STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505296	A. BUILDING _____ B. WING _____	**03/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST FRANCIS OF BELLINGHAM	**3121 SQUALICUM PARKWAY BELLINGHAM, WA 98225**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain resident dignity for one of four residents (#59) reviewed. Facility staff failed to assist the resident to brush her hair that resulted in two large mats of hair in the back of the resident's head which required the resident's hair to be cut off. This failure placed the residents at risk for diminished self-worth, self-esteem and overall well-being. Findings included . The resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. On 02/05/2020 at 10:58 AM, in an observation and interview with the resident, the resident was observed laying in her bed, her hair was down to her shoulders and had a great amount of dandruff looking flakes throughout her hair. The resident was asked if she was receiving showers, the resident stated, No, I have only got a few bed baths but I want a full shower, all I do is lay in this bed all day long. The resident was asked if the aides help her brush her hair, the resident stated no, she had not had her hair brushed. Observations on 02/06/2020, 02/07/2020, 02/11/2020, and 02/12/2020 revealed the resident's hair remained uncombed. On 02/13/2020 at 9:25 AM, the resident stated her hair was still not being brushed and now she had knots in her hair. The resident was observed to have large knots at the back of her head. Review of a nursing note dated 02/14/2020, documented 2 large mats of hair on the back of the head .aid attempted to brush through knots, knots were not able to be taken out and two large mats remain. Was re approached regarding and stated that she would be interested in seeing the hair dresser to have haircut. On 02/18/2020 at 1:51 PM, in an interview with Staff Z, a nursing assistant, Staff Z, stated part of the morning care for the resident included washing her face, combing her hair. When asked if the resident got her hair combed by him, he was not able to answer, during this interview the resident interjected and stated, No one ever brushes my hair. On 02/19/2020 at 11:47 AM, the resident was observed sitting in her wheelchair at the entrance of the beauty shop. The resident stated, she was waiting for her turn to get her hair cut off. The resident stated, she liked her hair long but the staff tried for a long time to brush the knots out and couldn't get them out. Staff AA, Regional Director of Operation was brought to the resident so that she could witness the resident's hair and that the lack of care had resulted in the resident now having to have her hair cut off. This is a repeat deficiency from 02/13/2019 Reference: (WAC) 388-97-0860 (1)(2)
F 0584 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on observation and interview, the facility failed to ensure a safe, clean, and comfortable environment for residents. Failure to: 1) ensure resident room walls had painting in good repair, 2) to ensure the shower room floor tiles were maintained, and 3) to not have the building smell like urine, all placed residents at risk for a diminished quality of life. Findings included . PAINT In an observation on 02/07/2020 at 8:19 AM, Resident #29's room walls had paint in poor repair. The wall with the window had several areas with paint needing repair to include an area approximately 8 x 36 inches. The walls had paint that was different colors. All walls of this resident's room needed re-painting as there were multiple areas with patched up type paint. In an interview on 02/20/2020 at 3:40 PM, Resident #29's daughter stated the issues with the paint had come up last year, but nothing yet had been done about it. URINE ODORS In observations on 02/11/2020 at 1:01 PM and 3:40 PM, and on 02/12/2020 at 10:30 AM, the A-wing hallways had strong odors of urine. A-WING SHOWER ROOM In an observation on 02/07/2020 at 7:25 AM, the A-wing shower room, first stall to the left, had approximately 10 missing floor tiles. In an interview on 02/25/2020 at 3:01 PM, Staff FFF stated he knew about the painting issues in Resident #29's room, and he said he would replace the missing tiles in the shower room floor. Reference: (WAC) 388-97-0880 (1)(2)
F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure seven of eleven sample residents (#3, #58, #66, #70, #28, #32 and #64), were free from abuse and neglect. The facility failed to adequately assess residents, provide adequate supervision, and interventions or implement procedures to prevent unsafe residents from leaving the facility unsupervised. The facility failed to investigate or report allegations of sexual assault and to adequately monitor for verbally and physically aggressive behavior, or behaviors that may provoke a reaction by residents or others, which included, wandering into other's rooms/space. These failures by the facility caused residents to be subject to possible emotional, verbal and physical abuse and placed all the residents at risk for abuse and neglect. This failure resulted in an immediate Jeopardy (IJ) related to neglect on 02/05/2020. The facility placed alleged perpetrator on one to one supervision, assessed residents, completed investigations, revised processes, and provided training to all staff, which led to the removal of the IJ on 02/28/2020. Findings included . Neglect, as defined at 483.5, means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of facility's policy titled, Abuse Prevention Policy and Procedure, revised 08/11/2017, showed each resident has the right to be free from abuse, see definitions: -Instances of abuse of residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish and can include verbal, sexual, physical and mental abuse; -All incidents, accidents and injuries of unknown origins and resident to resident contacts will be identified through the 24-hour report and incident reports in order to initiate an investigation; -The facility shall maintain a staffing plan that represents the needs of the residents and -The interdisciplinary care plan process should be used to target those residents with needs and behaviors that might lead to conflict or neglect such as residents with a history of aggressive behaviors, and residents who have behaviors such as entering other resident's rooms. Investigations- As soon as report of alleged or suspected abuse is received, the investigation shall begin in order to rule out or identify abuse. ELOPEMENT- RESIDENT #3 Resident #3 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #3's clinical record revealed a nursing note, dated 01/30/2020 at 6:17 PM, showed: Resident went out of the facility for shopping without telling staff, and resident located by Trader Joes (store) on the street. Staff went to get her, but resident was sent to the hospital by emergency medical services (EMS). Facility staff called the hospital and confirmed resident was there, having some tests and would return to

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) the facility. According to the Annual Minimum Data Set assessment (MDS), an assessment tool, dated 01/05/2020, showed that Resident #3 was moderately cognitively impaired, suffered from delusions (misconceptions or beliefs that are firmly held, contrary to reality), and required supervision to walk in room or hallways and with locomotion on and off the unit. During an initial observation and interview on 02/05/2020 at 11:27 AM, Resident #3 was observed sitting in her room on the bed. The resident had a front wheel walker next to her bed with a wander guard device observed attached to the right side bar of the walker. The resident did not have a wander guard on her person, either upper or lower extremities at the time of the observation. During the initial interview, Resident #3 made an allegation of sexual assault, which was immediately reported to the facility administration. During a joint interview and record review, on 02/05/2020 at 3:40 PM, the Director of Nursing Services (DNS) and Staff F, Administrator in Training (AIT), were both notified of the resident's allegation of sexual assault and elopement from the facility on 01/30/2020. Both staff members stated that the resident was safe to leave the facility independently and that the resident had a history of [REDACTED]. This information was inconsistent with the care plan for supervision and wander guard. Review of progress note, entered by AIT on 02/05/2020 at 5:02 PM, documented: Clarification to note made on 01/30/2020 at 6:17 PM. Facility was aware that resident had gone out shopping, they had checked in with the front desk at 10:30 AM and got a ride at the bus stop. Later the resident called around 12:30 PM to the main phone line asking to be picked up she was able to provide the address of her location. She did not wait and had decided to walk back. Upon arrival staff was notified that EMS had picked up resident and she was located at the emergency room . The AIT was unable to provide an assessment that deemed the resident safe to leave the facility independently. During a joint interview and record review on 02/05/2020 at 5:41 PM, the DNS stated that on 01/30/2020, Resident #3 went to the front desk and told receptionist she was going out of the facility. The DNS stated that Resident #3 was her own responsible person, stating that she often left the facility to shop but always returned. The DNS also stated Resident #3 had a cell phone that she used to call the facility when she needed to. On the day of 01/30/2020 the DNS stated the resident called the facility and gave the address of where she was and needed a ride back. When facility staff arrived to that address the resident was not there. DNS confirmed that the resident ended up at the emergency room but was unaware of exactly how she got there. The DNS stated that she did not complete an investigation related to this issue because the resident always went out and came back, stating I asked the Administrator and he told me it wasn't an investigation. The DNS was unable to provide an assessment that deemed Resident #3 safe to leave the facility unsupervised. During an interview on 02/05/2020 at 5:51 PM, Staff H, stated that she was aware Resident #3 frequently left the facility independently and she was told that this was ok for the resident to do. Staff H stated that on 01/30/2020, the resident approached the front desk and stated she was leaving the facility to go shopping. Staff H stated that she told Resident #3 to let the nurses know and to sign out in the book at the nurses station. She stated that on 01/30/2020 after the resident had left the faciity on the bus, she called down to the nurse's station and was told that Resident #3 had not notified staff she was leaving and had not signed out in the book. Staff H further stated that Resident #3 did not have a cell phone that she knew of and had told her several times that she did not have a cell phone. During an interview on 02/05/20 at 5:59 PM, Staff Y, Registered Nurse (RN), stated that she did not think the resident had a cell phone of her own, she would have to check the inventory sheet in the resident record. Staff Y also stated that whenever Resident #3 needed to make a call she would come to the nurses station and ask for help getting a phone number and help with dialing the phone. Review of Resident #3's inventory sheet, dated 01/14/2018, showed Resident #3 did not have a cell phone. This information was inconsistent with the DNS statement. Further review of a nursing progress note dated 02/02/2020 at 1:51 PM, documented: Front door sensor alarm was going off. Found resident walking on side walk towards the hospital, went to redirect and resident stated, I came for a walk it was nice and sunny outside, I will do my walk again tomorrow if it will be sunny like this. On 02/05/2020 at 5:15 PM, the DNS when asked to provide a completed copy of the incident report for the elopement out of the facility on 02/02/2020, she stated There was not one completed for that incident. During a joint interview, on 02/05/2020 at 6:14 PM, with Facility Administration, RCS Field Manager, Staff F (AIT) and Staff AA, Regional Director of Operations (RDO), details of the Immediate Jeopardy (IJ) were discussed including the residents involved. Staff AA was also notified at this time that Resident #3 had made an allegation of rape during initial screening and that she stated she had reported to the facility staff multiple times and they did not do anything. Facility administration confirmed that there were multiple progress notes that documented reported allegations, but that there were no investigations completed by the facility to rule out abuse or neglect, Staff AA stated, Yeah I know there is nothing. The facility administration was also notified that the wander guard device was located on the right bar of her walker and not actually on the resident's body, Staff AA confirmed this to be true. Discussed that there were no investigations completed for allegations of rape or the elopement from the facility and Staff AA stated I honestly don't even know what to say right now, every training we do, staff should know that all of these concerns should be taken seriously, reported and followed up on. The DNS stated that during the interview with the Resident #3 today (02/05/2020), regarding the allegation of assault, Resident #3 verbalized a name of a specific resident that had hurt her. The DNS confirmed that there was a resident fitting the description Resident #3 provided near the resident's room who was placed on a 1:1 observation while the facility completed the investigation. During an observation, on 02/06/2020 at 2:45 PM, the resident was observed sitting in a chair near the front exit. The wander guard device was observed on the right bar of the walker near the resident. There was no wander guard device observed at that time on the resident's body. During a dining observation and interview on 02/07/2020 at 7:53 AM, the resident was observed sitting at a table in the dining room. The resident was wearing a wander guard bracelet on her right wrist, which was noted to be extremely loose. The resident stated I wear this so they know where I am going. The resident also stated that It's always loose, and proceeded to remove the bracelet and place on the table during the interview, stating I take this off sometimes. Review of current State incident reporting log received and grievance log on 02/04/2020 showed no investigations and/or grievances were completed for Resident #3 related to leaving the facility unsupervised on 01/30/2020. Review of Resident #3's care plan printed on 02/07/2020 showed: Focus area- Resident used anti-psychotic medications related to behavior management due to [MEDICAL CONDITION]. Interventions included: Monitoring behaviors of attempts to make unplanned unsafe trips out of the facility (Initiated on 11/15/2019). Focus area- Resident is at high risk for elopement related to Elopement risk score of >8 (Date initiated 08/27/2019 with revision on 02/03/2020). Interventions included: Check wander device daily, located on right side of her front wheeled walker (initiated on 02/03/2020); Implement Code Pink Protocol (initiated on 02/03/2020); Assist with setting up an outing with staff member for shopping needs (initiated on 08/30/2019) The wander guard will be checked each shift for battery life and placement every shift- under walker and right wrist (initiated on 02/03/2020, revised 02/17/2020). Further review of the care plan showed that Resident #3 had been identified as a High Elopement Risk resident in August 2019 and was being monitored for making unplanned, unsafe trips out of the facility since November 2019. The care plan also showed that interventions that were implemented related to elopement included a wander guard device on the right side of the front wheel walker which was not initiated until 02/03/2020, four days after the resident left the facility unsupervised on 01/30/2020. The care plan also showed that the resident needed assist to set up outings and staff member assist for shopping needs (initiated 08/30/2019). During a joint record review and interview on 02/05/2020 at 5:59 PM, the DNS stated that she was told by administration that she did not need to complete an investigation when Resident #3 left the faciity on [DATE]. The DNS stated after she went through trauma training, she then knew that the assault allegations made by Resident #3 should have been investigated. The DNS further stated she was told that Resident #3 was ok to leave the facility independently and was not aware of staff accompanying her during outings. Review of current Physician orders [REDACTED]. Review of Medication Administration Record [REDACTED]. The order does not specify where the wander guard device is located. Review of the elopement risk evaluation, dated 02/07/2020, showed Resident #3 was a High Risk for wandering. The evaluation was completed eight days after the resident left the facility unsupervised on 01/30/2020. The evaluation describes the resident as forgetful/short attention span, exhibits/expresses fear and/or anxiety, and known wanderer/history of wandering. This was the only elopement risk evaluation completed in Resident #3's clinical record. Review of facility form titled Code Pink Guidelines dated 10/2015, showed the purpose of this assessment was to identify residents at risk for Elopement, establish a safe environment and develop an individualized plan of care. The guidelines showed: - An elopement/exit seeking/wandering assessment, called Code Pink documentation tool is completed at the time the resident is identified as at risk for elopement/exit seeking/wandering. - Definitions: B. Elopement- A resident exiting the building into an unsecured area without direct supervision who has been deemed not safe to do so. Review of Code Pink assessment dated [DATE] (completed date of 02/03/2020), showed: - Triggers that indicate elopement attempts- Resident used a front wheel walker for mobility, the resident likes to take walks on sunny days. - Known successful interventions- was blank and incomplete - Types of

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) supervision- visual checks - Other comments- the resident in the past can go out of facility on her own. Due to her Dementia progressing and not remembering where she lives at, she now needs an escort when leaving facility as of 02/02/2020. Review of a second Code Pink Assessment with the same initiation date of 02/01/2020 (completed date of 02/07/2020), showed: - Triggers that indicate elopement attempts- same as previous assessment - Known successful interventions- redirection, and wander guard on right hand and under her walker - Types of supervision- resident walks around facility be aware of resident as she is approaching exits. - Other comments- same as previous assessment. The first Code pink assessment did not list any known successful interventions, whereas the second one completed and closed six days after it was initiated, and after the elopement was identified by State surveyors showed interventions of wander guard on right hand and under her walker. This was found to be inaccurate as the wander guard device was only observed on Resident #3's walker until the facility was notified and then a wander device was placed on the resident's body on 02/07/2020. Review of the Safety device assessment and consent initiated on 02/01/2020, (locked/completed) on 02/10/2020, nine days after it was started, showed: -Type of device: Wander guard on right hand at all times, date initiated 02/01/2020. -Reason resident requires devices- Elopement. The first observation of Resident #3 wearing a wander guard device on her body was not until 02/07/2020, which made the information in this assessment inaccurate. Review of the ER notes dated 01/30/2020 showed: Resident's chief complaint was dizziness. Per triage notes the resident stated she went on the bus today to go shopping and then decided to walk back to the facility but got lost, was then picked up by EMS and noted that she felt dizzy and tired. The ER Doctor (MD), documented in notes that he suspected the majority of the residents symptoms are due to overexertion. MD stated that after observation in the ER and treatment with small bolus of intravenous (IV) fluid, the resident felt improved and was able to ambulate without return of symptoms. Documentation showed the resident received an IV bolus 500 milliliters of fluids in the ER. Follow up interview/record review on 02/06/2020 at 10:28 AM, the DNS confirmed Resident #3 did go to theER on [DATE], but was unable to provide any further information regarding that. The DNS stated that she hadn't actually received or reviewed the paperwork from the hospital encounter. Summary: Resident #3 left the faciity on [DATE] to a store that was approximately 1.5 miles away from the facility. Resident attempted to walk back to the facility, became fatigued and EMS was called by someone outside the facility to transport resident to the ER. The facility failed to accurately assess the resident's safety to be out of the facility independently, failed to implement appropriate interventions timely, to prevent elopement, and failed to properly investigate the situation. The facility also failed to assess Resident #3's clinical status [REDACTED]. UN-INVESTIGATED ALLEGATIONS OF SEXUAL ASSAULT During an interview and observation, on 02/05/2020 at 11:27 AM, Resident #3 stated, My back hurts because he raped me all the time. The resident continued by stating, It hurts [MEDICAL CONDITION] did it all the time on my back, pointing to her lower back. Resident #3 stated, He got someone younger to do it to me in the front and they raped me, all summer long this happened. When Resident #3 was asked if she knew who had hurt her she stated, Yes it was (Resident #6), he lives down the hall a few doors, makes me sick thinking there is a rapist in a place like this. The resident stated that these things happened at the facility, and she told the nurses here but they don't care, they don't do nothing. The resident again repeated, He would get someone younger to do the front, rape me from the front and continued stating, I told him I was going to report this to the police but he didn't care. Resident #3 denied being fearful of anyone at the facility currently, stating, Everyone is nice here. During a joint interview and record review on 02/05/2020 at 3:40 PM, the DNS and Staff F, AIT, were both notified of the resident's allegation of sexual assault. Both staff members stated that the resident had a history of [REDACTED]. Review of Resident #3's clinical record revealed the following nursing progress notes: - 08/25/2019- Resident woke and stated, I was raped. The resident told the nurse, It happened just now. LN documented she reported to oncoming nurse for continued monitoring - 09/16/2019- Resident came to LN cart pointed at a male resident and stated, He raped me last night. LN documented resident is known to make accusations against males. Reported to night shift nurse. - 09/22/2019- Resident stated to nurse that a male resident who she accused before had raped her once. LN documented resident has history of accusing other male residents and aides about rape, stating she suffers from [MEDICAL CONDITION] (Post-Traumatic Stress Disorder) of sexual abuse. - 11/03/2019- Resident approached nurse stating she had been raped by two men during the middle of the night and her butt hurt very much. The nurse assessed and found resident with hemorrhoids. The nurse documented per care plan when resident had hemorrhoids it can trigger a [MEDICAL CONDITION] response. The nurse explained the hemorrhoids to resident and that was why her butt hurt and she had blood on her night gown. On call nurse contacted and stated this was in her care plan and to monitor further for [MEDICAL CONDITION]. - 11/16/2019- Resident came to the nurse with allegations of men coming to her room and assaulting her. Resident complained of having sore bottom and requested cream. Resident redirected as has history of these kind of allegations. Nurse Manager informed. - 12/24/2019: Resident reported she felt men had come into her room last night which caused the new bruise to her arm 2.5 cm (centimeter) x 2 cm in size. Bruise appears to be light purple in color. Resident then later stated she must have hit her arm on something. Will place monitoring order on bruise. Review of current State incident reporting log and grievance log received on 02/04/2020, showed no investigations and/or grievances were completed or logged for the multiple allegations of assault and/or rape that were documented in the progress notes. During a joint record review and interview, on 02/05/2020 at 5:15 PM, the DNS confirmed multiple notes documenting reports of sexual allegations were in the resident's clinical record, however she was unable to provide any further information regarding the notes and stated that there were not incident reports completed for these allegations because she had a history of [REDACTED]. Allegations of sexual assault 02/05/2020 (initiated 01/30/2020, revised on 02/18/2020). Interventions included: - During weekly skin checks ask resident if she was having any rectal pain (initiated on 02/06/2020) - Has traumatic child hood/young adult hood history of sexual abuse. Per mental health provider crisis plan: Resident will talk about past abuse as if it was a recent occurrence. Interventions included 1:1 visits with staff, rest and space, engage in crafts and visits with staff members who she had a good rapport with. Helpful to engage with resident in a gentle manner and acknowledge concerns and clarify what she wants/needs- Graduated from mental health services on 01/01/2019, new referral sent on 02/06/2020 (initiated on 01/30/2020, revised on 02/09/2020). Focus Area- Resident has acute pain related to migraines, recurrent hemorrhoids (initiated on 01/16/2018, revised on 02/09/2020). Interventions included: -Resident has history of hemorrhoids that she associates with pain from past trauma. When she brings up traumatic events notify nurse or care manager so that she can be assessed (initiated on 05/14/2019). The facility failed to address the resident's past history of sexual assault with appropriate interventions present on admission 01/14/2018. The care plan regarding trauma was not initiated until 01/30/2020. Even after the facility administration had knowledge of the allegation of rape on 02/05/2020, and planned to protect Resident #3 by providing alleged perpetrator, Resident #6, with 1:1 supervision during investigation, the facility failed to ensure that 1:1 was done consistently. 1:1 Monitoring: In an observation and interview, on 02/07/2020 at 4:50 AM, there was an empty chair outside Resident #6's room (resident was on 1:1 monitoring for allegations of rape), Staff PP, RN, stated Staff CCC, NA, was supposed to be doing 1:1 monitoring of Resident #6, but he also had other duties including helping take care of other residents. In an interview, on 02/07/2020 at 5:03 AM, Staff CCC said he was supposed to be keeping an eye on Resident #6. He stated, No, when asked if he was supposed to leave the resident to do other work without monitoring him. In a review, on 02/07/2020 at 4:52 AM, the 1:1 monitoring form being used to document monitoring of Resident #6 by Staff CCC, had no documentation of monitoring after 4:00 AM. RESIDENT TO RESIDENT INTERACTIONS RESIDENT #58 Resident #58 admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly MDS assessment, dated 12/29/2019, showed he had no behaviors and was cognitively impaired but could make his needs known. He was independent in his mobility off the unit. Review of the care plan, initiated on 02/24/2016, showed a history of inappropriate sexual behavior as evidenced by inappropriate touching of self in public, behaviors of inappropriate touching of female staff and residents, exposing or touching of genitals in public spaces and aggressive hand gestures and verbalization. The care plan was revised on 02/08/2020 to include intrusive wandering into female rooms. The care plan directed staff to identify places he may wander to, redirect him when he attempts to go into female rooms and remind him of boundaries. Resident will be supervised during activities to maintain safety for resident and others. Review of the care plan, on 02/14/2020, did not include the new intervention for one on one supervision. Review of a 07/02/2019 at 3:53 PM activity progress note revealed, This res (Resident #58) and another female res (#66) were sitting near each other in an activity. Noticed that they were holding hands, and this res (#58) began to pull her hand closer to him and it seemed as if he was pulling toward his lap/private area. I intervened before anything happened and told res to stop. Other female res was laughing and smiling, was not upset about the situation. Residents were separated and no further behaviors noted at that time. Review of a 07/25/2019 progress note, showed Residents #58 and #66 were observed sitting in the solarium

