated the facility needed to find a new primary care provider for Resident #1 two days before discharge. Staff D also stated the new primary care provider did not request the facility to fax over the discharge information, and later found out the packet did not go with the resident to the appointment. Staff D stated, in hindsight we should have faxed it over. Resident #1's medical record did not contain evidence nursing or social service staff contacted the AFH and informed them of the importance to send the information in the discharge packet with the resident to the appointment with the physician. When the resident got to the appointment, the physician did not have information necessary to refill prescriptions needed and had to reschedule the appointment for a later date. Failure to send adequate supply of medications and provide medical documents to a new medical provider that were needed to write prescriptions for renewal, resulted in harm for Resident #1 when medications ran out and the new provider could not refill them. RESIDENT #17 Resident #17 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician order [REDACTED]. A physician history and physical dated 02/07/2020, showed to monitor [MED]gen levels every shift and continue supplemental [MED]gen, inhalers and nebulizer treatments and to continue [MEDICAL CONDITION] (breathing device) with routine settings. Progress notes dated 02/09/2020 and 0[DATE] showed staff sent the resident to the hospital on both dates for two to four days due to respiratory related decline. On 0[DATE]20, the physician ordered to discharge Resident #17 home with a bedside commode and wheelchair. Resident #17's medical record did not contain evidence staff obtained discharge physician orders [REDACTED]. On 0[DATE]20, the facility discharged Resident #17 with medications and appointment to follow up with a primary care provider, two days after the resident returned from hospitalization on [DATE]. The following concerns were identified regarding the discharge process: NO DISCHARGE CARE PLAN Resident #17's record did not contain a discharge care plan with measureable goals, timelines and interventions to determine when the resident was safe to discharge home. LACKED ARRANGEMENT FOR MEDICAL EQUIPMENT A therapy to nursing communication note dated 0[DATE]20 recommended Resident #17 transfer with a gait belt from a wheelchair for mobility and activities of daily living. A Discharge Planning Note written 0[DATE]20, showed Resident #17 would be sent home with a walker. The record did not show why staff did not implement physician orders [REDACTED]. During an interview on 03/18/2020 beginning 1:07 PM, Staff D Social Service Director (SSD) stated that Resident #17 used a walker to go to Bingo. Staff D stated that the resident took the facility rented breathing device machine home with her, and the facility did not know it at the time. During the same interview, Staff S Resident Care Manager (RCM S) stated that Resident #17 received [MED]gen via nasal cannula while in the facility and nebulizer treatments four times a day. During the same interview, Staff D SDS stated that Resident #17 informed the facility she had two [MED]gen tanks at home and an [MED]gen concentrator. Staff S stated that the resident's significant other brought a tank to the facility at the time the resident discharged . Discharge records did not show the name of [MED]gen and nebulizer suppliers, or contain evidence the facility confirmed [MED]gen tanks were full or needed to be refilled; or if supplier accounts were active and arrangements were made to restart home deliveries. The record did not show staff provided education to the resident to validate understanding how to operate all equipment. UNKNOWN DISCHARGE LOCATION A Discharge Planning Note dated 0[DATE]20 written at 10:51 AM showed the resident would discharge to [LOC] with current medications and own equipment of walker/cane. Resident #17's medical record did not identify the address or location where the resident planned go. The record did not identify staff attempted to review or assess the resident's home discharge location to ensure it met the resident's needs to be able to maintain and manage health conditions safely, or discussed concerns regarding unresolved care issues as potential for unsafe discharge. During a telephone interview on 0[DATE]20 at 2:46 PM, Staff F Social Services (SS), stated that Resident #17 stated she would discharge to the same location and would not provide an address for the facility. During an interview on 03/04/2020 at 10:20 AM, Staff D SSD stated that discharge planning started the first day of admission. The interdisciplinary team looked at all barriers for discharge such as [MED]gen needs, nebulizers, equipment, home health therapy and if residents had wounds and dressing supplies. A Hospital Discharge Summary dated 0[DATE]20 showed on 0[DATE]20, the evening the resident discharged home, Emergency Medical Services took Resident #17 to the emergency room with low [MED]gen levels that measured 62% on room air and rapid heart rate. Notes showed the resident ran out of [MED]gen and attempted to obtain [MED]gen delivery that night and the supplier was closed. Hospital history written 0[DATE]20 showed the resident discharged to a home camper ([DATE]20) and found out that the camper did not have a wheelchair ramp or electricity to power home [MED]gen tanks. The note showed the resident had to connect equipment to a neighbor's garage using an electrical extension cord. Reference WAC 388-97-0080 .