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) kissing. Review of a progress note, dated 09/18/2019 at 6:59 AM, Inappropriate mutual behaviors between this resident (#58) and female resident (#66). Residents separated and brought to their perspective rooms. Review of a progress note, on 09/26/2019, Resident #58 was visiting Resident #66 from the hallway. Resident #70 asked him to leave repeatedly. Resident #58 swore at her. RESIDENT # 70 Resident #70 admitted on [DATE]. She was alert and oriented and able to make her needs known. Review of a progress note for Resident #70, on 01/13/2020 at 5:00 PM, showed Resident # 58 had gone into (Resident #66's) room that he was told he cannot be alone with. The female resident's roommate (Resident #70) was raising her voice, telling him that he needed to get out of our room. Resident #58 was refusing to do so and attempted to kick at the roommate, but did not make contact .escorted the female resident and her roommate to the dining room. (Resident #58) again kicked at the roommate but again did not make contact. Resident #70 was very upset and stated that the male resident had come into her room to be with her roommate and she told him he needed to leave. Resident then stated the male resident then tried to kick her multiple times . Review of a progress note, dated 02/13/2020 at 3:00 PM, showed Resident #70 was resting in her room when another resident (Resident #58) coming down hallway stopped in front of this resident's door way and began shouting profanities (in Spanish) towards resident. After shouting a few words, specifically f*ck you, this resident then left doorway (self-propelling himself in wheelchair) down hall towards dining room and or activities. This behavior happened more than once and witnessed x1 by shower aide. Resident has been placed on a 1:1 and will be watched for any negative behaviors during this time. Review of a progress note, on 02/18/2020, from Staff CC, Mental Health Consultant, showed Resident #58's English is limited but easily makes needs known & holds appropriate basic conversations. Resident is impulsive and disinhibited .Bx (behavior) monitor displayed some inappropriate bx's including unwanted touching In an interview on 02/14/20 at 9:58 AM, Staff SS, RN, confirmed Resident #58 was on one to one supervision. She said At night, (Staff XX) was doing one on ones . I believe. (Resident #58) does not like (Resident #70) and he will target her and go by her room and swear. He did this a couple times yesterday. This had been going on for a long time actually. In an interview on 02/14/2020 at 10:23 AM, Staff VV, NAC, said Resident #58 was on one on one supervision for swearing at residents in Spanish. She said he had issues with one lady and he had a relationship with her roommate (Resident #66). Staff VV stated the roommate (Resident #70) did not like him. In an interview of 02/14/2020 at 10:30 AM, Staff SS, RN, provided the 15-minute check sheet. Staff XX, NAC had initialed noc shift including at 0600, 0610 and 0620. From 0640-0820, Staff SS, had signed the 15 minute checks. She was observed caring for her other residents during these entries. She had not been observed providing the one on one supervision. When asked she stated, Staff XX did one on ones then I did it a couple hours. In an interview on 02/14/2020 at 10:50 AM, Staff AA, Staff II, Staff U, and the Director of Nursing were informed Resident #58 did not receive one on one supervision from 0600 to 0820. Staff AA, had been unaware Resident # 58 was on one to ones. The DNS stated she would have to look into what happened and why he was not receiveing one on one supervision. In an interview on 02/14/2020 at 11:40 AM, Staff AAA, NAC stated she arrived at work at 8 AM and noticed she was assigned to one on ones with Resident #58 although she was unaware why. In an interview on 02/20/2020 at 2:18 PM, Staff I, NAC, stated, He is one on one now. He was visiting and going into other rooms .He is absolutely cognizant. He knows what is going on absolutely. He flirts with other women. He knows what he is doing and does not think it is wrong. We were in-serviced we have to sign on one on ones to protect the residents. RESIDENT #66 Resident #66 admitted on [DATE] with dementia with behavioral disturbance and cognitive communication deficit. She was cognitively impaired and unable to make her needs known. According to the Annual MDS, dated [DATE], she wandered 4 to 6 days in the seven-day look back period. Review of her Activities care plan dated 02/12/2020, showed unobtrusive wandering, dementia and flirtatious behavior toward some male residents; a specific male resident and she had a flirtatious relationship. (Resident #66) and male resident are unable to give consent if both residents would like to participate in an activity together, they must be under supervision. Review of a progress note on 06/26/2019, showed, Resident #66 was seen touching another resident inappropriately during group activity. I spoke with her and the other resident explaining that their behaviors were inappropriate. Informed the nurse of the situation. Review of a progress note on 07/02/2019 at 3:59 PM, This res and another male were sitting near each other in an activity. Noticed that they were holding hands, and other res began to pull her hand closer to him and it seemed as if he was pulling toward his lap/private area. I intervened before anything happened and told other resident to stop. This res was laughing and smiling . Review of a progress note on 07/05/2019 at 12:00 PM, the activity staff came and told this LN (licensed nurse) that during activities she had walked out of activities to take another resident to the bathroom and when she returned she saw (Resident #58) grabbing this residents (#66) chest area. She then told this LN that she immediately separated both residents from each other and ensured their safety . In a progress note on 07/09/2019 at 11:57 AM, showed Res (#66) lightly holding hands in morning activity with other male res (#58) whom she has been seen with. This writer sat directly next to residents to prevent further behaviors. Review of a progress note on 07/25/2019 at 2:14 PM, showed resid
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to timely identify, investigate, report to the state hotline and report to the facility Administrator the results of the allegations of abuse and neglect for five of eleven residents (#58, #66, #70, #17, #3) reviewed for abuse and/or neglect. This failed practice prevented the facility from identifying, timely reporting potential allegations of abuse and/or neglect, which placed residents at risk of potential ongoing further abuse and/or neglect. Findings included . According to the facility's policy titled, Abuse Prevention Policy and Procedure, dated 08/11/2017, All staff members and agents of the facility are mandatory reporters of abuse. It is the responsibility of the Director of Nursing and the Administrator of this facility to ensure that these policies and procedures are followed. The State of Washington's Nursing Home Guidelines-The Purple Book dated October 2015, Prevention and Protection, Incident Identification, Investigation, and Reporting directs what nursing home facilities report. The facility should report to the Department by the telephone and via the reporting log when there was reasonable cause to believe violations have occurred involving abuse, neglect, abandonment, mistreatment and injuries of unknown source. Facility would report to the department within two hours, if there was serious bodily injury; or within 24 hours, if there was not serious bodily injury. RESIDENT #58 Resident #58 admitted on [DATE] with [DIAGNOSES REDACTED]. Review of a 07/02/2019 at 3:53 PM activity progress note revealed, This res (Resident #58) and another female res (#66) were sitting near each other in an activity. Noticed that they were holding hands, and this res (#58) began to pull her hand closer to him and it seemed as if he was pulling toward his lap/private area. I intervened before anything happened and told res to stop. Other female res was laughing and smiling, was not upset about the situation. Residents were separated and no further behaviors noted at this time Review of a 07/25/2019 progress note showed Resident's #58 and #66 were observed sitting in the solarium kissing. Review of a progress note dated 09/18/2019 at 6:59 AM, Inappropriate mutual behaviors between this resident (#58) and female resident (#66). Residents separated and brought to their perspective rooms. Review of the facility's state reporting log did not show these investigations had been completed for Resident #58. RESIDENT #66 Resident #66 admitted on [DATE] with dementia with behavioral disturbance, pseudobulbar effect, and cognitive communication deficit. She was cognitively impaired and unable to make her needs known. Review of a progress note on 06/26/19, showed, Resident #66 was seen touching another resident inappropriately during group activity. I spoke with her and the other resident explaining that their behaviors were inappropriate. Informed the nurse of the situation. Review of a progress note on 07/02/2019 at 3:59 PM, This res and another male were sitting near each other in an activity. Noticed that they were holding hands, and other res began to pull her hand closer to him and it seemed as if he was pulling toward his lap/private area. I intervened before anything happened and told other resident to stop. This res was laughing and smiling ., Review of a progress note on 07/05/19 at 12:00 PM, The activity staff came and told this LN that during activities she had walked out of activities to take another resident to the bathroom and when she returned she saw (Resident #58) grabbing this residents (#66) chest area. She then told this LN that she immediately separated both residents from each other and ensured their safety . In an progress note on 07/09/2019 at 11:57 AM, showed Res (#66) lightly holding hands in morning activity with other male res (#58) whom she has been seen with. This writer sat directly next to residents to prevent further behaviors. Review of a progress note on 07/25/2019 at 2:14 PM, Resident was sitting with another resident and received a kiss on the cheek and stated just as a friend. In a progress note on 07/25/2019 at 2:34 PM, Around 1000 Resident sitting in solarium kissing male resident (#58) as witnessed by RA (restorative aide), both residents separated immediately, and interviewed, notified DNS, called

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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.

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) daughter. In an interview on 02/28/2020 at 12:01 PM, Staff D, Licensed Practical Nurse (LPN)/Staff Development Coordinator (SDC) stated resident-to-resident altercations need to have incident reports for aggressor and victim, they need to protect, assess, monitor and document any latent injury or emotional harm, and the hotline was to be notified. Review of the incident report log did not include investigations for Resident #58 or #66 for 07/02/2019, 07/25/2019, or 09/18/2019. The facility did not report to the hotline in a timely manner until 02/15/2020. RESIDENT #70 and #17 Review of an incident report, dated 02/12/2020, showed Resident #70 witnessed Resident #66 lifting up her sweatshirt and flashing her breasts. Resident #70 stated her and Resident #17 were the only two who saw it. The incident report showed Resident #70 flagged down a nurse working in the dining room to address Resident #66's behavior. The incident report did not include a statement from the staff member that Resident #70 flagged down to address Resident #66's behavior. The incident report did not identify any other residents that were in the dining room that may have been affected. The incident report did not show any responsible parties were notified. The incident report showed Residents #70 and 17 were placed on alert, but not Resident #66. The nurse that Resident #70 flagged down for help failed to report the incident and did not investigate the incident. Resident #70 reported the incident to a different nurse the day following the event, and the nurse that took the resident's statement reported the incident. In an interview on 02/26/2020 at 11:32 AM, Resident #70 stated she had to yell out to get Staff J's, Registered Nurse, attention to come and address Resident #66 lifting her shirt and exposing her breasts in the dining room. Resident #70 stated Staff J was aware of the incident as he was present in the dining room. In an interview on 02/26/2020 at 2:09 PM, Staff J, RN, stated he was the nurse working in the dining room during the incident with Resident #66 exposing her breasts in the dining room. Staff J stated he did not see Resident #66 expose her breasts, but stated he had seen her cupping her breasts. Staff J stated he separated the residents. When asked why Staff J did not report the incident, he stated, there was nothing to report. Staff J stated there was nothing malicious about the resident cupping her breasts. Staff J acknowledged that Resident #70 informed him that Resident #66 had lifted her shirt and exposed her breasts, but Staff J reiterated he did not see Resident #66 expose her breasts. In an interview on 02/26/2020 at 2:30 PM, The DNS acknowledged that Staff J should have reported the incident immediately and acknowledged that he failed to identify and report the incident in the required time frame for reporting an incident. The DNS stated Staff J should have reported it to the DNS, Resident Care Manager, and DSHS. RESIDENT #3 Resident #3 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Resident #3's clinical record revealed the following nursing progress notes: -08/25/2019- Resident woke and stated I was raped. The resident told the nurse It happened just now. LN documented she reported to oncoming nurse for continued monitoring. -09/16/2019- Resident came to LN cart pointed at a male resident and stated He raped me last night. LN documented resident is known to make accusations against males. Reported to night shift nurse. -09/22/2019- Resident stated to nurse that a male resident who she accused before had raped her once. LN documented resident has history of accusing other male residents and aides about rape, stating she suffers from [MEDICAL CONDITION] of sexual abuse. -11/03/2019- Resident approached nurse stating she had been raped by 2 men during the middle of the night and her butt hurt very much. The nurse assessed and found resident with hemorrhoids. The nurse documented per care plan when resident has hemorrhoids it can trigger [MEDICAL CONDITION] response. The nurse explained the hemorrhoids to resident and that was why her butt hurt and she had blood on her night gown. On call nurse contacted and stated this was in her care plan and to monitor further for [MEDICAL CONDITION]. -11/16/2019- Resident came to the nurse with allegations of men coming to her room and assaulting her. Resident complained of having sore bottom and requested cream. Resident redirected as has history of these kind of allegations. Nurse Manager informed. -12/24/2019: Resident reported she felt men had come into her room last night which caused the new bruise to her arm 2.5 cm x 2 cm in size. Bruise appears to be light purple in color. Resident then later stated she must have hit her arm on something. Will place monitoring order on bruise. Review of current State incident reporting log and grievance log received on 02/04/2020, showed no investigations and/or grievances were completed or logged for the multiple allegations of assault and/or rape that were documented in the progress notes. The facility did not report to the state hotline in a timely manner until 02/05/2020. During a joint record review and interview on 02/05/2020 at 5:15 PM, the DNS confirmed multiple notes documenting reports of sexual allegations were in the resident's clinical record, however she was unable to provide any further information regarding the notes and confirmed that the facility had not notified the state hotline regarding these allegations. Reference: (WAC) 388-97-0640 (5)(a); (6)(a)(c)
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate allegations of potential abuse/neglect and falls for thirteen of thirteen residents (#3, #13,#10,#22, #35,#58, #66, #69, #70,#174,#374, #375, #424) reviewed for allegations and accidents. Failure to conduct thorough investigations to identify root causes and all contributing factors related to the incidents, placed the residents at risk for unidentified abuse or neglect and inappropriate corrective actions. Findings included . RESIDENT #13 Resident #13 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED].) The resident was alert and oriented and able to make needs known. On 02/10/2020 the resident reported to the resident care manager that he waited an hour and a half for assistance during the night shift after putting his call light on. The resident needed to be repositioned in bed. As part of the facility investigation, the facility included call light audit information that was dated for the week of 12/30/2019 to 01/03/2020. These call light audits were completed before the allegation was made by the resident, therefore, the information was not pertinent to this investigation and would not assist in determining if there was a concern with answering call lights and be able to prevent re-occurrence. In an interview with the Director of Nursing (DNS) on 02/20/2020 at 9:36 AM, the DNS stated, she was overwhelmed with so many allegations to investigate and didn't have any further information to provide. RESIDENT #10 Resident #10 admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of an incident report, dated 02/14/2020, showed Resident #10 screamed at, told his roommate, Resident #22, to shut up, and called Resident #22 a profane name. Review of the comprehensive care plan, revised 12/23/2019, showed the resident had behaviors of yelling at staff/other residents. Review of progress notes showed the following: 08/25/2019: Resident #10 experienced intense frustrations throughout the evening, yelling at RN (Registered Nurse) and NAC's (Nursing Assistant Certified) about resident's roommate. The resident did not directly yell at the roommate but stated he wished his roommate would be kicked out of this place. 09/11/2019: Resident #10 expressed deep frustration with his roommate shifting in bed and making noises in his sleep. Resident #10 stated that, Can you please get a baseball bat and knock him in the head. Resident was told it was okay to express his frustrations but that it was not appropriate to express himself in that way. The resident stated okay well I wish someone would just get him out of here so I can sleep! 12/09/2019: Staff reported that resident had been easily agitated. Noted to be frequently yelling at staff while providing care to his roommate (Resident #22). 12/14/2019: Resident voiced he was upset with his noisy roommate. 12/14/2019: Resident voiced he was a little upset when his roommate screamed while being changed. In an interview on 02/26/2020 at 2:22 PM, The Director of Nursing Services (DNS), stated when there are roommate issues a grievance was filed and social services offered interventions. The DNS was unable to provide any information about why the issue was not addressed to prevent the resident to resident altercation on 02/14/2020. In an interview on 02/27/2020 at 1:49 PM, Staff A, Social Services Director, stated Resident #10 did not consistently complain about his roommate, Resident #22, but had complained. Staff A denied any grievances or concerns coming to her about Resident #10 and Resident #22's roommate situation. Staff A reviewed the progress notes in Resident #10's record of him complaining about his roommate and yelling at staff about (Resident #22). Staff A acknowledged that a grievance or something should have been done back when resident #10 was first complaining and acting out about his roommate. Staff A stated the issues should have been addressed at the time of the issues, and the facility failed to look into it, investigate it, and failed to prevent the resident to resident altercation of Resident #10 yelling at and calling Resident #22 names. Staff A acknowledged that the resident to resident incident was preventable had the facility acted on the resident's roommate concerns at the time they were voiced. RESIDENT #35 Review of an incident report, dated 08/01/2019, showed resident #35 was attempting to enter a female resident's room and telling her to take off her clothes. The incident report showed the incident occurred on 08/01/2019, but was not found by the facility until 02/13/2020. The incident report did not identify the female resident or obtain statements from the resident or others. The incident report did not include any staff statements. There was no alert charting in place for the resident and the unidentified female resident following

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 5) the event. The incident report showed that no family members/responsible parties were notified. The incident report showed the facility acknowledged they did not do a thorough investigation. In an interview on 02/26/2020 at 2:37 PM, the DNS stated the incident should have been reported when the incident occurred in August 2019, and acknowledged the facility failed to investigate the incident at the time of the incident and that they did not conduct a thorough investigation. RESIDENT's #58 & #66 Review of a progress note on 06/26/2019, showed, Resident #66 was seen touching another resident inappropriately during group activity. I spoke with her and the other resident explaining that their behaviors were inappropriate. Informed the nurse of the situation. Review of a progress note on 07/02/2019 at 3:59 PM, This res and another male were sitting near each other in an activity. Noticed that they were holding hands, and other res began to pull her hand closer to him and it seemed as if he was pulling toward his lap/private area. I intervened before anything happened and told other resident to stop. This res was laughing and smiling . There was no investigation for this occurrence until 02/15/2020. Review of a progress note on 07/05/2019 at 12:00 PM, The activity staff came and told this LN that during activities she had walked out of activities to take another resident to the bathroom and when she returned she saw (Resident #58) grabbing this residents (#66) chest area. She then told this LN that she immediately separated both residents from each other and ensured their safety . In a progress note on 07/09/2019 at 11:57 AM, showed Res (#66) lightly holding hands in morning activity with other male res (#58) whom she has been seen with. This writer sat directly next to residents to prevent further behaviors. Review of a progress note on 07/25/2019 at 2:14 PM, Resident was sitting with another resident and received a kiss on the cheek and stated, just as a friend. In a progress note on 07/25/2019 at 2:34 PM, Around 1000 Resident sitting in solarium kissing male resident (#58) as witnessed by RA (restorative aide), both residents separated immediately, and interviewed, notified DNS called daughter. There was no investigation for this occurrence until 02/15/2020. Review of the incident report log did not include investigations for Resident #58 or #66 for 07/02/2019, 07/25/2019, or 09/18/2019. Review of an incident report, dated 02/12/2020, showed Resident #70 witnessed Resident #66 lifting up Resident #66's sweatshirt and flashing her breasts. Resident #70 stated she and Resident #17 were the only two who saw it. The incident report showed Resident #70 flagged down a nurse working in the dining room to address Resident #66's behavior. The incident report did not include a statement from the staff member that Resident #70 flagged down to address Resident #66's behavior. The incident report did not identify any other residents that were in the dining room that may have been affected. The incident report did not show any responsible parties were notified. The incident report showed Residents #70 and #17 were placed on alert, but not Resident #66. The nurse that Resident #70 flagged down for help failed to report the incident and did not investigate the incident. Resident #70 reported the incident to a different nurse the day following the event, and the nurse that took the resident's statement reported the incident. In an interview on 02/26/2020 at 11:32 AM, Resident #70 stated she had to yell out to get Staff J's, Registered Nurse, attention to come and address Resident #66 lifting her shirt and exposing her breasts in the dining room. In an interview on 02/26/2020 at 2:09 PM, Staff J, RN, stated he was the nurse working in the dining room during the incident with Resident #66 exposing her breasts in the dining room. Staff J stated he did not see Resident #66 expose her breasts, but stated he had seen her cupping her breasts. Staff J stated he separated the residents. When asked why Staff J did not report the incident, he stated, there was nothing to report. Staff J stated there was nothing malicious about the resident cupping her breasts. Staff J acknowledged that Resident #70 informed him that Resident #66 had lifted her shirt and exposed her breasts, but Staff J reiterated he did not see Resident #66 expose her breasts. In an interview on 02/26/2020 at 2:30 PM, the DNS acknowledged the incident report was not thorough and did not contain an interview from the staff member that separated the residents in the dining room (Staff J). The DNS stated that Staff J should have reported the incident immediately and acknowledged that he failed to identify and report the incident. The DNS stated Staff J should have reported it to the DNS, Resident Care Manager, and DSHS. In an interview on 02/28/2020 at 12:01 PM, Staff D, LPN/SDC stated resident-to-resident altercations need to have incident reports for aggressor and victim. They need to protect, assess, monitor and document any latent injury or emotional harm. RESIDENT #69 Review of an incident report, dated 02/10/2020, showed the facility found a progress note, dated 09/24/2019, that showed Resident #69 was too clingy and possessive of an unidentified female resident, and the unidentified female resident had complained that Resident #69 had made a few comments indicating the resident was clingy and possessive. The incident report showed Resident #69 had a history of [REDACTED]. The incident report did not identify the female resident. The incident report did not have a statement from the unidentified female resident, and did not include statements from other residents or staff. The facility identified Resident #424 as the possible female victim and reported the incident under Resident #424. Resident #424 had discharged [DATE]. In an interview on 02/26/2020 at 2:14 PM, The DNS was unable to provide information when asked why this incident was not reported at the time of the incident in September 2019, and why were the involved residents not identified and put on alert. The DNS stated the facility should have investigated at the time of the incident. The DNS stated they were not even sure Resident #424 was the unidentified female, they were just guessing. The DNS acknowledged that the incident report was not thorough. RESIDENT #375 Resident #375 was a long term care resident. According to the Admission MDS assessment dated [DATE], she was cognitively intact. Review of the state reporting log showed that an allegation of abuse was made on 02/18/2020. Review of the investigation showed that it was completed on 02/25/2020 (witness statements included), three days past the due date. The investigation showed that the in-servicing was completed but it did not say what type of inservicing nor was there evidence that there was in-servicing. The investigation was not complete and thorough. In an interview on 02/25/2020 at 2:15 PM, Resident #375 stated that she does not remember the man's name on the night of the event but all she wanted to do was go to the bathroom and he wanted to lift her with the mechanical lift. She stated that she was able to stand and transfer to the toilet with some assistance. She stated she felt intimidated by him because he was so big. RESIDENT #174 Resident #174 was a long term care resident. Review of an abuse allegation dated 02/14/2020 showed Resident #174 reported rough handling by two staff members. In an interview on 02/24/2020 at 11:45 AM, Resident #174 stated that two NAC's hurt her hip during incontinent care. She stated she could only remember their first names but not their last names. Review of the investigation did not show witness statements from the alleged NAC's in question, nor was their evidence that the staff members were suspended pending investigation. In an interview on 02/24/2020 at 12:00, the DNS stated that the alleged NAC's in question should have been suspended pending the investigation and that witness statements should have been gathered. RESIDENT #374 Resident #374 was a short term care resident. Review of the state reporting log showed Resident #374 made an allegation of neglect on 02/14/2020. In an interview on 02/24/2020 at 9:28 AM, Resident #374 stated that she put her call light on in the wee hours in the morning and an NAC helped her to the bathroom and told her to push her call button when she finished but they never came back. Resident #374 stated, I just got up and went back to bed, I am just glad I am able to do that. Review of the investigation dated 02/14/2020 showed Resident #374 told the Licensed Nurse that she was left on the toilet on night shift, after her call light was on and no staff member had come to assist her, which resulted in Resident #374 transferring herself off the toilet to her bed. The investigation lacked the witness statement from the NAC that cared for her on 02/14/2020 and the call light audit that was part of the proposed plan of correction. RESIDENT #3 Resident #3 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #3's clinical record revealed the following nursing progress notes: -08/25/2019- Resident woke and stated I was raped. The resident told the nurse It happened just now. LN documented she reported to oncoming nurse for continued monitoring -09/16/2019- Resident came to LN cart pointed at a male resident and stated He raped me last night. LN documented resident was known to make accusations against males. Reported to night shift nurse. -09/22/2019- Resident stated to nurse A male resident who she accused before had raped her once. LN documented resident has history of accusing other male residents and aides about rape, stating she suffered from [MEDICAL CONDITION] of sexual abuse. -11/03/2019- Resident approached nurse stating I was been raped by 2 men during the middle of the night and my butt hurt very much. The nurse assessed and found resident with hemorrhoids. The nurse documented per care plan when resident has hemorrhoids it can trigger [MEDICAL CONDITION] response. The nurse explained the hemorrhoids to resident and that was why her butt hurt and she had blood on her night gown. On call nurse contacted and stated this was in her care plan and to monitor further for [MEDICAL CONDITION]. -11/16/2019- Resident came to the nurse with allegations of men coming to her room and assaulting her. Resident complained of having sore bottom and requested cream. Resident redirected as has history of these kind of allegations. Nurse Manager informed. -12/24/2019: Resident reported she felt men had come into her room last night which caused the new bruise to her arm 2.5 cm (centimeters) x 2 cm in size. Bruise appears to be light purple in color. Resident then later stated she must have hit her arm on something. Will place monitoring order on bruise. Review of current State incident reporting log and grievance log

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 6) received on 02/04/2020, showed there were no investigations and/or grievances completed or logged for the multiple allegations of assault and/or rape that were documented in the progress notes. The facility did not complete thorough investigations for any of the allegations documented in the progress notes. During a joint record review and interview on 02/05/2020 at 5:15 PM, the DNS confirmed multiple notes documenting reports of sexual allegations were in the resident's clinical record, however she was unable to provide any further information regarding the notes and stated that the facility did not complete thorough investigations for any of the progress notes reviewed with allegations for Resident #3. In an interview on 02/20/2020 at 4:30 PM, Staff II, Regional Nurse Consultant provided the previously requested incident report for the 09/18/2019 incident of inappropriate touching with Resident #58 and another unnamed resident. Staff II said that was all the facility had on the incident. She said the nurse who wrote the progress note no longer worked at the facility. She added that it was difficult to accurately investigate incidents that occurred months ago. In an interview on 02/25/2020 at 12:18 PM, The DNS confirmed the incident reports were not investigated at the time of occurrence so it was difficult to determine if a plan to prevent reoccurrence was in place or the care plans had been followed. No additional information was provided. In an interview on 02/28/2020 at 12:01 PM, Staff D, LPN/SDC stated resident to resident altercations need to have incident reports for the aggressor and victim. The nurses need to assess, monitor and document any latent injury or emotional harm. The facility staff's failure to investigate resident to resident altercations and falls precluded them from ruling out abuse and neglect and detracted from the ability to implement interventions to prevent repeated incidents and prevent injury. The facility failed to interview staff and consider whether staff providing care had done so in accordance with their plans of care. The failure to utilize this information to make adjustments in supervision and training, and to communicate to staff best practices to mitigate hazards to residents, placed all resident's at risk for abuse, neglect and serious injury. Reference: (WAC) 388-97-0640 (6)(a)(b)
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written notice of transfer, including the reason for the transfer, to the resident and/or representative for two of three residents (#5 and #63), reviewed for hospitalization . This failure placed residents at risk of not having the opportunity to make informed decisions about transfers and access to an advocate who informed residents about options and resident rights. Findings included . Review of the facility's policy titled, Transfer or Discharge, Emergency, dated December 2019, showed, Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures .prepare a transfer form to send with the resident . The facility policy was outdated and failed to address the current regulatory requirement. RESIDENT #5 Resident #5 admitted to the facility on [DATE]. She was cognitively impaired. The resident was transferred to the hospital on [DATE]. Resident #5's medical record did not contain the notice of transfer or discharge documentation. The medical record showed no documentation the resident's responsible party or Ombudsmen received written notification of the resident's transfer to the hospital including the reason. RESIDENT #63 Resident # 63 admitted to the facility on [DATE]. He was cognitively impaired. Review of his medical record showed he was transferred to the hospital on [DATE], 01/24/2020 and 01/28/2020. Resident #63's medical record did not contain the notice of transfer or discharge documentation for the three transfers. The medical record showed no documentation the resident's responsible party or Ombudsmen received written notification of the resident's transfer to the hospital including the reasons. In an interview on 02/04/2020 at 12:16 PM, Resident #63's responsible party said he went to the hospital three times and she was only notified once by the facility that he was in the hospital. She said the other two times she was contacted by the hospital alerting her that he had been admitted there. She said she had not been given any paperwork or signed any papers when he was transferred to the hospital or when he returned. In an interview on 02/19/2020 at 11:41 AM, Staff B, Licensed Practical Nurse/Resident Care Manager, stated she usually contacted the family when residents were transferred to the emergency room . She said a bed hold would be completed in a non-emergency situation. She confirmed she was not aware of the notice of transfer discharge requirement. In an interview on 02/25/2020 at 12:28 PM, The Director of Nursing Services said it was her expectation that the nurses completed this upon hospital transfer and document that in the medical record. In an interview on 02/27/2020 at 10:19 AM, Staff A, Social Services stated she was responsible for the transfer discharge paperwork and asked the resident or their responsible party to sign it if she was in the facility. She said she did not document this or include a progress note about it. She said she did inform the Ombudsmen as soon as possible but was not aware the Field Manager needed notification. Reference: (WAC) 388-97-0120 (2)(a-d)
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written bed-hold notice, at the time of transfer or within 24 hours of transfer to the hospital, for three of three resident's (#5, #63 and #129), reviewed for hospitalization . This failure placed the resident at risk for a lack of knowledge regarding their right to hold their bed while in the hospital. Findings included . Review of the facility's policy and procedure titled, Bed hold dated 04/2018, showed, To provide clear communication regarding the expectations between the property and the resident/family members in regards to holding a room during an absence. When residents are absent from the property for any reason, the resident will continue to be billed for the apartment rental. Residents will be billed for the apartment until all personal belongings are removed from the apartment. Residents will not be billed for the service level charges while absent from the building. Apartments will be held for up to sixty days. RESIDENT #5 Resident #5 admitted to the facility on [DATE]. She was cognitively impaired. The resident was transferred to the hospital on [DATE]. Review of the medical record revealed no evidence a bed hold notice was offered or signed by the resident's representative. Review of Resident #5's progress notes showed no documentation the resident and/or representative were provided bed hold notification. RESIDENT #63 Resident # 63 admitted to the facility on [DATE]. He was cognitively impaired. Review of his medical record showed he was transferred to the hospital on [DATE], 01/24/2020 and 01/28/2020. Resident #63's medical record did not contain bed hold documentation for the three transfers. The medical record showed no documentation the resident's responsible party had received the bed hold information. In an interview on 02/04/2020 at 12:16 PM, Resident #63's responsible party said he went to the hospital three times and she was only notified once by the facility that he was in the hospital. She said the other two times she was contacted by the hospital alerting her that he had been admitted there. She said she had not been given any paperwork or signed any papers when he was transferred to the hospital or when he returned. In an interview on 02/19/2020 at 11:41 AM, Staff B, Licensed Practical Nurse/Resident Care Manager said she usually contacted the family when residents were transferred to the emergency room . She said a bed hold would be completed if a non-emergency situation. In an interview on 02/27/2020 at 10:19 AM, Staff A, Social Services, said the nurses were responsible for handling bed holds. In an interview on 02/19/2020 at 10:31 AM, Staff X, Registered Nurse stated she completed bed hold paperwork when she transferred residents to the hospital and then routed the form to social services. In an interview on 02/19/2020 at 10:51 AM, Staff M, Medical Records confirmed no bed hold notices were located for Resident #5 and #63. RESIDENT #129 The resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the residents clinical records, revealed the resident was transferred to the hospital on [DATE]. No record of a bed hold notice was found in the clinical record. On 02/14/2020 at 10:34 AM, in an interview with Staff C, the resident care manager, verified the resident was not provided with a bed hold opportunity. Review of a laminated card located at the nurses stations instructed nurses to fill out the bed hold form in the files in bottom right hand drawer (if pt (patient) unable to sign request POA(power of attorney) come into sign ASAP(as soon as possible)). In an interview on 02/25/2020 at 12:28 PM, The Director of Nursing Services said it was her expectation that the nurses complete this upon hospital transfer and document that in the medical record. Reference: (WAC) 388-97-0120 (4)
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and**

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	505296	A. BUILDING _____ B. WING _____	03/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST FRANCIS OF BELLINGHAM	3121 SQUALICUM PARKWAY BELLINGHAM, WA 98225

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7) **prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to review and revise care plans for two of 21 residents (#38 and #63) reviewed for care planning. The failure to review and revise care plans by the interdisciplinary team after each assessment placed the residents at risk for weight loss, dehydration, unmet care needs and a diminished quality of life. Findings included . RESIDENT #38 Resident #38 admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the care plan printed on 02/05/2020 at 10:30 AM, showed a problem for mood and behavior and listed GDR (Gradual Dose Reduction) of [MEDICATION NAME] (anti-psychotic) TBD (to be determined) on 10/23/2019. There was no revision as of 02/26/2020 at 9:40 AM. Review of the Admission Care Area Assessments (CAA's) on 06/08/2019 showed a risk of dehydration and recommended fluids pushed with 2,000 milliliters (ml) every day as the goal. The nutritional status showed staff were to proceed to the care plan interventions to minimize the risk of impaired nutrition and maintain a stable weight. Review of the care plan showed the resident had a potential for nutritional problems with the goal of no unanticipated weight loss and for the resident to be free of impaired hydration. The care plan directed staff to offer 180 ml of thickened fluids three times daily, conflicting with the CAA. Review of the dietary notes showed the resident had significant weight loss of 6% or 9.2 pounds beginning 01/15/2020. Review of a progress note dated 01/22/2020 at 7:50 AM revealed Resident declining, and deconditioned. Hospice consult for continuation of care and comfort measures. Review of the care plan showed his nutrition care plan was not revised until 02/20/2020. RESIDENT #63 Resident #63 admitted [DATE] with a [DIAGNOSES REDACTED]. He was unable to use his left side. In an interview and observation on 02/05/2020 at 10:56 AM, Resident #63 had missing teeth and the remaining teeth were in poor shape with black decay. He said he went to the dentist and he was interested in obtaining dentures. He said he would like dentures but wanted to be sure he should spend his money on them since they were so expensive. Review of the care plan showed there was no dental care plan to address his poor dental health and desire and request for dentures. Review of the clinical record showed he was transferred to the hospital on [DATE] and they were unable to replace his feeding tube. His care plan was not revised to include interventions to meet his nutritional needs when he no longer had the feeding tube to provide nutrition and hydration. Review of the care plan on 02/05/2020 showed no alteration in nutrition care plan present. The feeding tube had been discontinued off of the care plan on 02/04/2020 but there were no interventions to direct staff how to maintain his nutrition orally. The care plan showed he was able to eat with supervision in the dining room. Review of a nutrition note on 02/10/2020 revealed his weight was down 7.5% or 13 pounds in 30 days. In an interview on 02/21/2020 at 10:50 AM, Staff K, NAC stated, He can feed himself but, like today I had to help him. It was like he was distracted. He confirmed the resident needed one person physical assistance for feeding and did not consistently feed himself. Additionally, his care plan did not reflect the bilateral bed canes he had on his bed. In an interview on 02/25/2020 at 12:28 PM , the Director of Nursing Services was informed of the lack of care plan revisions for Resident's #38 and #63. No additional information was provided. This is a repeat deficiency from 02/13/2019. Reference: (WAC) 388-97-1020 (5)(b)
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review the facility failed to provide assistance with activities of daily living to include personal hygiene and bathing for 12 of 18 dependent residents (#12, #20, #30, #38, #58, #63, #66, #59,#28, #32, #18, and #8), reviewed for activities of daily living (ADL's). Facility failure to provide the resident, who was dependent on staff for assistance with grooming, and showers placed the resident and others at risk for poor hygiene, unmet care needs and a diminished quality of life. Findings included . Review of the facility policy titled, C.N.A. Standards of Care, undated, directed staff to provide oral care, wash hands and face in the morning and evening, shower per schedule and shave man/woman as needed. RESIDENT #12 Resident #12 admitted on [DATE], with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 01/25/2020, showed she had lower extremity impairment, required assistance with personal hygiene and did not receive a shower in the look back period. Review of the shower record look back from 09/01/2019 to 02/25/2020, showed no showers in September, October or November 2019. She received one shower in December on 12/18/2019. She received no showers in January or February of 2020. In an observation on 02/25/2020 at 8:19 AM, Resident # 12 was in bed. She had food on her shirt and her hair was uncombed. She complained of itching all over and said the medications were not helping her. She said her shower days were Thursday's and Sunday's but she preferred Staff UU, NA (Nursing Assistant), to shower her but she couldn't as she was unlicensed. The resident said the shower room was always cold and even her teeth chatter. She said showers would help her itchiness. RESIDENT #20 Resident #20 admitted to the facility on [DATE] and was dependent on staff for all care. Review of the MDS, dated [DATE], showed he required extensive assistance for bathing. He had limitations in all extremeties and did not reject care. Review of the shower record look back from 09/01/2019 to 02/25/2020, showed three showers in September 2019, four showers in October 2019, three showers in November 2019, and four showers in December 2019. In an observation on 02/04/2020 at 9:57 AM, Resident #20 was in bed awake with greasy hair with white flakes. His eyes had matted green matter, teeth had thick debris, and his lips were dry and scabbed. In an observation on 02/05/2020 at 1:49 PM, he was brought to the solarium, moaning, his hair remained very greasy. His eyes had green eye matter and his left eye was partially closed as a result of this. His lips were dry and crusty with no evidence of oral care. He was observed with lack of grooming 02/06/2020 at 6:06 AM, 8:17 AM, 10:59 AM, 11:44 AM, and 1:16 PM. RESIDENT #30 Resident #30 admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly MDS, dated [DATE], showed she required extensive assistance with bathing and personal hygiene. She did not reject care and did not receive a shower in the look back period. Review of the shower documentation showed she received ten showers in the past six months. She received showers on 09/09/2019, 10/07/2019, 11/04/2019, 12/09/2019, 12/30/2019, 01/06/2020, 01/20/2020, 01/27/2020, 02/03/2020, and 02/20/2020. In an observation on 02/04/2020 at 9:45 AM, Resident #30 was in her wheelchair in the hall with green eye matter and 1/4 inch long, white chin hairs. Similar observations were noted all days of survey. In an observation on 02/07/2020 at 7:57 AM, she was in the hall with dried brown matter on her right hand and under her fingernails. In an observation on 02/12/2020 at 8:20 AM, the resident was in the dining room asleep in her wheelchair. Her pants had a large bulge in her peri area. At 9:52 AM, she was asleep in her doorway with no evidence of grooming. She continued with the large bulge and her pants were wet and visibly soiled down to her mid thigh on both sides. She smelled strongly of urine. At 10:05 AM, Staff K, NA walked past her and went on his break. At 10:22 AM, she had been moved back by her bed and she remained in her soaked pants. She was then restless and moving her legs up and down on the foot rests. At 10:30 AM, Staff U, Regional Nurse Consultant was asked to observe the resident with this surveyor. At that time, the resident's shirt was wet four inches from the bottom also. The strong urine odor remained. Staff U, said she would assist her. In an observation on 02/14/2020 at 8:14 AM, Resident #30 was in the hall. Her hair was uncombed and facial hair remained. She stated, Need a washcloth to get this crap off my face. In an interview on 02/19/2020 at 12:11 PM, Saff K, NA, said the resident required assistance with all ADL's. He stated, I do not typically shower her. Her shower day is Monday one of my days .Shaving is one of the things I think she doesn't fight. She does not shy away from shaving. In an interview on 02/25/2020 at 12:10 PM, the DNS was informed similar to last year there was overall lack of grooming for the resident. No additional information was provided. RESIDENT #38 Resident #38 admitted on [DATE] with dementia,adult failure to thrive, respiratory and [MEDICAL CONDITION]. Review of the Change of Condition MDS on 01/28/2020, showed he required extensive assistance with his ADL's. Review of the shower documentation beginning 10/03/2019 showed he received fifteen showers in the past five months. He received showers on 10/14/2019, 11/07/2019, 11/24/2019, 12/07/2019, 12/12/2019, 12/20/2019,12/27/2019, 12/29/2019, 01/05/2020, 01/06/2020, 01/19/2020, 01/26/2020, 02/05/2020, 02/16/2020 and 02/23/2020. In addition to his missed showers, he missed the [MEDICATION NAME] medicated shampoo that was to be applied every Monday and Thursday for his dry scalp. In an observation on 02/06/2020 at 10:29 AM, Resident #38 was in his recliner eating breakfast. His hair was uncombed and he was in need of a shave. He was observed in similar appearnace all days of survey. In an interview on 02/19/2020 at 12:18 PM, Staff K, NA Other days he is more than amicable. It can change very fast. Shaving and oral care depends on his mood. His shower days are Sunday and Wednesdays. In an interview on 02/25/2020 at 12:16 PM, the DNS was informed of his lack of showers and grooming. She stated, He is on hospice now. He sleeps a lot,