F 0661 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to prepare discharge summaries that included a recapitulation of resident stay and final summary of discharge status for three of five residents (Resident #s 1, 3 and 17) reviewed for discharge. This prevented persons, agencies and continuing care providers involved with residents, to not have information necessary for post discharge care. Findings included . Refer to F 660 for medical history and failure to develop, update comprehensive care plans, implement and document safe discharges for residents (#s 1 and 17). RESIDENT #1 Resident #1 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On [DATE], the facility discharged the resident to an adult family home (AFH). Resident #1's medical record did not include a recapitulation of the resident's stay that included all aspects of the course of illness/treatment; therapy services; management of medical conditions; pertinent lab tests or consultation reports. The record did not include a final summary of the resident's actual physical and mental status at the time of discharge. A Discharge Summary (Recap of Stay) v1 form for Resident #1 remained blank in most areas and unsigned. The form did not include a summary of medical history; special treatments or summary of specific aspects of the course of illness or stay in the facility. During an interview on [DATE]20 at 11:08 AM, Staff F Licensed Practical Nurse (LPN) stated that upon transfer to the AFH, the resident would bring discharge paperwork that included a recap (recapitulation) of stay that would show the course of treatment. Staff F also stated the discharge summary should show Resident #1's use and response to medications. RESIDENT #17 Resident #17 admitted to the facility on [DATE] and had two hospitalization s between [DATE] to [DATE]. On 0[DATE]20, the resident discharged to an unknown location and later that night went to the emergency room for worsening of respiratory condition. Resident #17's record did not contain a recapitulation of stay that summarized the course of illness; treatments provided such as [MED]gen therapy, wound care, medications; pertinent labs; or consultation reports. The record did not include a final summary of the resident's physical or psychological status at the time of discharge. During a telephone interview on 03/18/2020 at 1:07 PM, Staff C Director of Nursing (DON) stated that she did not see a final nursing discharge summary in Resident #17's medical record. RESIDENT #3 Resident # 3 admitted to the facility on [DATE] and discharged [DATE]. Medical [DIAGNOSES REDACTED]. A nursing noted dated 0[DATE] showed Resident #3 could verbalize medications taken and walked to the bathroom with a walker. A nursing note dated 12/16/19 showed staff provided medication management, wound care and therapy services. Resident #3's record did not include a recapitulation of stay that summarized the course of illness/treatment such as wound care, therapy services, pertinent lab tests or consultations if obtained wound care or services therapy provided. During an interview on [DATE]20 at 11:53 AM, Staff J Medical Records (MR) stated that recaps of stay should be done but were not done consistently. During an interview on 03/04/2020 at 2:40 PM, Staff C Director of Nursing (DON) stated that she looked at the process for recap of stay today and the physician's summary of the course of events will be done now. Reference WAC 388-97-0080(7)(a)(b) .
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.** **Provide appropriate treatment and care according to orders, resident's preferences and goals.**

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and recorded review the facility failed to reassess Resident condition following return from a four day therapeutic leave for one of seven residents (Resident #2) reviewed for monitoring and assessment. This failure placed Resident #2 at risk for unidentified change in condition that could require timely intervention to prevent further complication. Findings included. Record review of Resident #2's medical record showed she admitted to the facility on [DATE]. Resident #2's [DIAGNOSES REDACTED]. Progress note dated [DATE] describe Resident #2 left the facility to stay with a friend for a few days. Progress notes documented that the Resident had her physician's permission for the therapeutic leave and that she was expected to return on Monday the 16th at 7pm. There is no documentation available in the Resident's record for [DATE] the evening of her return. The Resident's medical record failed to describe her return to the facility or her condition when she returned. In interview [DATE] at 11:05 am Staff F, Licensed Practical Nurse (LPN) reports he is unsure what happen when the Resident returned to the facility on [DATE]. Staff F states nursing staff should have documented her return to the facility and assessed her condition upon her return. Progress note dated 12/20/2019 showed Resident #2 called 911 herself for transport to the emergency room because of [MEDICAL CONDITION].