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F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 8) refuses grooming and showers. In an interview on 02/26/2020 at 10:01 AM, the contracted Hospice RN stated, We provide one shower weekly. RESIDENT #58 Resident #58 admitted on [DATE] with dementia, cardiac and kidney disease. Review of the Quarterly MDS, dated [DATE], showed he did not receive bathing in the look back period and he did not reject care. Review of shower documentation beginning 10/01/2019, showed he received six showers in five months. In October he received a shower on 10/07/2019, no showers in November, one shower in December on 12/10/2019, two showers in January (01/01/2020 and 01/20/2020), and one in February 2020 on 02/19/2020. RESIDENT #63 Resident #63 admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the bathing documentation beginning 09/01/2019, showed he received showers on 09/09/2019, 09/12/2019, and 09/30/2019. In October, he received showers on 10/14/2019 and 10/24/2019. He did not receive any showers in November. In December, he received one shower on 12/09/2019. In January, he received seven showers. In February, he recieved showers 02/03/2020, 02/06/2020, 02/20/20 and 02/27/2020. In an observation on 02/04/2020 at 9:52 AM, the resident was up in his wheelchair with uncombed hair and in need of a shave. He was observed in a similar manner all days of survey. In an interview on 02/05/2020 at 10:56 AM, he was in his wheelchair and had not been groomed or shaved. He said he liked to be clean shaven but only one nurse does that. He said he was in the Army and said you only got caught once not clean shaven. In observations on 02/11/2020 at 2:10 PM and 3:40 PM, Resident #63 was sitting in his room with a strong smell of urine and no evidence of grooming. In an observation on 02/21/2020 at 8:36 AM, Resident #63 was in the dining room. His breakfast had been served but no one was providing meal assistance. In an observation on 02/25/20 at 1:10 PM, Resident #63 was sitting in the hall, disheveled. His facial hair remained. His hair was still uncombed. He had applesauce on shirt. His lips were dry and food was present around his mouth. In an interview on 02/04/2020 at 12:08 PM, Resident #63's responsible party stated he liked to be clean shaven with frequent haircuts. She stated, He liked to be well groomed always. In an interview on 02/20/2020 at 2:11 PM, Staff I, NA, stated He needs full care .never refuses care. In an interview on 02/25/2020 at 12:28 PM, the DNS was informed of the residents lack of showers and grooming. RESIDENT #66 Resident #66 admitted [DATE] with [DIAGNOSES REDACTED]. Review of the Annual MDS, dated [DATE], showed she required extensive assistance with ADL's and did not receive a shower in the look back period. Review of the bathing documentation beginning 11/03/2019, showed she received five showers in four months. She received showers on 11/03/2019, 11/09/2019, 12/13/2019,12/20/2019, 01/03/2020 and no showers in February. In an interview on 02/25/2020 at 12:15 PM, the DNS, was informed of lack of grooming and showers. She stated it was her expectation that showers be provided per resident preference and grooming every shift. RESIDENT #59 Resident #59 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The resident was alert and able to make her needs known. On 02/05/2020 at 10:58 AM, in an observation and interview with the resident, the resident was observed laying in her bed, her hair was down to her shoulders and had a great amount of dandruff looking flakes throughout her hair. The resident was asked if she was receiving showers, the resident stated, No, I have only got a few bed baths but I want a full shower. Review of the resident's shower record for the last 30 days revealed the resident received 4 bed baths during the past 30 days and no showers. Many refusals were documented in the shower record but there was no follow up to find out why the resident was refusing the showers. On 02/14/2020 at 11:16 AM, in an interview Staff RR, NA, stated she had given the resident some bed baths but the resident did not want a shower. When asked why the resident did not want a shower, Staff RR stated, she did not know. On 02/14/2020 at 10:34 AM, in an interview with Staff C, Resident Care Manager stated, if the resident refused a shower, the aides should re-approach at a later time and if the resident refused again the aide should report it to the nurse so that the reason of the refusal could be looked into. Staff C further stated she did not know why the resident was refusing showers and would look into it. After the above interview with Staff C, the resident received a shower on 02/14/2020. RESIDENT #28 Resident #28 admitted to the facility on [DATE]. According to the resident's Quarterly MDS assessment, dated 11/17/2019, she had no cognitive impairment. In an interview on 02/05/2020 at 8:54 AM, the resident stated she wanted to bathe three times a week, but only got to bathe once weekly. Review of a resident roster annotated with bathing preferences, dated 02/11/2020, revealed the resident was care planned to bathe three times weekly, to include on Sundays, Wednesdays, and Fridays. Review of a bathing/shower form that listed bathing for the last 30 days, print date 02/06/2020, revealed documentation the resident had bathed only five times in the past 30 days, and there were no documented refusals. RESIDENT #32 Resident #32 admitted to the facility on [DATE] for rehabilitation after having a fall at home resulting in a left wrist fracture. On admission the resident had [DIAGNOSES REDACTED]. According to the resident's admission MDS assessment, dated 05/23/2019, she had severe cognitive impairment. Review of a resident roster annotated with bathing preferences, dated 02/11/2020, revealed the resident was care planned she wanted to bathe twice weekly. Review of a bathing/shower form that listed bathing for the last 30 days, print date 02/07/2020, revealed documentation the resident had bathed only five times in the past 30 days, and there were no documented refusals. In an interview on 02/14/2020 at 11:58 AM, Staff NN, Shower Aide, stated she only worked Thursdays, Fridays, and Sundays, and she didn't know who did bathing on days she was off, she didn't think there was anyone else though, that she knew of. RESIDENT #18 Resident #18 admitted to the faiclity on 08/04/2019. He required one person assistance with bathing. Review of the bathing documentation beginning 08/01/2019 until 02/26/2020 showed he received 18 showers in seven months. He received showers on 08/01/2019, 08/06/2019,08/20/2019, 09/03/2019, 09/07/2019, 09/10/2019, 09/17/2019, 10/01/2019, 10/14/2019, 11/05/2019, 11/12/2019, 12/10/2019, 12/14/2019, 01/04/2020, 01/21/2020, 01/28/2020, 02/04/2020 and 02/08/2020. In an interview on 02/14/2020 at 11:12 AM, Staff K, NA, stated he had refused showers a couple of times but he was unaware if he refused care from the shower aide. He said the shower aides got pulled to the floor from shower duties when they were short on the floor, In an interview on 02/05/2020 at 11:51 AM, Resident #18 stated You only get one shower every one to two weeks. It is up to them whether you get a shower or not. I would like two showers a week. RESIDENT #8 Resident #8 was admitted to the facility on [DATE]. He required one person assistance with bathing. During an observation and interview on 02/05/2020 at 11:07 AM, Resident #8 was lying in bed watching TV. He was observed to have thick white matter in lower teeth and gums, unchanged from prior day's observation. The resident stated he would like to brush his own teeth if they would set him up, but they haven't offered. Resident #8 was also observed with facial hair, approximately 1 inch long stubble. Resident #8 stated I am used to shaving every day, but they haven't offered those things either. During an observation on 02/07/2020 at 5:06 AM, the resident was found wearing same black/gray shirt as the prior 3 days. During an observation & interview on 02/14/2020 at 8:49 AM, Resident #8 continued to be positioned flat on his back since earlier observation at 6:30 AM. Resident observed with approximately 1 inch long facial hair stating I feel good when I shave, I like to shave every day if I can. Resident #8, stated that he feels like it was a week ago that he shaved last, and he can't recall the last time his teeth were brushed. Resident continually observed with a white matter built up along lower gum line and had not yet eaten breakfast today. During an interview on 02/14/2020 at 8:52 AM, the Hospice Bath Aide, stated she came in every Friday to bathe Resident #8. The bath aide stated Resident #8 doesn't like facial hair and she shaves him every Friday because it doesn't seem like it gets done if I don't do it. She stated that every Friday when she comes in Resident #8 has facial hair. The bath aide further stated that she doesn't document in the resident's clinical record, We have our own paperwork, but she lets the facility staff know when she's done. Review of current comprehensive care plan printed on 02/06/2019 showed: Focus: Resident has an ADL self-care performance deficit limited mobility related to stroke with left sided weakness. Interventions in place included: 1 person max assist for showering, 1 person physical assist for combing hair, brushing teeth, shaving, washing/drying face, hands and perineum, resident prefers to be shaved 2 times a week. Review of the bathing documentation titled Documentation Survey Report V2, showed: May 2019: No showers documented as being given. June 2019: One shower documented as given by facility staff on 06/29/2019 July 2019: No showers documented as being given. [DATE]: One shower documented as given by facility staff on 08/12/2019, two on 08/19/2019 and one on 08/26/2019. [DATE]: One shower documented as given by facility on 09/02/2019, 09/09/2019 and 09/16/2019. October 2019: One shower documented as given by Hospice on 10/14/2019. [DATE]: Two showers documented as given by Hospice on 11/04/2019 and 11/24/2019. [DATE]: Two bed baths documented as given by hospice on 12/27/2019 and 12/30/2019. [DATE]: One bed bath documented as given by hospice on 01/11/2020. [DATE]: Two bed baths documented as given by hospice on 02/14/2020 and 02/22/2020. In an interview on 02/14/2020 at 11:00 AM, Staff RR, NAC, stated there were not enough staff to provide residents with needed care. Staff RR stated in the mornings they only have about ten minutes to provide resident's care and it was not enough time as some residents can take longer such as 25-40 minutes. Staff RR stated managing ten to twelve

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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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.

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 9) residents was hard, and stated they did not feel they could do a good job for the residents. During a joint interview and record review on 02/14/2020 at 11:52 AM, Staff NN, Shower aide/Nursing Assistant (NA), stated she is a part time shower aide that works on Thursday, Friday and Sundays from 8 am to 4 pm. Staff NN, stated that Hospice resident's are only showered by the hospice bath aides when they come in. Staff NN was unable to state why Resident #8's bath records had so many holes and undocumented showers, as she only works 3 days a week. Staff NN stated I missed two Fridays in January due to weather, I am pretty sure it was the 10th and the 17th. Review of the Whatcom Hospice Binder at the nurse's station form titled Whatcom Hospice Coordination of care for the Skilled Nursing Facility Patient dated 01/03/2020 showed what to expect when patient goes on hospice. Under the section titled Certified Nursing Assistants duties showed: 1) Visit 1-2 times weekly; 2) Can bring bathing supplies with them; 3) Are a supplement to the bathing the patient already gets (Not intended to take the place of your services but to give the patient additional TLC (tender loving care) if desired). During an interview on 02/24/2020 at 3:10 PM, The DNS confirmed that Resident #8 was receiving Hospice Services and that Hospice is the only ones that shower him. The DNS stated He gets 1 shower a week and that is his preference. The DNS agreed that the agreement in the Hospice binder at the nurse's station stated that Hospice services are not intended to take the place of facility services, they are in addition to. The DNS stated she would review the shower records and get back to me, but did not provide any additional information during the survey. During an interview on 02/26/2020 at 10:00 AM, Whatcom Hospice RN, stated his understanding of showers for Hospice residents is that Hospice provides 1 a week in addition to what the facility already provided. He further stated that all hospice staff document care or notes on a hospice form that is left with the facility. Reference: (WAC) 388-97-1060 (2)(c)
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide meaningful and engaging activities to residents with cognitive impairments for seven of eight residents (#18,#30, #20, #38, #63, #64, #29) reviewed for activity concerns. This failure placed residents at risk of feelings of boredom, decreased quality of life and increased behaviors. Findings included . Review of the facility's policy titled, Activity Policy dated 02/2005, showed It is the policy of this facility to encourage each resident to maintain normal leisure activity and to return to self care. The facility will provide an activities program that will address the intellectual, social, spiritual, creative and physical needs, capabilities and interest of each resident. The activity program will promote each resident's self-respect by providing activities that support self-expression and choice. RESIDENT #18 Resident #18 admitted [DATE] with [DIAGNOSES REDACTED]. He responded that music, animals, and keeping up with the news were very important to him. Review of the clinical record showed the resident had multiple falls on 09/02/2019 at 12:30 PM, 09/11/2019 at 1:45 PM, 09/22/2019 at 6:30 AM, 10/01/2019 at 2:15 PM, 10/08/2019 at 11:30 PM, 11/13/2019 at 4:00 PM, 11/18/2019 at 1:20 PM, 11/20/2019 at 1:00 AM, 11/21/2019 at 9:30 PM, 11/26/2019 at 3:20 AM, 11/29/2019 at 2:31 AM, 11/30/2019 at 4:45 AM, 11/30/2019 at 8:15 AM, 12/04/2019 at 6:30 AM, 12/06/2019 at 8:00 PM, 12/09/2019 at 11:50 AM, 12/10/2019 at 8:15 PM, 12/11/2019 at 11:30 PM, 12/12/2019 at 12:15 AM, 12/11/2019 at 11:30 PM, 12/16/2019 at 10:40 PM and 01/12/20 at 11:15 AM. In an interview on 02/05/2020 at 12:09 PM, Resident #18 said he wanted to join the club down there at the end of the corner but it seems like no one wants me to. He said no one helped him join it. He said he liked to watch TV but the TV head phones broke and they did not have anymore. He said he also like bowling. In an interview on 02/14/2020 at 11:07 AM, Staff K, NAC (Nursing Assistant Certified) stated he turned on his TV last Saturday and he enjoyed watching a football game. In an interview 02/20/2020 at 2:48 PM, the Director of Nursing Services (DNS) stated the resident could benefit from additional interventions for his frequent falls. In an interview on 02/21/2020 at 10:35 AM, Staff O, Activity Director, stated she was new to the position and just getting to know the resident. She said she had not reassessed Resident #18. She stated he told her he suffered from anxiety. She said staff should be inviting all the residents to the activities. In an interview on 02/21/2020 at 1:09 PM, Staff WW, Activity Assistant, said she did not see him in activities on the days that she worked. She stated she was not familiar with his plan of care and knew group activities were good for some residents while one on ones were best for others. In observations on 02/05/2020 at 8:42 AM, 9:47 AM, 9:52 AM, 9:54 AM he left his room walked into the solarium, looked around and then walked back to his room. In observations on 02/10/2020 at 1:22 PM, 1:23 PM, 1:30 PM, he left his room went into the solarium to see no activities occurring and walked back to his room. RESIDENT #30 Resident #30 admitted on [DATE] with [DIAGNOSES REDACTED]. According to the Quarterly MDS assessment on 11/20/2019, she required assistance for locomotion in her wheelchair and did not refuse care. Review of her care plan showed she was dependent on staff for activities, cognitive stimulation and social interaction related to cognitive impairment. She enjoyed pet therapy, people watching and coffee hour. In observations on 02/04/2020 at 9:45 AM, Resident #30 was in her wheelchair in the hall. At 10:56 AM and 1:02 PM she was in her wheelchair in her room facing the bare wall. In an observation on 02/05/2020 at 1:46 PM, she was in her wheelchair at bedside asleep. In an observation on 02/06/2020 at 10:41 AM, she was in the solarium asleep. At 11:54 AM she was asleep in the dining room. At 1:21 PM, she was in the activity room asleep. In observations on 02/07/2020 at 7:57 AM, 8:21 AM and 11:16 AM she was in the solarium asleep in her wheelchair in front of the TV. There was no meaningful stimulating activity. In an observation on 02/10/2020 at 8:27 AM, she was in the dining room awaiting breakfast. At 9:38 AM, 10:20 AM, 11:23 AM she was in her wheelchair in her room positioned to stare at a blank wall. At 2:45 PM, she was reclined back in her wheelchair with her left shoe off trying to sit up as she was tilted back in her wheelchair. She stated, I am alive. In observations on 02/11/2020 at 9:48 AM, she was tilted back and asleep in the solarium. At 11:18 AM, she was in the solarium with 8 other residents, 6 of which were sleeping. At 1:26 PM, she was in her room by the bed facing the bare wall. At 3:35 PM, she was in her wheelchair in her room with the privacy curtain partially closed around her. In observations on 02/12/2020 at 8:20 AM, she was asleep in the dining room. At 9:52 AM, she was asleep in her doorway. At 10:22 AM, she was by her bed staring at the blank wall. At 1:50 PM, she was in her room in her wheelchair by her bed. At 3:00 PM, she was asleep in the solarium. In observations on 02/13/2020 at 8:20 AM, she was in the dining room asleep. At 10:06 AM she was in the hall asleep in her wheelchair. In observations on 02/14/2020 at 10:10 AM, she was in the solarium in front of the TV with the Price is Right on. She had no glasses on . At 11:08 AM, she remained in the same location asleep. In multiple observations on 02/18/2020 at 9:20 AM, 11:07 AM, 12:06 PM, 1:45 PM, 2:13 PM and 3:36 PM, she was asleep. In observations on 02/19/2020 at 8:23 AM, she was in the dining room asleep. At 9:40 AM and 11:03 AM she was asleep in the solarium. In multiple observations on 02/20/2020 at 8:18 AM, 9:24 AM,10:50 AM, 11:38 AM, 2:14 PM and 3:34 PM, she was asleep. In observations on 02/21/2020 at 8:35 AM, 11:05 AM, 1:02 PM she was observed without meaningful activities. In observations on 02/24/2020 at 8:33 AM, 10:17 AM, 11:16 AM, 12:31 PM and 2:34 PM she was observed to be asleep or without any meaningful activities. In observations on 02/25/2020 at 8:15 AM, she was in the dining room asleep. At 10:03 AM, she was in the solarium asleep. At 1:18 PM, she was in the hall and stated, I am hanging in there. In subsequent observations on 02/26/2020, 02/27/2020 and 02/28/2020 she was observed to be asleep or without any stimulating activity The facility failed to provide Resident #30 with meaningful activities in accordance with her current preferences, and mental and physical abilities. RESIDENT #20 Resident #20 admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the care plan showed the resident was dependent on staff for activities, cognitive stimulation, and social interaction. He would need invitation and assistance/escort to activity functions. He used to shake head yes or no if interests, now he does not. He now enjoys sitting in the living room looking outside, going outside to get fresh air and sun. He had some DVD's in native language. Staff was directed to help him put the DVD on so he could watch them. Review of the activity assessment on 11/16/2019 showed he spent most of his time laying down or in the living room looking outside or watching TV. He enjoyed music or news channels played in his native language. He enjoyed having the newspaper read to him and was scheduled for 1:1 visits, music and pet therapy from an outside vendor. In observations on 02/04/2020 at 9:57 AM and 12:56 PM, he was observed in bed with no music, movie or other stimulating activity. In an observation on 02/05/2020 at 8:41 AM , he was in bed awake with no stimulating activity. At 10:50 AM he was in bed asleep. At 1:49 PM, he was brought to the solarium asleep. In all observations on 02/06/2020 at 8:17 AM,10:59 AM, 11:44 AM and 1:16 PM he was in bed asleep. In all observations on 02/07/2020 at 5:48 AM, 6:05 AM, 7:10 AM, 8:33 AM , he was observed in bed asleep. In observations on 02/10/2020 at 8:22 AM, 9:37 AM,10:20 AM, he was in bed asleep. In observations on 02/11/2020 at 8:59 AM, he was in bed asleep. At 9:46 AM, 11:17 AM, 1:00 PM, 2:05 PM and 3:36 PM, he was in bed awake staring at the blank wall in front of him. In observations 02/12/2020 at 8:25 AM and 9:50 AM, he was in bed awake with no activity items present. At 11:23 AM, 12:11 PM he was in bed awake and staring at the TV screen with the fixed blue DVD start screen. At 1:54 PM, he was in bed staring at the wall. In multiple observations on 02/13/2020, 02/14/2020, 02/18/2020, 02/19/2020, 02/20/2020 and 02/21/2020 he was observed to be in bed asleep, with no TVor music playing or any meaningful activities. In an interview on 02/20/2020 at 2:14 PM, Staff I, NAC,

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	505296	A. BUILDING _____ B. WING _____	03/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST FRANCIS OF BELLINGHAM	3121 SQUALICUM PARKWAY BELLINGHAM, WA 98225