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide a consistent restorative program and periodic evaluation of program effectiveness for two of four residents (#s 11 and 19) reviewed for restorative services. This placed residents at risk to decline in strength and ability to participate in activities of daily living and/or worsening of contractures. Findings included . Facility Restorative Nursing Program procedure directed staff to summarize progress toward goal completion on a quarterly basis and for the interdisciplinary team to review progress in comprehensive care plan review meetings. Goals were to be revised based on individual resident needs. RESIDENT #11 During observation and interview on 02/11/2020 at 4:40 PM, Resident #11 sat up in bed and stated that staff did not get her up out of bed often and did activities in her room. The resident stated she did need assistance from staff for some tasks and did not need help to eat. Resident #11 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #11's Activities of Daily Living care plan included interventions for a restorative program revised 11/25/19. Interventions included for staff to assist the resident to sit at parallel bars and do 30 sit-ups fifteen minutes a day; and active range of motion to both upper and lower extremities with one-pound weights. Both programs were care planned for six days a week. Restorative program participation documents showed during 10 days between 02/25/2020 and [DATE]20, Resident #11 received the program five times. On 0[DATE] at 2:15 PM, and during a telephone meeting on [DATE]20 beginning 3:56 PM, the investigator requested evidence staff provided restorative services during the month of January 2020 and the rest of February 2020 and conducted a periodic reassessment of Resident #11's restorative program. None were provided. The facility did not provide evidence Resident #11 received restorative services in January 2020, beginning of February 2020. No further evidence was provided the facility conducted a periodic reassessment of the resident's level of participation, response to the program and its effectiveness. On 03/06/2020, the investigator received a list of residents who currently received restorative services from Staff R, Restorative Nurse (RN). Resident #11's name did not appear on the list. RESIDENT #19 Resident #19 admitted to facility on 04/26/18 with [DIAGNOSES REDACTED]. An undated restorative nursing program care plan showed to apply a resting right hand splint six hours a day and perform hand hygiene. Notes showed the resident could apply the splint by himself. Additional restorative services included active assist of range of motion of the right upper extremity shoulder in all planes for 15 minutes six days a week. Following a request on 03/06/2020 and again on 0[DATE] for a three month review of the resident's restorative participation, the facility provided a 14 day look back that included only ten days from 0[DATE]20 to 03/06/2020. Staff documented Resident #19 received hand hygiene and splinting to the right hand one day during the ten-day review. Twice the resident refused. Staff documented the resident received range of motion to the right upper extremity/ shoulder for fifteen minutes a day one day during ten days. Twice the resident refused. The record did not show if staff reoffered restorative at a different time after refusal or evaluated the reason for the refusals. During an interview on 03/06/2020 at 3:06 PM Staff R RN, stated that the former restorative nurse left the facility the middle of December 2019. Staff R stated that the MDS corporate nurse assumed charge of the restorative program one month ago and had to create a new list to identify residents on the program. Staff R also stated currently the facility did not have any restorative aides and a new restorative aide would begin 0[DATE]. WAC 388-97-1060(3)(d)(j) .
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** Based on observation, interview and record review the facility failed to provide adequate supervision to prevent incidents of choking while eating; and/or adequately assess and monitor residents following incidents of choking; and/or care plan interventions to prevent future choking episodes for two of four residents (#s 6 and 7) reviewed who had a history of [REDACTED]. Findings included . RESIDENT #6 During observation on 03/04/2020 at 12:07 PM, Resident #6 lay in bed with eyes closed. The bed was low to the floor and had a mat on the right side of the bed. The resident did not respond when spoken to. Resident #6 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 10/08/19, Resident #6 discharged to the hospital and readmitted on [DATE]. A hospitalist progress note dated 10/10/19 documented a speech therapy evaluation showed the resident had dysphagia consistent with advanced dementia and advanced diet to a mechanical soft consistency with nectar thick liquids and reflux precautions. A Hospital Discharge Summary dated 10/11/19 showed the resident had right upper and lower lobe aspiration pneumonitis/aspiration pneumonia and returned to the facility medically stable. During an interview on [DATE]20 at 1:30 PM Staff I, Dietary Manager (DM) presented a diet card that showed Resident #6 received a dysphagia advanced diet. A Care Plan initiated 06/02/19, revised 12/16/19, showed for staff to assist Resident #6 to the dining room and eat upright in wheelchair for all meals. The care plan showed the resident could