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F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 10) said I try to get him up. I should have got him up today but didn't have time. He does not speak. He does not have visitors. I haven't seen his daughter in over a year. He used to be able to communicate but now sleeps a lot. She said he had a TV on his desk but she was unsure if he had a DVD player. In observations on 02/24/2020 at 2:33 PM, 02/25/2020 at 10:06 AM and 02/28/2020 at 11:32 AM he was in bed awake and the TV was on English TV programs. In an interview on 02/25/2020 at 12:15 PM, the DNS was informed the resident had not been observed out of bed or off his back on any observation all days of survey. He was not observed to be engaged in any meaningful activity. No additional information was provided. The facility failed to provide Resident #20 with meaningful activities in accordance with his culture, current preferences, and mental and physical abilities. RESIDENT #38 Resident #38 admitted on [DATE] with dementia and adult failure to thrive. Review of the care plan showed he was dependent on staff for activities, cognitive stimulation, and social interaction related to cognitive impairment, disinterest. Review of the Kardex (directive to staff on how to provide care) showed the resident needed assistance /escort to activities of interest and encouragement to attend. His preferred activities were country magazines, fishing, wood working, newspaper, music, animals. He also enjoyed leisure time in his room watching TV. Staff were directed to offer music and pet therapy. Review of the Quarterly activity assessment dated [DATE] showed the resident spent the majority of his day sitting in his recliner in his room watching television. He took frequent naps and enjoyed pet visits and listening to music as well. In multiple observations all days of survey the resident was observed to be asleep. During infrequent observations when he was awake, there was no music or TV on or otherwise meaningful activities. In an interview on 02/19/2020 at 12:18 PM, Staff K, NAC said He sleeps a lot. I have not seen him go to activities. He used to get up and toddle around in his wheelchair but not now. That is a change for him. In an interview on 02/25/2020 at 12:16 PM, the DNS was informed of his somnolence and lack of activities. She said he was on Hospice. The facility failed to provide Resident #38 with meaningful activities in accordance with his current preferences, and mental and physical abilities. RESIDENT #63 Resident # 63 admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the activity notes on 08/30/2019 showed the resident enjoyed staying active outside of facility and was interested in Western movies, music and books, outdoor strolls, animals as natural therapy, history discussion and sports watching. Activity staff were to support the resident and invite him to activities of interest. Review of a progress note dated 02/09/2020, showed Staff SS, Registered Nurse, documented resident was being parked near nursing cart so he can be observed unless in his bed. No further falls . In an observation on 02/20/2020 at 3:27 PM, Resident # 63 was in bed. His TV was on but it was facing away from him. During multiple observations all days of survey, the resident was not observed in an activity until 02/26/2020 at 10:05 AM when he was noted to be engaged and smiling. In observations on 02/25/2020 at 1:10 PM, he was in his wheelchair in the hall. At 2:27 PM, he was in the same location and stated, I am just watching the world go by. The facility failed to provide Resident #63 with meaningful activities in accordance with his culture, current preferences, and mental and physical abilities. RESIDENT #64 The resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Observations of the resident included: On 02/04/2020 at 9:52 AM, the resident was observed sitting in his wheelchair in his room. On 02/04/2020 at 12:56 PM, the resident was observed in his bed sleeping. On 02/05/2020 at 10:15 AM, resident was observed siting in his wheelchair by the nurses station, looking around. On 02/06/2020 at 10:46 AM, the resident was observed in bed in his room. On 02/06/2020 at 1:14 PM, the resident was observed in his room. On 02/10/2020 at 1:37 PM, the resident was observed sitting in the hallway by the nursing station, looking around. On 02/11/2020 at 9:38 AM, the resident was observed sitting in his wheelchair by the nursing station sleeping. On 02/11/2020 at 2:00 PM, the resident was observed wheeling himself around the facility. On 02/12/2020 at 10:14 AM, the resident was observed sitting by nursing station. During the days of the facility survey, the resident was not observed to participate in any type of activity. In an interview with Staff I, a nursing assistant, was asked about the residents participation in activities. Staff I stated, she did not think the resident attended any activities. Review of the resident's clinical record, revealed the residents activity assessment and activity care plan had not been updated since the admission activity assessment was completed on 01/03/2018, (2 years prior.) 02/18/2020 at 1:55 PM, in an interview with Staff O, Activity Director, Staff O verified the resident did not participate in activities. Staff O further stated understanding the resident needed an updated activity assessment and a personalized activity program since the residents needs and capabilities have changed since he was admitted to the facility. RESIDENT #29 The resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. In multiple observations, on multiple days of the survey from 02/04/2020 - 02/28/2020, the resident was never observed doing an activity or being visited or invited to any activities at all. Review of the resident's care plan, print date 02/06/2020, revealed she had many interests to include watching TV, cooking shows, reading, crochet, talking, pet visits, and walking/wheeling outdoors. Review of Activity - One on One, and Activity - Group Activity reports for 30 days, print date 02/06/2020, revealed there was no documentation at all of any activity participation for the 30 days reviewed. In an interview on 02/19/2020 at 12:19 PM, Staff O, Activity Director, was unable to provide any information about the lack of activities for the resident. In an interview on 02/25/2020 at 12:10 PM, The DNS was informed, similar to last year, there was an overall lack of activities. No additional information was provided. In an interview on 02/28/2020 at 11:17 AM, Staff J, Registered Nurse, stated, These residents need more activities. If they are bored what are they gonna do, act out, get into it with others. They need watched closely or they act out . They (facility) say they will add more activity. They need more than just sitting in the solarium not good. This is a repeat deficiency from SOD dated 02/13/2019. Reference: (WAC) 388-97-0940 (1)(2)
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure five of 21 residents (#33, #38, #12, #63, and #28) received care and treatment in accordance with professional standards of practice and received the necessary care and services to attain or maintain their highest practicable level of well-being. These failures resulted in potential harm for Resident #33 who had a larger catheter placed than ordered which resulted in pain and potential harm for Resident #38 who did not receive bowel medications when required. All other residents were at increased risk of unmet care needs. Findings included . CATHETER USE RESIDENT#33 Resident #33 admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. Review of an investigation dated 01/17/2020 showed the resident reported to therapy that the wrong catheter size was placed causing pain to the point that they could not walk and the therapist did not feel that staff was listening to them. The nurse met with the resident and explained that with an enlarged prostate that catheter placement could cause discomfort. In an interview on 02/14/2020 at 7:49 AM, Staff T, RN (Registered Nurse), stated there was a nurse that did chart about the catheter change a few days after it. She said she assessed the resident and there was blood present and the leg strap was pulling at him. She said upon more research, the resident reported he had penis pain and blood with pain 5 out of 10. He stated something didn't feel right. Staff T said if this had occurred for her and they were out of the correct catheter size, she would have waited to get the correct size. In an interview on 02/14/2020 at 8:03 AM, Staff GGG, LPN (Licensed Practical Nurse), said she had heard someone put the wrong catheter size in and caused him pain. She said she spoke with the resident who complained of pain. She said the resident reported pain in the mornings and evenings. In an interview on 02/18/2020 at 1:29 PM, Resident #33 stated a man and woman came in, the woman pushed a catheter in and did not get the right one in, it was awful painful . it hurt quite a bit, She had taken the old one out and the ripped one out, not a painful as the new one going in. I would rate the pain at a 9,usually had a little pain but not that much pain. It would be comparable to a woman having a baby. In an interview on 02/19/2020 at 9:35 AM, Staff HHH, Medical Supply Clerk confirmed there were no 16 french catheters in the supply bin currently and it could take 24 hours to receive one. At 11:07 AM, Staff HHH provided central supply item sign out sheets and confirmed no Foley catheter was signed out for the resident on 01/09/2020 through 01/10/2020. He stated no one informed him they were out of 16 french catheters or he would have ordered them. In an interview on 02/19/2020 at 1:58 PM, Staff MM stated on 01/09/2020, Staff III reported that she had replaced the catheter in the evening shift and had a little difficulty replacing it and the catheter was not draining. Staff MM said he looked at it and got a flush kit tried to flush the catheter and it would not flush. Staff MM

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 11) said the resident had a large prostrate and they had been using a coude tip. He said the facility had no coude catheters. He said he placed a 20 French catheter and it drained the rest of the shift. He confirmed the physician order [REDACTED]. In an interview on 02/19/2020 at 2:40 PM, the Director of Nursing (DNS) stated it was her expectation nurses would call the physician and let them know if the catheter was clogged or plugged, if that was the case. She stated the resident did not have a physician order [REDACTED]. She said she removed his catheter and made one attempt to insert the catheter and met resistance. She said she then left the room and asked Staff MM to have a look. She said Staff MM reinserted a new one although she was not present for the procedure. Staff MM then told her he got a new one placed. She said she thought the order was for a 16 french catheter. She stated she did not document this and had not been interviewed by the facility staff prior to now. The facility failed to thoroughly investigate the placement of a larger catheter that resulted in pain of a 9 out of 10 on a scale of 1 to 10 and resulted in missed therapy for the resident. BOWEL MONITORING/CONSTIPATION According to the facility's electronic Bowel Care Protocol, undated, showed: Administer Milk Of Magnesia (MOM) 1200 mg/5 ml follow with 40 milliliters (ml) of water every 24 hours as needed; [MEDICATION NAME] 10 mg(milligram) suppository, insert rectally for no bowel movement X 4 days; and Fleet enema as needed for constipation RESIDENT #38 Resident #38 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the 30 day bowel record lookback revealed from 01/21/2020 until 01/29/2020 at 2:39 PM he had no bowel movements (BM) documented. Review of a progress note dated 01/27/2020 at 7:30 PM showed the resident was on the no BM list. MOM given no results this shift reported to next shift. There were no subsequent progress notes after. In addition to the bowel protocol, he had an order for [REDACTED]. Review of the January MAR indicated [REDACTED]. No additional bowel medications were offered or administered per physician orders. There was no documentation in the medical record that the physician was notified of his constipation. In an interview on 02/27/2020 at 11:15 AM Staff L, Licensed Practical nurse (LPN) stated, We offer MOM and if not effective to goes to a suppository and if that is not effective we give a enema. If the resident is independent when the alert pops up we would go ask the resident about their BM's and assess them. In an interview on 02/27/2020 at 2:43 PM, the DNS said it was her expectation that nurses looked at bowel monitors every shift and she looked daily. She said if they have not had a BM then they get a bowel assessment. The facility failed to follow the bowel protocol resulting in Resident #38 experiencing no bowel movement for eight days. CARDIAC MEDICATION PARAMETERS RESIDENT#12 Review of Resident #12's physician orders [REDACTED]. The order directed nurses to administer [MEDICATION NAME] (blood pressure medication) for BP greater than 170 for her hypertension. Review of vital signs without [MEDICATION NAME] administered were as follows: 173/73 on 12/05/2019 185/80 on 12/23/2019 178/67 on 12/25/2019 188/78 on 12/29/2019 172/73 on 12/31/2019 172/74 on 01/03/2020 180/78 on 01/20/2020 178/79 on 01/23/2020 172/71 on 01/25/2020 173/72 on 01/28/2020 185/76 on 01/31/2020 206/79 on 02/13/2020 177/78 on 02/14/2020 180/74 on 02/15/2020 191/72 on 02/23/2020 205/85 on 02/24/2020 Review of the Pharmacist consult on 12/25/2019 showed the resident was on three medications for her blood pressure, Losartan, [MEDICATION NAME] ER and [MEDICATION NAME] every eight hours as needed. The pharmacist documented her BP's were trending high in this resident on [MEDICAL TREATMENT]. In an interview on 02/10/2020 at 3:04 PM, the DNS was informed of the high blood pressures, lack of cardiac assessment when the blood pressures were taken and missed [MEDICATION NAME] administrations. She confirmed these were medication errors but did not provide the medication error reports. In an interview on 02/21/2020 on 11:30 AM, Staff II, Regional Nurse Consultant said the nurse would be unable to see a pattern of vital signs and if the vital sign is rechecked then it stops in PCC (electronic medical record) At 1:48 PM, she said she looked into the blood pressures and had the doctor review them. The doctor now requested weekly updates. In an interview on 02/27/2020 at 10:30 AM, Staff BBB, Regional Director of Clinical Operations, said the facility used medical director guidelines for vital signs. RESIDENT #38 Resident #38 had orders for [MEDICATION NAME] 3.125 mg twice daily for hypertension. Nurses were to hold the dose for SBP (Systolic blood pressure, top number of blood pressure)<100. Review of the MAR indicated [REDACTED]. In an interview on 02/18/2020 at 10:40 AM, Staff R, Consultant Pharmacist, said he reviewed blood pressures to see if they were trending low and if the nurses were holding medications appropriately. He confirmed medication administered outside the parameters would be a medication error. In an interview on 02/27/2020 at 2:43 PM, the DNS was informed of [MEDICATION NAME] being administered outside of parameters. She had no medication error for this resident. RESIDENT #63 Resident #63 admitted on [DATE] with multiple cardiac issues. Review of the physician's orders [REDACTED].<60, [MEDICATION NAME] 5 mg once daily, hold if SBP <100 or HR<50, [MEDICATION NAME] 75 mg every six hours , hold for SBP<100 HR<50. Review of the pharmacist recommendation on 12/25/2019 showed he was currently on the following anti-hypertensive regimen: 1. [MEDICATION NAME] 75 mg via peg tube (feeding tube) every 6 hours; 2. [MEDICATION NAME] 2.5 mg via peg tube every day; 3. [MEDICATION NAME] 0.125 mg/day to check pulse and HR prior and ; BP's listed 12/20/19 to 12/25/19 [MEDICAL CONDITION](hypertension) The pharmacist recommendation was not addressed until 01/09/2020. The physician ordered labs and increased the dose of his [MEDICATION NAME]. Review of vial signs without further assessment and physician notification: 153/102 on 02/07/2020 HR 47 on 02/08/2020 HR 58 with [MEDICATION NAME] not held on 01/23/2020 180/119 and 146/100 on 12/30/2019 147/101 on 12/28/2019 HR 48 with [MEDICATION NAME] not held on 12/13/2019 160/103 on 12/24/2019 165/104 on 11/01/2019 In an interview on 02/25/2019 at 12:16 PM, the DNS was made aware of the abnormal vital signs with lack of assessment and physician notification. She said she did not have medication errors for this resident on 12/13/2019 or 01/23/2020. No additional information was provided. WEIGHT MONITORING RESIDENT #12 Resident #12 admitted on [DATE] with multiple cardiac diagnoses, kidney disease requiring [MEDICAL TREATMENT] and protein calorie malnutrition. Review of her [MEDICAL CONDITION] care plan directed staff to obtain weights daily. Review of her weight history showed her weight had not been obtained daily since admit. RESIDENT #38 Resident #38 had an order for [REDACTED]. In an interview on 02/18/2020 at 3:05 PM, Staff J, RN said the resident had significant [MEDICAL CONDITION] (swelling) in his legs and commented maybe he could be seen by a doctor tomorrow. In an interview on 02/27/2020 at 11:13 AM, Staff L, LPN said for abnormal vital signs, she would first look for doctor ordered parameters. Then she would recheck their vital signs and look at their history for normals. If they were still abnormal, she would call the doctor and provide the history for them to review. In an interview on 02/27/2020 at 2:43 PM, the DNS was informed of [MEDICATION NAME] being administered outside of parameters. She had no medication error for this resident. RESIDENT #28 The resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to the Quarterly MDS assessment, dated 11/17/2019 she had no cognitive impairment. In an observation/interview on 02/05/2020 at 9:03 AM, the resident stated she had redness under her right breast, she pulled up her shirt and under her right bra/breast area the skin was red from side to side. Review of the residents Medication Administration Records (MARs) and Treatment Administration Records (TARs) for February 2020 revealed she had an order for [REDACTED]. Review of the January & February 2020 MARs/TARs revealed there were orders for Weekly Skin Audits to be completed with (N) to be marked if no skin issues, and (Y) to be marked for new skin issues. On 02/03/2020, 01/06/2020, and 01/27/2020, the nurses put check marks that skin audits were done, but no Y or N. If there were new skin issues, the order directed to document in PCC (PointClickCare, the electronic healthcare record). In an interview on 02/24/2020, the DNS was unable to provide any information about the lack of documentation regarding the status of the breast fold rash, even though the MARs/TARs reflect she had been receiving treatment since 09/04/2019. The DNS was unable to provide any information why nurses weren't following the order instructions to write in a Y or N in the weekly skin audit order. This is a repeat deficiency from 02/13/2019. Reference: (WAC) 388-97-1060 (1)(3)(b)(j)(k)
F 0685 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Assist a resident in gaining access to vision and hearing services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of two residents (#32) was offered her eyeglasses to wear on a regular basis. The facility failed to care plan eyeglasses, and to offer the resident her eyeglasses for wearing on a routine basis which placed the resident at risk for impaired vision and for diminished quality of life. Findings included . RESIDENT #32 The resident admitted to the facility on [DATE] for rehabilitation after having a fall at home resulting in a left wrist fracture. On admission the resident had [DIAGNOSES REDACTED]. According to the resident's admission Minimum Data Set (MDS) assessment, dated 05/23/2019, she had severe cognitive impairment. In observations from 02/04/2020 - 02/24/2020 the resident was never observed to be wearing her eyeglasses. Review of an Occupational Therapy Evaluation & Plan of Treatment, dated 05/16/2019, revealed Patient wears glasses 24 hr (hours). Review of the resident's Admission Record, dated 05/16/2019, revealed the facility had taken a picture of the resident on the day of admission, and she was wearing eyeglasses. Review of the resident's care plan, print date 02/06/2020, revealed there was no care planning done regarding the resident's eyeglasses. In an interview on 02/21/2020 at 11:59 AM, Staff FF, Registered Nurse (RN), said she didn't think the resident had eyeglasses. Staff FF then looked in the medication cart and she found a pair of eyeglasses that were labeled with the resident's name. Staff FF then stated I think she takes them off a lot. In an interview on 02/21/2020 at 12:06 PM, Staff E, RN, said she took care of the resident on the other wing when she first admitted , and she said the resident had her eyeglasses all the time, and sometimes she wore them and sometimes she carried them in her hands. Reference: (WAC) 388-97-1060 (3)(a)

F 0686 **Level of harm -** 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 provide care and services to prevent and heal pressure ulcers/pressure injuries for three of four residents (#32, #29, and #12) reviewed. The failure to float heels, to turn and reposition routinely, and to use standard resident handling practices, placed residents at risk for developing skin injuries. Resident #32 was harmed when she developed two pressure ulcers in the facility. The facility then failed to protect her heels by relieving pressure per the care plan, to put her back to bed between meals, to relieve pressure on her coccyx, and to use standard resident handling practices during incontinent care which resulted in delays in healing of her two skin pressure injuries. Findings included . RESIDENT #32 The resident admitted to the facility on [DATE] for rehabilitation after having a fall at home resulting in a left wrist fracture. On admission the resident had [DIAGNOSES REDACTED]. According to the resident's admission Minimum Data Set (MDS) assessment, dated 05/23/2019, she had severe cognitive impairment. The MDS indicated Resident #32 was not at risk of developing pressure ulcers and did not have any unhealed pressure ulcers. Review of the quarterly Minimium Data Set (MDS), dated [DATE], showed that Resident #32 required extensive assistance of 1-2 persons with bed mobility, transfers, and personal hygiene and was always incontinent of bowel and bladder. This MDS indicated the resident was at risk of developing pressure ulcers. Review of a wound consultant report, dated 02/11/2020, revealed the resident had two skin injuries; an unstageable pressure injury to the coccyx that measured 4.9 x 4.2 x 0 cm (centimeters), and a full-thickness left heel wound with necrotic/eschar tissue (necrotic is non-viable tissue due to reduced blood supply; eschar is dry, black, hard necrotic tissue) that measured 6 x 7 x 0 cm. Review of the care plan, print date 02/06/2020, revealed a focus area that the resident was at risk for skin impairment related to dementia, diabetes, and lack of self care. Interventions included: -resident to be up in wheelchair for all meals -ensure she is back in bed between meal times -ensure she is turned and repositioned when she is in bed -she was to

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	505296	A. BUILDING _____ B. WING _____	03/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST FRANCIS OF BELLINGHAM	3121 SQUALICUM PARKWAY BELLINGHAM, WA 98225

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 12) have heel protectors on both feet at all times. In an observation on 02/10/2020 at 9:02 AM, the resident was being wheeled out of the dining room in her wheelchair, she had no heel protectors on. In an observation on 02/10/2020 at 10:14 AM, the resident was sitting in her wheelchair by the nursing station. The resident was not wearing heel protectors. The resident also was not wearing heel protectors this same day at 11:05 AM, 11:38 AM, 12:19 PM, 12:25 PM, and 1:58 PM (note: during all of these observations, the resident was sitting in her wheelchair, and not back in bed between meals). In observations on 02/11/2020 at 10:17 AM, 11:06 AM, and 2:12 PM, the resident was sitting in her wheelchair and not back in bed between meals, like her care plan directed. In an observation on 02/14/2020 at 5:57 AM, the resident was in bed, the sage boots (brand of heel protector) were in her wheelchair, and her heels were in contact with the bed without anything underneath to float them off of the bed. Also noted, the resident's left foot did not have sock on at this time. In an interview on 02/14/2020 at 6:08 AM, Staff T, Registered Nurse, was asked about the observation at 5:57 AM where the resident's left heel with bandage was observed sitting directly on the mattress. Staff T stated that the resident's heel wound started bleeding last night and Staff T and had not put the sock back on that left foot either, and that Staff T relied a lot on the nursing assistants for that. In an observation on 02/14/2020 at 8:48 AM, Staff ZZ, Nursing Assistant, was observed doing incontinent care on the resident. To turn the resident to her side, Staff ZZ grabbed the drawsheet and gave it a brisk tug, causing friction against the resident's wound. After removing the resident's briefs there was an unpleasant odor from her groin area even though she had not been incontinent of stool. In an observation on 02/19/2020 at 9:36 AM, the resident was observed sitting in her wheelchair between meals. In an observation/interview on 02/24/2020 at 10:42 AM, the resident was observed sitting in her wheelchair in the Solarium, the resident was asked if she wanted to be up in her wheelchair, she stated I'd rather be in bed. The resident was asked why she was up in her wheelchair, she stated she didn't know. In an interview on 02/24/2020 at 10:47 AM, Staff ZZ was asked about the resident being up in her wheelchair and not back in bed between meals per her care plan, Staff ZZ stated I just haven't gotten to it yet, I'll get to it. In an observation on 02/24/2020 at 1:26 PM, the resident was observed asleep in her wheelchair in the Solarium. In summary, this resident developed two skin injuries in the facility. The resident did not get her heels protected per her care plan, she did not get pressure relieved between meals per her care plan, staff did not use proper resident handling techniques during incontinent care, and staff did not ensure Resident #32's Sage boots were worn per her care plan, she developed a heel and a coccyx pressure injury. RESIDENT #29 The resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to her quarterly MDS, dated [DATE], the resident was rarely/never understood, needed 2-person assist with bed mobility, transfers, dressing, toilet use, and personal hygiene, and was at risk of developing pressure ulcers. In an interview on 02/05/2020 at 3:17 PM, the residents' daughter stated she would come to visit, and no staff would come and reposition her mother for hours and hours. Review of the resident's Kardex (care directives for nursing assistants), print date 02/20/2020, revealed for bed mobility Resident #29 required two people to assist the resident. Review of the Braden Scale for Predicting Pressure Sore Risk, dated 12/05/2019, revealed the resident was at high risk for developing a pressure sore. Review of the care plan, print date 02/06/2020, revealed the resident required reposisitoning in bed for skin integrity. In observations on 02/07/2020, the resident was in bed on her back at 6:53 AM, 8:37 AM, and 10:42 AM. In observations on 02/10/2020, the resident was in bed on her back at 8:58 AM, 10:15 AM, 11:06 AM, 11:37 AM, and 12:20 PM. In an interview on 02/12/2020 at 12:28 PM, Staff C, RN, stated residents still needed to be repositioned even if they were on the APP mattress (pressure-relieving mattress). In an observation on 02/20/2020 at 3:24 PM, Staff ZZ was observed doing bed mobility by herself for the resident during incontinent cares. In an interview on 02/21/2020 at 2:26 PM, Staff D, Staff Development Coordinator, was asked about Staff ZZ doing incontinent care on the resident with only 1 person assist who was at high risk for skin injury, he looked in the electronic health record and stated the resident was supposed to be 2-person assist. He stated he would address it with Staff ZZ. RESIDENT #12 Resident #12 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. tissue), diabetes. She did not reject care. Review of the Admission MDS dated [DATE] showed the resident admitted with a stage I or greater pressure ulcer including one stage 3 pressure ulcer and one venous or arterial ulcer. In an interview on 02/05/2020 at 12:03 PM, Resident #12 said she had been in the hopital for five months for wounds prior to admit. She said currently she had wounds on her right leg and two blisters that had overloaded with fluid and opened up. She said she had wounds on her left stump and her right heel but they had healed. Review of a progress note from Staff GG, ARNP on 02/21/2020 showed the resident's right lower extremity positive for darkened, reddened, and warm skin with small open areas .improved but still draining. Review of the clincial record as of 02/27/2020, showed her skin and wound evaluations were last assessed on 01/27/2020 (four weeks earlier). Measurements were: distal 2.2 cm X 2.8 cm, mid 2.0 cm X 2.0 cm, proximal 1.0 cm X 1.7 cm The TAR (treatment administration records) directed staff to monitor open area to RLE (right lower extremety) until resolved beginning 01/05/2020 until 02/05/2020 when it was removed from monitoring although it was not resolved. Review of the care plan showed actual skin impairment including a stage III (stage 3) right heel pressure ulcer, and a left stump and left inner knee post surgical wound that had resolved. Staff were directed to complete a skin assessment weekly and place the SAGE boot to her right foot while the resident was in bed. Review of the Kardex directed staff to encourage the resident to wear a SAGE boot on her right foot while in bed. During multiple observations all days of survey, Resident #12 was not observed to wear the SAGE boot on her right foot when she was in bed. During an observation of wound care on 02/27/2020 at 12:16 PM, performed by Staff E, RN, Staff E stated that Resident #12's wound was greatly improved since admit and the resident's leg remained fragile and high risk. Staff E said she was unaware of how frequently staff do her dressing changes. No wound measurements were obtained at that time. In an interview on 02/25/2020 at 12:20 PM, the Director of Nursing was informed there were no weekly measurements for the resident's right leg and that Resident #12 had not had her SAGE boot on as careplanned. The DNS provided no additional information. In an interview on 02/28/2020 at 12:11 PM, Staff D, Staff Development Coordinator, was informed the resident's wounds were last measured on 01/27/2020. He confirmed that wounds were to be assessed daily, wounds measured weekly and documented. He said if there was no change in the wound within two weeks then another treatment was to be requested when the physician was updated. Reference: (WAC) 388-97-1060 (3)(b)
F 0688 **Level of harm -** 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 ensure appropriate services were provided to maintain, increase and/or prevent a decrease in range of motion for three of five residents (#12, #32 and #59) reviewed for range of motion. This failure resulted in harm for two residents when Resident #12 developed foot drop (paralysis of muscles that lift the foot), and right knee contracture(shortening of muscles in a fixed position) and decline in function, and Resident #32 was harmed when she developed a contracture she did not have when she admitted to the facility, and the facility had not provided restorative services recommended by therapy services. When the facility did provide restorative services, there was a six week delay in starting them. The facility placed residents at risk for a decline in range of motion, developing pain, and contractures. Findings included . RESIDENT #12 Resident #12 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. tissue), and [MEDICAL CONDITION]. The resident required kidney [MEDICAL TREATMENT] three times a week for kidney failure, and did not reject care. Review of the Physical Therapy (PT) evaluation on 04/23/2019 revealed, RLE (right lower extremity) moves through full range against gravity and was within functional limits. Review of a PT evaluation on 05/28/2019 showed that Resident #12's right lower extremity ROM (range of motion) was within functional limits. Review of a PT evaluation on 09/28/2019 showed that Resident #12 experienced a decline in ROM related to a right knee flexion contracture, and included a short term goal: for the resident to increase her ankle range of motion using modalities and ROM to increase ankle ROM. Review of a physician order [REDACTED]. Review of the clinical record showed Resident #12 was not evaluated by PT at that time. Review of a progress note dated 12/29/2019, showed,Resident has a restorative nursing program to maintain/improve functional status related to amputation/prosthesis care, impaired physical mobility, risk/loss of ROM, Restorative Programs 1. AROM (active range of motion) to bilateral upper and lower to decrease risk of contractures 2. Exercise program to maintain strength. (Resident #12) refuses to do the RA (restorative) program. We will be dc'ing (discontinuing) the program as of today. The restorative care plan intervention was resolved on 12/29/2019. The care plan showed the resident had previously been on a restorative program to maintain/improve functional status related to amputation/prosthesis care, impaired mobility, risk of loss of ROM three to six times a week for fifteen

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F 0688 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 13) minutes. Review of a PT evaluation on 01/14/2020 showed RLE ROM=impaired (knee 0-45, ankle lacks 25 degrees from neutral dorsiflexion). This showed Resident #12 experienced decline in her ROM. The Kardex (directs nursing assistants how to care for resident) did not include any restorative or range of motion directives. Review of the Minimum Data Set (MDS) assessment, dated 01/25/2020, documented the resident had impaired functional range of motion in her lower extremity and did not receive any restorative therapy in the lookback period. Review of a provider note from Staff GG, Advanced Registered Nurse Practitioner note dated 01/31/2020 showed on 12/11/2019 patient requested RA (restorative aid) to work with her. Review of restorative aide charting, between 01/01/20 and 02/26/2020, documented Resident #12 received nursing rehab AROM to Bilateral upper and lower (location of extremity was not specified) to decrease risk of contractures on five days of January 2020 and February 2020. There was no prior documentation of restorative care. Review of restorative program documentation showed the resident was to receive restorative three to six times a week. Resident #12 received restorative for a total of five days between January and February 2020. Review of behavior monitoring between 01/01/2020 and 02/26/2020 showed no refusals of care for Resident #12. In an interview and observation on 02/25/2020 at 8:19 AM, Resident #12 was in bed. The resident said she was concerned she did not get therapy or restorative and now her right foot had foot drop. Resident #12 attempted to move her right ankle but it barely moved. The resident said she had been on therapy upon admit and at one time was non weight bearing and had wounds. The resident said her insurance stopped therapy and she was supposed to get restorative. Resident #12 said she wasn't getting restorative and her doctor ordered it. Resident #12 said she complained to the Director of Nursing (DNS) and Staff G, Restorative Aide. The resident said the DNS and Staff G both came in later and said So are you going to do restorative or what? Resident #12 said she told them yes however, it needed to be scheduled around the [MEDICAL TREATMENT] appointments. Resident #12 said Staff G worked with her in the gym but mostly doing balloon toss which did not help or stop her foot drop. Resident #12 stated she tried to do the bands herself but it was better if someone else helped her. She said, I am concerned. I cannot stand on this. I am afraid. I cannot get a prosthesis now and need to get my electric wheelchair and go home. During observation of Restorative care performed by Staff LL, RA, on 02/26/2020 at 1:53 PM, Resident #12 was in bed. The resident stated, I am glad you are here or I was going to raise holy hell. Staff LL, RA began to perform heel stretches to the resident's right foot. The resident called out,Oh Lordy and Staff LL stopped. Staff LL was unable to do complete range of motion to Resident #12's right foot . Staff LL commented, Her heel cords are tight. The resident said it had been ten months since she walked and she was no longer able to stand because of the foot drop. In an interview on 02/25/2020 at 12:20 PM, the DNS was informed of the recently developed right foot drop and documentation showing Resident #12 was not consistently receiving restorative care. The DNS said the resident had an active restorative plan but the resident refused it. She provided no additional information. In an interview on 02/26/2020 at 3:00 PM, Staff G, RA, said the resident had come to the gym to do balloon toss. Staff G said Resident #12 did not do too much with her lower extremities. Staff G said it was hard to get to the resident's restorative with her [MEDICAL TREATMENT] schedule, and stated, Unfortunately, we were not documenting the refusals because there is no space to write that in or leave a note. According to Staff G, the DNS was overseeing the restorative program but was busy with the whole building, and could not recall when the last restorative meeting was to review the resident's programs. In an interview on 02/27/2020 at 9:58 AM, Staff DD, Rehab Manager/ Physical Therapy Assistant confirmed the resident had foot drop in her right foot. Staff DD said she worked with Resident #12 on four occasions, most recently for a wheelchair evaluation. Staff DD stated that the resident had not been seen for her right foot or was assessed for any devices. In an interview on 02/27/2020 at 10:03 AM, Staff EE, Physical Therapist stated the resident was currently on caseload for a power wheelchair evaluation. Staff EE said at one time she set the resident up for a restorative program for her ankle in June (2019). She said Resident #12 was on and off therapy a few times and was first seen in April 2019 until there was a change in payor source. Staff EE said in November of 2019 the resident was seen to increase her ankle dorsiflexion. Staff EE said Resident #12's baseline range was -(negative)25 degrees and the goal was for her to be at minus 15. According to Staff EE, the resident reached -20 degrees dorsiflexion at discharge. My recommendation would be she get restorative consistently. It does not take that much to have us come in and do RA even after [MEDICAL TREATMENT]. Staff EE said she did not take measurements but the resident's ankle was within functional limits upon admit and the foot drop was acquired in the facility since admission. Resident #12's resultant injury resulted in a physical impairment, decline in function and increased dependency on caregivers with a decreased ability to return to her prior living environment. RESIDENT #32 The resident admitted to the facility on [DATE] for rehabilitation after having a fall at home resulting in a left wrist fracture that required surgical repair. On admission the resident had [DIAGNOSES REDACTED]. According to the resident's Admission MDS assessment, dated 05/23/2019, she had severe cognitive impairment. In an interview on 02/19/2020 at 11:20 AM, Staff DD, Director of Rehabilitation, stated the resident now had a hand/wrist contracture that she didn't have when she admitted to the facility. In an interview on 02/21/2020 at 11:30 AM, Staff DD stated the resident had Occupational Therapy services twice while at the facility, the first time was after admission, and the second time was around 08/06/2019 because the resident had developed a contracture. Staff DD provided two Therapy RA referral forms, one was dated 06/17/2019 and the second was dated 09/03/2019. Review of a Therapy RA Referral form, dated 06/17/2019, revealed the resident had been referred to Restorative Nursing to get active ROM six times weekly to the left wrist, in order to maintain her current level of performance and in order to prevent a decline. Review of another Therapy RA Referral form, dated 09/03/2019, revealed the resident had a left hand contracture, and was referred for passive ROM and a splint/brace assistance, six times weekly. Review of the resident's clinical record revealed the first referral (dated 06/17/2019) did not result in the resident receiving restorative services. Review of the resident's care plan, print date 02/06/2020, revealed the second referral resulted in the resident being care planned to receive restorative, but not for 6x/weekly as recommended by therapy, the care plan reflected she was care planned for 3-6x weekly. The care plan indicated the restorative services were care planned as of 10/15/2019. Review of a Documentation Survey Report, dated October 2019, revealed the resident started restorative services on 10/15/2019, about six weeks after the referral from Occupational Therapy. The resident received restorative services as follows: -10/15/2019 - 10/31/2019 - 7 times -November 2019 - 5 times -December 2019 - 6 times -January 2019 - 4 times -02/02/2020 - 02/20/2020 - 5 times In an interview on 02/20/2020 at 10:53 AM, Staff G, Restorative Aide, was asked why the the resident did not receive restorative services as required per the care plan, Staff G stated, Obviously I should have tried to work with her more. In an interview on 02/21/2020 at 12:23 PM, the DNS was asked for documentation to show the resident got restorative services after the first Occupational Therapy referral, (06/17/2019), she was unable to provide any information. The DNS was asked about the delay in providing restorative services from 09/03/2019 - 10/14/2019, she stated it took time to process the referral. The DNS was asked why the resident wasn't care planned to receive restorative services 6x/weekly per the referral, the DNS stated that was therapy's preference, not nursing, and that restorative was a nursing function. The DNS was asked why the resident wasn't receiving restorative services even the 3-6x/weekly as she was care planned to receive, the DNS was unable to provide any information. The DNS was asked about the contracture, she was unable to provide any information. RESIDENT #59 The resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The resident was alert and able to make her needs known. In an interview on 02/04/2020 at 11:36 AM, Resident #59 stated she had a hip injury that required surgery and was admitted to the facility to receive rehabilitation services. The resident stated, she was concerned about not getting exercises anymore. She stated she was getting therapy and then the aids were supposed to be trained to give her exercises but that has not happened, I am wondering what's going on, I can't just lay here in bed. Review of the resident's Physical therapy functional performance of encounter dated 01/20/2020 documented, discussed with resident upcoming discharge from therapy and transition to Restorative program, RA program established. Review of the physical therapy discharge summary dated 01/21/2020, documented, Skilled services discharge completed with resident. Therapist encouraged resident to get up in chair daily, participate with RA program. Review of the resident's progress notes, revealed no restorative notes were present. Review of the resident's task list showed no restorative task available for the resident. Review of the resident's Kardex did not include a restorative program. In an interview with Staff G, a restorative aid on 02/12/2020 at 1:52 PM, Staff G stated the resident was not on a restorative program. In an interview with Staff C, Resident Care Manager on 02/12/2020 at 2:19 PM, Staff C verified the resident was not on a restorative program but should have been and would now begin the program. This is a repeat deficiency from 02/13/2019. Reference: (WAC) 388-97-1060(3)(d)

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F 0688 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 14)
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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 ensure resident supervision for two of three residents reviewed for wandering (#64, #58, and #18), failed to determine the circumstances of a resident's multiple falls to implement appropriate measures to prevent re-occurrence for one of three residents (#18) reviewed for falls. These failures placed the residents at potential risk of harm related to avoidable incidents. Findings included . RESIDENT #64 The resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the resident's nursing notes documented: On 12/27/2018, Resident went into old room and attempted to eat cookies that were in the room. On 10/01/2019, found resident confused and wandering into another resident's room. On 1/07/2020, the resident was consistently going into a different room and trying to lock himself in the room. On 01/25/2020, the resident was frequently found in someone else's room and had to be redirected to his own room. On 02/01/2020, the resident was found several times in a ladies room peeing into the garbage can. On 02/14/2020, the resident entered another residents room, pulled his pants down exposing his genitals and proceeded to urinate on the floor, in front of the other resident. On 02/16/2020, the resident was found in a resident's room and noted urine in the trash can. On 02/20/2020 at 2:05 PM in an interview with Staff I, a nursing assistant, Staff I stated, the resident moved fast into other resident's rooms and needed to be closely watched. On 02/24/2020 at 10:15 AM in an interview with Staff YY, a nurse that works in the resident's area. Staff YY was asked about the resident wondering into other resident rooms, Staff YY stated, the resident was confused and needed redirection to his room or to the restroom, Staff YY further stated the nursing assistants needed to keep a closer eye on the resident. Review of the resident's Care plan and kardex (care guide) on 02/05/2020, revealed the resident's behaviors were not included and no directives on how staff were to respond to them. Not until 02/10/2020, were the residents wandering into other rooms and urinating in the room behaviors included in the resident's care plan. On 02/27/2020 at 9:16 AM, in an interview with the Director of Nursing Services, (DNS), the DNS was asked about the resident's behaviors, the lack of care planning and lack of supervision for the resident, the DNS stated, she did not have any information to provide, except that the behaviors were now care planned and staff were providing more supervision. Review of a 07/02/2019 at 3:53 PM, activity progress note revealed, This resident (#58) and another female resident (#66) were sitting near each other in an activity. Noticed that they were holding hands, and this resident (#58) began to pull her hand closer to him and it seemed as if he was pulling toward his lap/private area. I intervened before anything happened and told res to stop. Other female res was laughing and smiling, was not upset about the situation. Residents were separated and no further behaviors noted at this time Review of a progress note, dated 07/25/2019, showed Residents #58 and #66 were observed sitting in the solarium kissing. Review of a progress note dated 09/18/2019 at 6:59 AM, Inappropriate mutual behaviors between this resident (#58) and female resident (#66). Residents separated and brought to their perspective rooms. Review of a progress note dated 09/26/2019, documented Resident #58 was visiting Resident #66 from the hallway. Resident #17 asked him to leave repeatedly. Resident #58 swore at her. Review of a progress note for Resident #70 on 01/13/2020 at 5:00 PM showed Resident # 58 had gone into (Resident #66's) room that he was told he cannot be alone with. The female resident's roommate (Resident #70) was raising her voice, telling him that he needed to get out of our room. Resident #58 was refusing to do so and attempted to kick at the roommate, but did not make contact .escorted the female resident and her roommate to the dining room. (Resident #58) again kicked at the roommate but again did not make contact. Resident #70 was very upset and stated that the male resident had come into her room to be with her roommate and she told him he needed to leave. Resident then stated the male resident then tried to kick her multiple times . Review of a progress note on 02/13/2020 at 3:00 PM, Resident #70 was resting in her room when another resident (Resident #58) coming down hallway stopped in front of this resident door way and began shouting profanities (in Spanish) towards resident. After shouting a few words, specifically f*ck you, this resident then left doorway (self-propelling himself in wheelchair) down hall towards dining room and or activities. This behavior happened more than once and was witnessed by a shower aide. Resident #58 was not placed on one on one supervision until 02/13/2020 at 3:40 PM. The facility failed to provide adequate supervision after wandering, inappropriate touching and behaviors of verbal aggression resulting in verbal resident-to-resident altercations. Further, the facility did not provide immediate interventions to assure the safety of residents, and to assess the root cause to prevent further resident-to-resident altercations. The facility lacked assessment and monitoring of the residents for psychosocial harm. The facility had an abuse policy in place but failed to implement the measures. RESIDENT #18 Resident #18 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. On 02/05/2020 at 11:57 AM, in an interview with the resident, the resident stated he had fallen out of bed many times since his admission to the facility. Review of the resident's clinical record revealed the resident had sustained at least 22 falls from day of admission until present. Review of a fall investigation dated 09/02/2019 at 12:30 PM, documented the resident was found with his feet on the side of his bed in a crouched position and one hand stretched out behind him holding onto the bed. Interventions put in place to prevent re-occurrence were to include: Educating the resident to use his call light, review and update his care plan and resident was to wear nonskid socks at all times. Review of the resident's care plan that was included with the incident report revealed, only the fall was updated as a fall on the care plan, no changes in interventions were included as was planned to prevent re-occurrence. Review of the resident's clinical records, revealed a nursing note dated 09/11/2019, documenting, the resident was found on the floor, laying on his back beside his bed, the resident was not wearing non-skid socks (although, one of the interventions to prevent falls was for the resident to wear nonskid socks.) and stated he rolled out of bed. This incident was not on the facility incident log and was not investigated. Review of a fall incident report dated 09/22/2019, documented, at 6:30 AM, the resident was lying in bed, at 7:00 AM, the resident was found lying on the floor without socks, (although, one of the interventions to prevent falls was for the resident to wear nonskid socks). The resident stated, he fell while trying to go to the washroom. To prevent re-occurrence the resident's care plan was updated to include staff to provide frequent reminders to ensure resident uses his call light and to provide frequent checks for safety. Furthermore, no neurological checks were performed and no information about when the resident was last toileted was collected as part of the facility fall investigation. Review of a fall investigation dated 10/01/2019, documented at 2:15 PM, the resident was found on the floor, the resident sustained [REDACTED]. The resident stated, he was trying to get out of bed. The facility investigation lacked witness statements and information on when the resident was last toileted. Review of a fall dated 10/08/2019, documented at 11:30 PM, the resident was heard calling for help, the resident was found on the floor next to the bed on his hands and knees, barefoot (although, one of the interventions to prevent falls was for the resident to wear nonskid socks). The resident stated, he was getting out of bed to use the restroom and slid off the bed. The intervention put in place was to keep the resident's bed in the lowest position. Review of a fall investigation dated, 11/13/2019, documented at 4:00 PM, a nurse heard yelling for help and found the resident on the floor lying on his left side facing the door, call light was clipped to his bed but not on, the resident stated he was trying to get up from the bed, he fell and landed on his left side. The plan to prevent re-occurrence was to include bedrails on his bed. A progress note, dated 11/18/2019 at 1:20 PM, documented the resident was found halfway down the floor, his upper half of the body was resting at the edge of the bed and hanging on to his bedrail, eased resident down to the floor on a sitting position, assisted resident up and back to bed, encouraged resident to use call light when needing help to get up (although as noted in the previous falls the resident has not used his call light) and to keep his nonskid socks on for safety. This incident was not on the facility incident log and no incident report was completed. A progress note dated 11/21/2019, documented, at 9:30 PM, the resident was found calling for help, sitting on the floor with back leaning against his bed. A fall scene investigation report dated 11/20/2019 at 11:17 PM, documented, the resident attempted to self-transfer, had bare feet, (although, one of the interventions to prevent falls was for the resident to wear nonskid socks) when he was last toileted was unknown, resident stated he stood up to go to the hallway, he slid out of bed, his arm catching on the small assist bar attached to his bed. The resident's care plan was only updated to include this fall. Review of a fall investigation dated 11/26/2019, documented at 3:20 AM, while assisting the resident's roommate, the resident was witnessed attempting to get out of bed, began to slip, and was assisted to the floor. The