hold a cup and feed self and eat finger foods independently. A physician order [REDACTED]. The resident's nursing aide Kardex (care plan) as of 03/04/2020 did not include stategies for eating slowly, small bites and sips or to remain upright for 20 to 30 minutes after meals. A facility investigation dated 0[DATE] showed Resident #6's roommate called staff to the room who found the resident in bed with cyanotic colored lips, face and choking on breakfast. The report showed staff placed the resident in an upright position, the resident self-dislodged food from his airway. During an interview on [DATE] at 2:20 PM Staff G, Licensed Practical Nurse, resident Care Manager (LPN, RCM), stated that Resident #6 had cognitive impairment and needed to eat all meals in the dining room and needed cueing. Staff G also stated that if the resident wanted to get out of bed to eat aide staff needed to notify the nurse and staff had to sit with the resident. Staff G also stated that the resident did not have cueing at the time of the incident and may have slipped down from a sitting positon and staff were not to feed the resident unless he sat upright. During an interview on [DATE]20 at 2:35 PM, Staff L Licensed Practical Nurse (LPN), stated that her medication cart was around the corner from the room and overheard the resident's roommate yell for help. Staff L also stated when she went in to the room the resident was in bed and did not sit upright as he should be. Staff L stated that she did not know why staff did not get the resident up to eat that day. The resident's nursing aide Kardex (care plan) as of 03/04/2020 did not direct nursing aide staff to notify the nurse if the resident declined to eat in the dining room and wanted to eat in room. Following the incident, Staff L stated that she immediately added the location of where Resident #6 should eat onto the medication record so it would show nursing staff where aides should deliver the food tray. During an interview on [DATE]20 at 3:00 PM, Staff C, Director of Nursing (DON) stated that some residents struggle to eat in bed and eat more effectively if staff get them up. Nursing staff failed to adequately supervise to ensure Resident #6 out of bed to eat and staff delivered the meal tray to the dining room or notify the nurse the resident needed staff to supervise the resident to eat in the room. RESIDENT #7 Observation on [DATE]20 at 12:44 pm Resident #7, is lying in bed with head of bed 1/8 elevated. Most of the food on Resident #7's lunch tray has been eaten but she continues to eat what is left. She prop herself up on one elbow when she takes a bite and then returns to an almost lying flat position in between bites. Record Review of Resident #7's medical record showed she admitted to facility on 10/13/2013. [DIAGNOSES REDACTED]. Review of facility investigation dated [DATE] described Resident #7 experienced a choking incident in the dining room. Resident had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505123	A. BUILDING _____ B. WING _____	**03/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BREMERTON CONVALESCENT & REHABILITATION CENTER	**2701 CLARE AVENUE BREMERTON, WA 98310**

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) food stuck in her throat and was coughing. The facility investigation also reflected follow up of the incident would be: Continue to monitor resident for change in condition r/t choking. Resident #7's progress notes on [DATE] reflect the choking incident. The progress notes for that day also document contact informing Resident #7's daughter of the incident and contact with hospice discussing Resident #7's increased level or anxiety. Resident #7's progress notes dated 2/5/2020 through 2/9/2020 lack any description of assessment done to ensure Resident did not aspirate during the choking incident. Progress notes through that time period fail to address the choking incident, how the Resident is being assessed, to prevent any further choking incidents and any psycho/social harm the Resident may have experienced. In interview on [DATE]20 12:50 pm with Resident #7 at 12:50 she reports I used to have a feeding tube to eat but I was able to get my feeding tube out and go back to eating regular food. Resident #7 reports she normally eats in the dining room but did not feel like going to the dining room today. Resident #7 describes I do not like sitting up on the side of the bed that is not a comfortable position for me. Review of Resident #7's care plan reveals interventions for dysphagia are tube feeding. The care plan failed to reflect Resident tube feeding had been discontinued and removed 0[DATE]. During an interview on [DATE]20 at 2:21 pm Staff G, Licensed Practical Nurse (LPN) Unit Coordinator, stated that the care plan for Resident #7 needed to be updated. Resident #7 is now on a regular diet and eats in the Olympic dining room. Staff G, LPN reported that it is her expectation that nursing staff should have documented Resident #7's condition for at least three days all three shifts following the choking incident. Staff G, LPN reported that she believes nursing did assess Resident #7 for swallowing difficulties following the incident but failed to document it adequately. Staff G reports the care plan should have also been reviewed following the choking incident and the care plan should reflect interventions to include Resident #7's current diet and ensure the Resident is supervised adequately when eating. WAC 388-97- 1060(3)(g) .