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 15) resident stated he wanted to fix his blankets, the resident was again not wearing non-skid socks, (Although one of the interventions to prevent falls was for the resident to wear nonskid socks). The incident report contained a note from the Director of Nursing Services (DNS), the DNS noted the residents care plan was reviewed and no changes to the plan of care, as all safety devices were in place to help prevent injury if fall did occur. Review of a fall investigation dated 11/29/2019, documented at 2:31 AM, the resident was found sitting on floor, against his bed, the resident was again barefoot, the resident stated he was trying to get out of bed to go to the nurses station and slid. The resident care plan was updated with interventions to include lab work to be obtained, review of the resident clinical record revealed the lab work was not completed. The resident sustained [REDACTED]. the resident to use his call light, on 02/14/20 at 11:07 AM, in an interview with Staff K, a nursing assistant, Staff K stated, the resident will call for assistance, I do not think he understands how to push his call light. On 02/14/2020 at 12:03 PM, in an interview with Staff L, a nurse who works with the resident, Staff L, stated when a fall occurred, the nurses collected data for the fall incident reports and these were reviewed by the resident care manager who decided what occurred after the fall. Staff L further stated, she did not participate in any type of fall committee and was not asked her opinion on what could have caused it and how to prevent the resident's falls. The facility failed to provide adequate supervision and failed to conduct a comprehensive evaluation and root cause analysis of the resident's falls to include a medication review, toileting needs/wants, environmental hazards, risks and accommodation of needs that could possibly be contributing to the resident's multiple falls and prevent re-occurence In an interview with the DNS on 02/21/2020 at 9:30 AM, the DNS stated, the facility had now began to meet as a team to identify the root cause analysis of the resident's falls and were currently working on identifying a way to prevent the falls. This is a repeat deficiency from 02/13/2019. Reference: (WAC) 388-97-1060 (3)(g)
F 0692 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure four of eight residents (#38, #63, #30, and #59) received the necessary care and services to prevent a significant and severe weight loss. This failed practice caused harm for Resident #38 and #63 in the form of severe weight loss, signs of dehydration with dry lips and placed the residents at risk for adverse health, safety and diminished quality of life. Findings included . According to the State Operations Manual (SOM), with an implementation date of 11/22/2017, the Centers for Medicare and Medicaid Services defined the parameters for significance of unplanned and undesired weight loss for severe weight loss as greater than 5% in one month. Review of the facility's policy titled, Nutrition & Hydration: Nutrition at risk, dated March 2015 showed Nutrition at Risk (NAR) is aimed at recognizing the patient (s) at risk or already experiencing impaired nutrition, by improving, or maintaining acceptable parameters of nutritional status through integrated interdisciplinary interventions .Patient (s) are assessed and reviewed by the NAR committee when they meet the following criteria: * weight change of 5% (percent) in 30 days, 7.5 % in 90 days, or 10% in 180 days unless determined through assessment and documentation on nutritional progress note with evidence why this would not be required; * Consistent meal intake of less than 50% with impaired skin or weight decline; * Consistent meal intake of 0-25%; * Acute fluid balance alteration if unexpected i.e. resulting in a 5% or greater weight loss or gain: and significant change in condition confirmed by Interdisciplinary Team (IDT); *Patients being reviewed by NAR will continue to be seen weekly or bimonthly as designated by the IDT(interdisciplinary team) and discontinued once stable. RESIDENT #38 Resident #38 admitted on [DATE] with [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) assessment dated [DATE], defined a clinically significant weight loss episode for nursing home residents as a loss equal to or greater than 5% within a 30-day period or 10% within a 180-day period. Review of the Admission Care Area Assessments (CAA's) on 06/08/2019 showed a risk of dehydration and recommended fluids pushed with 2,000 milliliters (ml) every day as the goal. The nutritional status showed staff were to proceed with the care plan interventions to minimize the risk of impaired nutrition and maintain a stable weight. Review of the care plan showed the resident had a potential for nutritional problems with the goal of no unanticipated weight loss and for the resident to be free of impaired hydration. The care plan directed staff to offer 180 ml of thickened fluids three times daily, conflicting with the CAA. Review of the weight summary showed on 12/31/2019, he weighed 152.8 pounds and on 02/11/2020 his weight was 138.6 pounds, a 14.2 pound weight loss, this reflected a 9.3% weight loss within 6 weeks. Review of the dietary notes showed Resident #38 had significant weight loss of 6% or 9.2 pounds beginning 01/15/2020. Review of a progress note dated 01/22/2020 at 7:50 AM revealed Resident declining, and deconditioned. Hospice consult for continuation of care and comfort measures. Review of the care plan showed Resident #38's nutrition care plan was not revised until 02/20/2020. Review of the dietary notes showed the following: 01/22/20 weight 138.0, loss of 12.5% or 19.8 pounds resident declining and deconditioned. Hospice consult placed for continuation of care and comfort measures; 02/06/20 weight 142.0 , loss of 6.9 % or 10.6 pounds in 30 days and 10% or 15.8 pounds; weight is stable at this time continue to monitor for significant changes; and 02/13/20 weight 138.6, loss of 9.2%/14.0 pounds in 30 days. Resident has [DIAGNOSES REDACTED]. Will monitor for significant changes Review of the physician orders [REDACTED]. Review of the clinical record showed multiple charting omissions for health shake intake and facility staff did not document the amount of health shake intake consumed. The resident received the honey thick liquids as ordered for hydration as follows: November 2019: received 5 of 90 shifts December 2019: received 14 of 93 shifts January 2020: 6 of 93 shifts February 2020: 2 of 78 shifts as of 02/27/2020 at 3:23 PM Review of the meal intake 01/15/2020 through 02/27/2020 showed: 0-25% of meal eaten=39 meals 26-50% of meal eaten=8 meals 51-75% of meal eaten=30 meals Meal replacement only offered once for his meal intake of less than 50%. In observations on 02/04/2020 at 1:03 PM and 3:10 PM Resident #38 was in bed asleep. There were no fluids at bedside. In observations on 02/05/2020 at 10:50 AM, 1:47 PM and 2:34 PM, Resident # 38 was in bed asleep with no fluids at bedside. In observations on 02/06/2020 at 8:17 AM, Resident #38 was in his recliner asleep. At 10:29 AM, he was in his recliner eating breakfast and stated I don't feel good. He was observed asleep at 11:44 AM and 1:17 PM with no fluids at bedside. In observations on 02/07/2020 at 4:50 AM, he was observed asleep in his recliner. At 6:00 AM, he was awake his lips were very dry and scabbed. He stated Thirsty, I am not good. There was no water or any fluids available. At 7:10 AM, 8:34 AM, and 11:21 AM, he was in his recliner asleep with no fluids available. His lips remained dry . In observations on 02/10/2020 at 8:33 AM, Resident # 38 was asleep in his recliner. At 9:42 AM he was in his recliner with his breakfast tray, trying to bring thickened juice with a fork up to his mouth. He ate 20% of his pureed entree. At 11:27 AM, 1:08 PM, 2:48 PM he was in bed asleep. There were no fluids at bedside. In observations on 02/11/2020 at 8:58 AM and 9:45 AM he was in bed asleep. There was no breakfast tray present. The meal monitor indicated he was unavailable. At 11:15 AM, he was in his recliner awake. His lips were dry. At 1:23 PM, he was in his recliner asleep. At 2:05 PM, he was standing up with unsteady gait. At 3:27 PM, he was asleep in his recliner with no fluids present on any observation. In observations on 02/12/2020 at 9:50 AM, he was awake in his recliner. At 11:27 AM and 12:10 PM he was in bed asleep, At 1:50 PM, he was in his recliner asleep. At 3:03 PM, was in his wheelchair facing the window asleep. There was a full ice cream on his overbed table. There was no water or other fluids present. In an observation on 02/13/2020 at 8:22 AM, he was in his recliner sleeping. At 10:02 AM, he was in his recliner eating. He stated, I do not feel well. I am sleepy. He ate 40% breakfast but only 90 ml juice. At 11:46 AM, 2:56 PM, and 3:25 PM, he was asleep in his recliner with no fluids present. In observations on 02/14/2020 at 6:22 AM, 7:38 AM he was asleep in his recliner. At 10:00 AM and 11:08 AM, he was observed asleep. His breakfast tray had been delivered and was untouched. His fluids were full and covered with Saran wrap. At 12:22 PM he was asleep in his recliner with no fluids available. In an interview on 02/18/2020 at 3:03 PM, Staff J, RN said he was not sure how much health shake the resident was supposed to get. Staff J said maybe Resident #38 had his own supply or the kitchen provided the shakes. Staff J confirmed the resident was to receive 240 ml of honey thick liquids every shift. In observations on 02/18/2020 at 9:26 AM and 11:05 AM, the resident was in bed asleep. At 1:53 PM Resident #38 was in his recliner with dry lips with thick mucous like strings on his upper and lower lips. The resident asked for water. At 3:02 PM and 3:33 PM Resident #38 was asleep in his recliner. There was no water or any fluids at bedside. In an interview on 02/19/2020 at 12:18 PM, Staff K, NAC said He sleeps a lot. He drinks coffee pretty well. This morning he did not drink anything. He does not always drink anything on his tray. Once he poured it on his lap. If I give it to him he may pour it and it is a catch 22. If we leave it, he dumps it on himself. In observations on 02/19/2020 at 8:45 AM, Resident #38 was asleep in bed. At 10:00 AM, the resident was sitting on the side of his bed. At 12:02 PM and 2:23 PM, Resident #38 was in bed asleep. There was no water or any fluids at bedside. In observations on 02/20/2020 at 8:18 AM, Resident #38 was in bed asleep. At 9:22 AM, the resident was sitting on the side of the bed and breakfast was delivered. At 10:45 AM, 11:37 AM, 2:20 PM and 3:20 PM, the same two half filled cups of juice remained at bedside In observations on 02/21/2020 at 8:40 AM, 9:47 AM, Resident #38 was asleep. At 11:18 AM, the resident was asleep and his breakfast tray remained untouched. At 1:06 PM, Resident 338 was observed asleep. In observations on

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F 0692 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 16) 02/24/2020 at 10:02 AM, Resident #38 was in his recliner asleep with two glasses of juice covered with Saran wrap. At 11:19 AM and 12:29 PM, drinks remained untouched at bedside. At 2:23 PM, the resident was in bed asleep with no drinks at beside. In all observations on 02/25/2020 at 8:28 AM, 9:57 AM,10:27 AM, 1:10 PM and 2:33 PM, Resident #38 was asleep with untouched fluids at bedside. In an interview on 02/25/2020 at 12:16 PM, the Director of Nursing Services was informed of concerns of dry lips, lack of fluids available at bedside, excessive somnolence and untouched meal trays. The DNS said Resident #38 was on Hospice. An updated weight was requested but no additional information was provided. In observations on 02/26/2020 at 9:02 AM the resident was in his recliner with a glass of milk on his overbed table. At 3:07 PM no fluids were available. In an interview on 02/26/2020 at 11:32 AM, Staff Q, Registered Dietician was informed of concerns of dry lips, lack of fluids available at bedside, excessive somnolence and untouched meal trays. Staff Q stated, His weight fluctuates and goes up and down. I recommended a hydration pass 240 ml three times a day at a minimum and a nutrition shake three times a day between meals. In observations on 02/27/2020 at 9:00 AM, Resident #38 was in his recliner with one untouched glass of juice. His lips were dry. At 9:26 AM and 10:03 AM the resident had no breakfast tray. At 10:44 AM and 11:36 AM, the resident was asleep and no fluids were available. In observations on 02/28/2020 at 10:44 AM and 11:34 AM, Resident #38 was observed asleep in his recliner with dry lips and no fluids present. RESIDENT #63 Resident #63 admitted on [DATE] with [DIAGNOSES REDACTED]. He had left sided paralysis and required extensive assistance with ADL's (activities of daily living). Review of the Quarterly MDS dated [DATE], showed that the resident had a swallowing disorder and loss of liquids and solids from his mouth when eating or drinking. The assessment also indicated Resident #63 held food in his mouth or had residual food in his mouth after meals. He received his total calories and fluids via a feeding tube, and had no weight loss during the assessment period. Review of the care plan showed a revision on 01/02/2020 for progressive self feeding: Redirect patient towards food. Place individual items in patients field of vision and direct to eat. Hand under hand guidance or point to utensil and cups and provide cueing to eat and drink. Review of a progress note on 01/28/2020 showed that Resident #63 was sent to the hospital to replace his feeding tube but they were unable to replace it. Review of the care plan on 02/05/2020 showed no alteration in nutrition care plan present until 02/12/2020. The feeding tube had been discontinued off of the care plan on 02/04/2020 but there were no interventions to direct staff how to maintain his nutrition by mouth. The care plan showed Resident #63 was able to eat with supervision in the dining room. In a provider note dated 02/07/2020, Staff GG, Advanced Registered Nurse Practitioner (ARNP) documented the resident was at risk for depression,PEG (implanted feeding tube) tube was pulled out once again and patient was sent to ED (Emergency Department) for replacement. This is unable to be replaced he is now p.o. (by mouth) nutrition. Weight loss significant. RD following PEG tube pulled . Patient is fully P.O at this time. Makes this difficult to maintain weight and patient does have some dysphasia (difficulty swallowing). Will have to monitor closely. Review of a nurse progress note dated 02/09/2020, showed Dining aides report that resident sleepy during meals and not swallowing well. Needed cueing to swallow and some of his food dribbled out of the left side of his mouth. The nurse also had to remind him to swallow before drinking more of the med pass and he lets it dribble out of the L (left) side of his mouth. Resident has had a 12 pound wt loss in the last month. Will write a note to MD to follow up on this. Review of a nutrition note on 02/10/2020 revealed Resident #63's weight was down 7.5% or 13 pounds in 30 days. In an interview on 02/21/2020 at 10:50 AM, Staff K, NAC stated, He can feed himself but like today I had to help him. It was like he was distracted. Staff K confirmed the resident needed one person physical assistance for feeding and did not consistently feed himself. Review of a nutritional note on 02/25/2020 at 9:56 AM, showed the resident's weight was 161.2 pounds and he had lost 6.0 % or 10.2 pounds in 30 days. Review of the HS (bedtime) snack documentation 02/01/2020 to 02/26/2020 showed the resident refused the HS snack all but four nights. There was no follow up as to a possible different snack that Resident #63 would accept. Review of Resident #63's meal intake from 01/14/2020 through 02/27/2020 showed : 0-25%= 49 meals 26-50%=27 meals 51-75%=22 meals The nutritional supplement was offered only 4 of the 76 meals indicated times and the amount consumed was less than ordered on those occasions. In an interview on 02/05/2020 at 10:56 AM, Resident #63 stated he tried to eat on his own and did not want the tube feeding again. He said The first thing staff told me when I came here was not to pull on it or it would hurt and the first thing they do is pull it out. He also said he was interested in getting his teeth fixed. In observations on 02/06/2020 at 10:50 AM, 11:51 AM and 1:17 PM, the resident was observed with no food or fluids present. In observations on 02/07/2020 at 4:55 AM, 5:50 AM, 7:07 AM, Resident #63's lips were dry. He had no fluids at bedside. At 8:26 AM, the resident was in the dining room receiving meal assistance. At 11:13 AM, Resident #63 was in his room sliding down in his wheelchair. No fluids were available. In an observation on 02/12/2020 at 2:50 PM, the resident stated he thought he was losing weight and staff had to help him eat. He said he was not very hungry, his mouth was dry with long mucousy strings. In an observation on 02/21/2020 at 8:36 AM, the resident was in the dining room with his breakfast in front of him. No one was providing meal assistance. Staff K, NAC, was the only staff present at the table with five other residents in need of meal assistance. According to Staff K, the restorative aide came on at 10 AM and helped at lunch but that he just had to assist residents during breakfast. In an observation on 02/25/2020 at 8:20 AM, 1:10 PM and 2:27 PM, the resident was sitting in the hallway, with dry lips. During multiple observations on all days of survey, there were no fluids at bedside. In an interview on 02/25/2020 at 12:28 PM, the DNS was informed of nutrition concerns and weight loss with the need for more assistance in the dining room. Additionally, the nutrition care plan was not revised when Resident #63 was off tube feed and required meal intake to meet his nutritional needs. The DNS said he is was on NAR and we are looking at him. We are going to call the daughter as he is not able to meet his nutritional needs without the tube feeding. He does not want his peg tube. No additional information provided. In an interview on 02/26/2020 11:40 AM, Staff Q, RD was informed of concerns the resident had dry mouth, lack of fluids in between meals, lack of quiet environment and assistance in the dining room with subsequent weight loss. Staff Q stated, He does not want the tube feed he has told me that. As soon as his tube feed came out abruptly, we tried to do Cal Dense (nutritional shake) in between meals, tried to supplement like a tube feed and added vitamins. Staff were to push minimum 1500 ml in between meals and offer fluids in between meals. She said nursing was doing weekly NAR and she met with him again. She stated, Tube feed was providing 1800 calories a day and abruptly gone so he would lose weight. He likes ice cream but we cannot give him because of texture we offer a magic cup supplement. I really wanted them to push supplements for calorie and protein dense OJ too and fortified foods. She confirmed she did not revise care plans. RESIDENT #30 Resident #30 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of her Quarterly MDS, dated [DATE], revealed Resident #30 required extensive assistance of one for eating, and did not reject care. Review of the nutrition care plan last revised 01/04/2019 showed Resident #30 enjoyed comfort foods such as peanut butter flavored items and coffee, and her favorite meal was breakfast. The care plan directed staff to alternate bites/sips-small bites-slow rate-use small metal spoon when assisting resident with feeding presenting in midline-place cup in hand to encourage self feeding. Resident being followed by IDT in NAR, implement recommendations as she allows to encourage optimal PO intakes. Review of the 05/22/2019 Annual MDS Nutritional Status CAA showed Resident #30 was on a regular diet with drinkable puree texture and required encouragement and cueing. Review of the Medication Administration Records for 2019 and 2020 directed staff to provide House med pass 2.0 (nutritional supplement) 240 ml in a coffee cup three times daily. Review of the MAR indicated [REDACTED]=76 meals 26-50% of meal eaten=4 meals 51-75% of meal eaten=2 meals Resident #30 was offered meal replacement on 22 of 80 indications for consuming less than 50 % of her meal. Review of the physician's orders [REDACTED]. On 03/01/2019, Resident #30 weighed 149 pounds. Her last previously recorded weight was on 02/04/2020 at 139.0 pounds. In observations on 02/06/2020 at 10:41 AM, Resident # 30 was up in her wheelchair in the Solarium requesting water. At 11:54 AM, she was in the dining room asleep. In observations on 02/07/2020 at 7:57 AM, she was in the hall drinking a health shake out of a disposable cup instead of a coffee cup. She tried to eat her disposable cup and the nurse intervened. At 8:22 AM, Resident #30 was in the dining room. Her food was served but she was not initiating eating. There were no staff present. At 11:16 AM, the resident was sitting in the he solarium and stated I love breakfast. I eat everything. In observations on 02/10/2020 at 8:27 AM, Resident #30 was in the dining room awaiting breakfast. At 1:06 PM, the resident was in the dining room. Her food and drinks were untouched. There was a chair by her but no one assisted. In observations on 02/11/2020 at 8:56 AM, the resident was in the dining room. Her drinks were 1/2 full and she ate 40% of her breakfast. In observations on 02/12/2020 at 8:20 AM and 12:12 PM, Resident #30 was in the dining room asleep in her wheelchair. In an observation on 02/13/2020 at 8:20 AM and 8:50 AM, Resident #30 was in the dining room asleep. There was no staff by her, and the resident's yogurt, cereal, health shake and 2 glasses of juice were untouched. In an observation on 02/19/2020 at 8:23 AM, the resident was in the dining room asleep, her liquids were completely untouched, and there was no staff by her. In an observation on 02/20/2020 at 8:18 AM, Resident #30 was in the dining room asleep. Her meal was untouched and no staff were around to assist her. In an observation on 02/21/2020 at 1:02 PM, the resident was in the dining room, her food and liquids were untouched. There was no staff offering assistance. In an

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F 0692 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 17) observation on 02/24/2020 at 8:33 AM, Resident #30 was in the dining room with staff leaning over her who then left, and the resident's breakfast was untouched. In an observation on 02/28/2020 at 11:57 AM, Resident #30 was in the dining room with juice in front of her but she did not initiate to drink it, and no staff was present. In an interview on 02/19/2020 at 12:11 PM, Staff K, NAC stated All she does is drink health shakes. She does not eat food. She will drink apple juice, cranberry juice the vast majority is apple juice. She is on liquidized diet. You put fluids up to her lips and she will take it. In an interview on 02/25/2020 at 12:10 PM, The DNS was informed the resident had orders for Health shakes 240 ml three times daily but was not receiving this as ordered or consistently. She was also informed weekly weights were not being obtained. A recent weight was requested but not provided. In an interview on 02/26/2020 at 11:27 AM, Staff Q, RD was asked about Resident #30's weight loss and lack of adequate nutrition intake, including the need for more meal assistance. Staff Q stated, She seems to be stable. She has been stable, she fluctuates which is normal . RESIDENT #59 The resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident was alert with some confusion. Review of the resident's clinical record, revealed the resident's weights to be as follows: On 12/19/2019, the resident weighed 165lbs On 01/06/2020, the resident weighed 153lbs On 01/24/2020, the resident weighed 138.6lbs On 02/06/2020, the resident weighed 138lbs On 02/07/2020, the resident weighed 138lbs On 02/21/2020, the resident weighed 134lbs Review of the resident's admission Minimum Data Set (MDS) assessment dated [DATE], the MDS showed that the resident required supervision, oversight, encouragement or cueing for eating. Review of the resident's Kardex (care directives for the nursing assistants) documented: Modified independent after set up for eating. The Kardex erroneously documented the resident ate independently. In an observation on 02/05/2020 at 08:58 AM, the resident was observed in her room, with her breakfast tray in front of her. The resident had only eaten a few bites, there was no staff in the room supervising or encouraging the resident to eat. The resident was asked about her breakfast, the resident stated, oh, I think I am done. On 02/18/2020 at 1:50 PM, the resident was delivered her lunch food tray to her room and left on her bedside table, no assistance or encouragement was provided to the resident. The resident ate a few bites of her meal and then fell asleep. In an observation on 02/24/2020 at 10:27 AM, the resident was observed in bed, the resident had her breakfast tray in front of her, she had only eaten about 3 bites of toast. No staff was in the resident's room encouraging or cueing the resident to eat. On 02/24/2020 at 10:24 AM, in an interview with Staff Z, a nursing assistant, Staff Z stated that the resident was served her meals in her room, no assistance or encouragement was provided to the resident because the resident was independent with eating. Staff Z further stated that he used the information on the resident's Kardex to provide the resident care. On 02/24/2020 at 11:36 AM, in an interview with Staff C, the resident care manager, Staff C stated she was responsible for creating the resident's care plan, when asked about the resident's MDS information regarding eating, and the discrepancy of the care plan, Staff C stated she would look into it. Staff C was asked about the resident's weight loss and the lack of encouragement/cueing being a contributing factor, Staff C did not offer any more information. This is a repeat deficiency from SOD dated 02/13/19. Reference: (WAC) 388-97-1060 (3)(h)
F 0698 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure consistent ongoing communication and collaboration with the [MEDICAL TREATMENT] facility regarding care and services for one of one residents (#12) reviewed for [MEDICAL TREATMENT]. This failure had the potential to cause unmet care needs, medical complications, inadequate quality of care and a diminished quality of life. Findings included . A review of the facility's [MEDICAL TREATMENT] policy, titled [MEDICAL CONDITIONS], Care of a Resident with updated October 2010, showed that residents with [MEDICAL CONDITION] will be cared for according to currently recognized standards of care . Resident #12 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Record review of the Quarterly Minimum Data Set assessment dated [DATE] revealed the resident was cognitively intact. Record review of the comprehensive care plan with the goal date of 06/18/2018 revealed the care plan lacked resident centered interventions and collaboration of [MEDICAL TREATMENT] care by the nursing home and [MEDICAL TREATMENT] staff. The care plan did not indicate what care or medications the facility would provide, nor what care the [MEDICAL TREATMENT] center would provide. Additionally, there was no direction to staff on how to address [MEDICAL TREATMENT] treatment refusals. Review of the form titled [MEDICAL TREATMENT] Communication Form dated from 12/04/2019 through 02/26/2020 showed Resident #12 had incomplete assessment information on 14 of the 31 dates reviewed excluding her refusals: --12/09/2019 showed the facility's pre-assessment and post-assessment were not completed. --12/16/2019 showed the facility's pre-assessment and post-assessment were not completed. --12/20/2019 showed the post bleeding assessment was incomplete. --12/24/2019 and 12/26/2019 revealed no [MEDICAL TREATMENT] documentation from the facility nor the kidney center. --01/04/2020 showed no post-assessment. -01/20/2020 and 01/22/2020 revealed no [MEDICAL TREATMENT] documentation from the facility nor the kidney center. --01/27/2020 showed no pre-assessment. --02/10/2020 showed the facility's pre-assessment and post-assessment were not completed. -02/12/2020 and 02/15/2020 revealed no [MEDICAL TREATMENT] documentation from the facility nor the kidney center. -02/21/2020 showed no pre-assessment. -02/24/2020 revealed no [MEDICAL TREATMENT] documentation from the facility nor the kidney center. In an interview on 02/10/2020 at 3:04 PM, The Director of Nursing Services (DNS) stated she was unsure if the resident was on a fluid restriction. In an interview on 02/25/2020 at 2:20 PM, the DNS acknowledged the missed communication between the kidney center and facility and missing components of the care plan. In an interview on 02/28/2020 at 12:07 PM, Staff D, Staff Development Coordinator /LPN, said facility staff begin the [MEDICAL TREATMENT] communication paperwork and the kidney center always sends the paperwork back. He stated the facility staff were responsible to complete the pre and post [MEDICAL TREATMENT] assessments. No additional information was provided. Reference: (WAC) 388-97-1900 (5)(c)
F 0700 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assess, obtain physician orders, resident/representative consent, educate and develop care plan/care directives for the use of bedrails (side rails) for four of four residents (#59,#60, #12 and #63) reviewed. This failure had the potential to place residents at risk for injury and diminished quality of life. Findings included . Review of the facility's policy titled, Restraint and Device Guideline dated 11/15 noted: When a safety device is determined to be needed to provide a safe environment for the resident the RCM or designee will: A. Complete or update the Safety Device Assessment B. Notify the Physician of evaluation and obtain needed order. The order will include: -Why the device is needed -Type of safety device being used C. Notify resident and/or Representative - The responsible party may give consent over the phone to a Licensed Nurse. The form will be completed and check box marked for Telephone/verbal consent D. Initiate the evaluated safety device and provide resident education as needed E. Initiate Care plan and update status sheet F. Document information on the 24 hour report and update treatment record as indicated. G. Document in progress notes: - Why the device is needed, what had previously been attempted - Notification of Physician, resident, responsible party - The resident was placed on Alert and information was placed on the 24 hr report. - Risk benefits were explained and informed consent reviewed and consent obtained RESIDENT #59 On 02/13/2020 at 12:16 PM, the resident was observed to have bilateral quarter side rails on her bed. The resident stated the rails had been on her bed since she admitted to the facility. Review of the resident's clinical record revealed the resident did not have a physician order, consent, an assessment or care planned for the side rails. On 02/14/2020 at 10:34 AM in an Interview with the Staff C, the resident care manager, verified the resident did not have a physician order, consent, an assessment or care plan for the side rails RESIDENT #60 The resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident stated the rails had been on his bed since he admitted to the facility. On 02/12/2020 at 11:16 AM, the resident was observed to have bilateral side rails on his bed. Review of the resident's clinical record revealed the resident did not have a physician order, consent, an assessment or care plan for the side rails. On 02/14/2020 at 10:34 AM in an interview with the Staff C, the resident care manager, verified the resident did not

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	505296	A. BUILDING _____ B. WING _____	03/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST FRANCIS OF BELLINGHAM	3121 SQUALICUM PARKWAY BELLINGHAM, WA 98225

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F 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 18) have a physician order, consent, an assessment or care planned for the side rails. RESIDENT #12 was admitted to the facility on [DATE]. In an interview and observation on 02/04/2020 at 9:58 AM, Resident # 12 was in her room. Her bed had a left side rail. In an interview on 02/25/20 at 12:20 PM, the Director of Nursing Services (DNS) was informed the resident only had a left side rail and her safety device assessment showed bilateral side rails were initiated on 09/27/2019. The consent was obtained late on 01/23/2020, four months after side rails were in place. In a follow up interview on 02/27/20 at 2:43 PM, the DNS said Resident #12 had bilateral side rails but puts one down to watch TV. RESIDENT #63 Resident #63 was admitted to the facility on [DATE] with upper and lower extremity impairment on one side. In an observation and interview on 02/05/2020 at 11:10 AM, Resident # 63 was observed with bilateral bed canes and bolsters at the end of his bed. He said they were in place to Keep me inside the ride at all times. He commented the bolsters could be cold at times when he rolled over and it would cause him to back up quickly. Review of the clinical record showed no assessment, physician order, or care plan for the devices. The 01/13/2020 safety assessment was for a bolster mattress and tilt in space wheelchair. The assessment did not address the bed canes nor include alternatives attempted prior. In an interview on 02/25/2020 at 12:28 PM, the DNS was informed the resident had bilateral bed canes and also bilateral bolsters with no bed cane consent, no order or care plan for these devices. No additional information was provided. In an interview on 02/28/2020 at 12:05 PM, Staff D, Licensed Practical Nurse/Staff Development Coordinator, stated the process for side canes/rails was a therapy evaluation, safety device assessment, care plan, consent from resident or responsible party if they are not oriented and a physician order [REDACTED]. No additional information provided. This is a repeat deficiency from 02/13/2019. Reference: (WAC) 388-97-1060 (g)
F 0712 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that the resident and his/her doctor meet face-to-face at all required visits.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that physician visits were completed timely for two of five residents (#43 and #134) reviewed for physician visits. This failure placed the residents at potential risk for delayed treatment or unmet medical needs. Findings included . Review of facility policy titled Physician visits skilled nursing facility dated 11/11/2005, showed that a physician shall see each resident at least once every 30 days for the first 90 days after admission and then visits much be at least once every 60 days thereafter. After the initial visit, at the option of the physician, visits may alternate between the physician and one of the following: Physician assistant, Nurse practitioner, Clinical nurse specialist. Resident #134 admitted to facility under his Medicare benefit on 8/20/2019. The resident was seen by the physician on 08/26/2019. The resident was then seen by the Nurse practitioner on 09/27/19 and again on 10/22/2019. Resident #134 was not seen by the physician again until 11/07/2019, which did not alternate every other visit with nurse practitioner. Resident #43 was admitted to the facility on [DATE]. During review of the physician visits showed that the resident had been seen by the Nurse practitioner on 02/13/2019. Resident #43 was not seen by again by the physician and/or nurse practicioner until she was sent to the hospital on [DATE]. In an interview on 02/26/2020 at 10:43 AM, Staff M, Medical Record Director, confirmed that Resident #134 did not have alternating visits with nurse practitioner and that resident #43 had a four month period of time without any visits. Staff M was not able to provide any additional information regarding visits from either physician or nurse practitioner. Reference: (WAC) 388-97-1260 (4)(c), (6-7)(i-ii)
F 0725 **Level of harm** - Actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to 1) ensure there was sufficient numbers of nursing staff to provide care and services or provide adequate supervision to prevent accidents/elopements/wandering, 2) meet the needs or wants of the residents, 3) ensure all residents received showers, 4) answer call lights timely, 5) and to have enough staff to have consistent clinical systems in place to identify skin issues, bowel and bladder issues, restorative programs for two of two units reviewed for staffing. These failures caused harm for residents, placed residents at risk for unmet care needs and resulted in negative resident outcomes. Findings included . RESIDENT INTERVIEWS: RESIDENT #63 In an interview on 02/04/2020 at 12:13 PM, Resident #63's representative stated the resident had told her he had to wait a long time for staff to respond to his call light. RESIDENT #128 In an interview on 02/04/2020 at 2:02 PM, Resident #128 stated she had 45 minute wait times at times to get help, and stated it could be that long of a wait on any of the shifts. The resident stated she had only been at the facility for about two weeks. RESIDENT #45 In an interview on 02/05/2020 at 9:22 AM, Resident #45 stated there was not enough staff available, and sometimes there were only two people because the A wing gets most of the staff. The resident stated sometimes they get a light duty staff member and voiced concern for needing assistance with Hoyer lifts. The resident stated wait times were as long as 30 minutes, and voiced her roommate had negative outcomes due to waiting half an hour. In an interview on 02/07/2020 at 11:26 AM, Resident #45 stated she was supposed to receive assistance from female staff only, and on night shift there was only one male available. The resident stated males had been providing her care even though she was supposed to be assisted by female staff only. RESIDENT #59 In an interview on 02/05/2020 at 11:03 AM, Resident #59 stated it took a long time for someone to answer her call light when she turned it on for assistance. RESIDENT #18 In an interview on 02/05/2020 at 12:24 PM, Resident #18 stated there was not enough staff available to get the care and services he needed. RESIDENT #60 In an interview on 02/05/2020 at 2:03 PM, Resident #60 stated at times it took an hour to get his call light answered, and it happened on all shifts. RESIDENT #29 In an interview on 02/05/2020 at 2:23 PM, Resident #29's family stated they did not believe the facility had enough staff. The family member stated the nurses were constantly working double shifts, and the CNA's had to do double and triple shifts. The family member stated there was a long history of staffing concerns. The family member stated it was hard to find a staff member when they needed something. In an interview on 02/05/2020 at 3:08 PM, another family member of Resident #29 stated they did not think the staff knew the residents and stated they had be reminded of Resident #29's back fracture when turning her in bed. The family member stated they had to post a sign on the wall to remind staff of Resident#29's back fracture. The family member stated they were concerned because staff were coming to work coughing a lot and, did not feel ill staff should be around the resident's. RESIDENT #12 In an interview on 02/05/2020 at 2:33 PM, Resident #12 stated call light times ranged from five minutes to 30 minutes, depending on how many CNA's there were. The resident stated she did not think the facility had a handle on it with all the CNA's. RESIDENT #28 In an interview on 02/24/2020 at 3:22 PM, Resident #28 stated she had waited 30 minutes for assistance and resulted in her being incontinent and soaking her bed. In an interview on 02/26/2020 at 8:37 AM, Resident #28 stated that last night about 12:30 AM, she got sick and threw up in her bed. She stated she put her call light on and no one came for over half an hour. RESIDENT COUNCIL: In a resident council meeting, on 02/06/2020 at 11:32 AM, the group stated call lights being answered were an issue and that when they go down the hallways the call lights were lit up like a Christmas tree. The group stated getting showered was an issue. One member of the group stated she didn't get her shower yesterday, only on Sunday, and stated she complained and it did her no good. Another member of the group stated there were issues with getting timely assistance on and off the bedside commode. One group member stated there was a wandering resident that climbed into her roommate's bed and that staff would come and remove the wandering resident 20 minutes later. RECORD REVIEW: Review of the facility assessment, dated 06/30/2018 through 07/29/2019, showed the facility did not identify staffing needs related to resident population, care needs, and census. Review of daily staffing sheets, dated 10/09/2019-10/31/2019 showed the following: On 10/09/2019: Day shift B-wing showed four NACs (Nursing Assistant Certified) scheduled. Of the four scheduled, one was injured and one was light duty, leaving two fully capable NACs to care for residents on B wing. 10/11/2019: Day shift B-wing showed two NACs scheduled, whereas A-wing had four NACs. Night shift showed two NACs scheduled for A-wing, with one of the NACs listed as only working 11 PM- 4 AM. Leaving a total of three NAC'S for A and B wings. 10/12/2019: Night shift showed three NAC's scheduled for A wing, and two NAC's for B wing. One NAC called out on B wing, leaving one NAC scheduled for B wing. 10/16/2019: Day shift showed A and B wings to be scheduled with three NAC's each, totaling six. One NAC was moved from B wing to A wing, giving A wing four NAC's and leaving B wing with Two NAC's. 10/17/2019: Night shift showed two NAC's scheduled for A wing and one NAC scheduled for B wing. 10/18/2019: Night shift showed two NAC's scheduled for A wing and one NAC scheduled for B wing. 10/21/2019: Day shift showed 4 NAC'S scheduled for A wing, and three NAC's scheduled for B wing. A wing had a call out, and an NAC was pulled from B-wing to make four NAC's for A-wing, and

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F 0725 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 19) leaving two NAC's for B-wing. 10/22/2019: Day shift showed 4 NAC'S scheduled for A wing. Two NAC's called out, leaving two NAC'S for A wing. 10/23/2019: Evening shift showed five NAC's scheduled. Of the five NAC's scheduled to work A and B wing, one called out, one was not to arrive till 5 AM, and one was scheduled to leave at 5 AM, leaving three NAC's for A and B Wings. 10/24/2019: Night shift showed five NAC's scheduled. Of the five NAC's scheduled, one was scheduled until only 2 AM, and one was scheduled to arrive at 5 AM, leaving three NAC's for A and B wings for the hours of 2 AM till 5 AM. 10/25/2019: Night shift showed four NAC's scheduled. Of the four NAC's scheduled, one was scheduled until only 2 AM, leaving three NAC's for A and B wings. 10/26/2019: Evening shift for B-wing showed two NAC's scheduled as a third scheduled person was crossed out. 10/27/2019: Day shift showed for B-Wing one NAC called out leaving two NAC's for the day shift for B wing. 10/31/2019: Night shift showed four NAC's scheduled for A and B wing. One NAC scheduled for A-wing showed the one NAC worked until 2 AM, leaving three NAC's for A and B wing. Review of the daily staffing sheets, dated 02/03/2020-02/08/2020 showed the following: 02/06/2020: Night shift showed one NAC scheduled for B wing. 02/07/2020: Night shift showed one NAC scheduled for B wing. RESIDENT #129 Resident #129 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The resident sustained [REDACTED]. The falls occurred on the following dates: 01/18/2020, 01/29/2020, with two falls on 02/02/2020. After every fall, the facility was unable to get the resident off the floor and called emergency medical services (EMS) to assist with getting the resident up from the floor. In an interview on 02/25/20 at 1:22 PM, the DNS stated, she called EMS to help get the resident off the floor because the resident was obese and the staff were not able to get her up. The resident required many people to lift her up and during that time there was not enough staff to help. GRIEVANCES/RESIDENT COUNCIL: Review of resident council notes, dated 08/07/2019 through 02/19/2020, showed the following: * 08/07/2019: Showed under old business- concerns for call lights not being answered while staff were on breaks. Under new business showed concerns for call lights being turned off and not addressing residents' concerns/needs. Under issues to follow up, it showed concern for call lights- waiting, turning off, and not being answered. * 09/04/2019: Showed under new business- concerns for staff turning off call lights without addressing resident's needs. Under issues to follow up, call lights was listed. * 09/18/2019: Showed under new business- concerns for call lights and staff not leaving the call light on if not able to answer it right away. * 10/02/2019: Showed under old business- concerns for call lights being turned off and needs not being met. Under new business- concern for call lights. * 10/16/2019: Showed under old business- concerns for call lights. Under new business concerns for answering call lights for both residents in room not just one, and showers not getting done on scheduled days. * 11/02/2019: Showed under old business- concerns for call lights and answering call light for both residents in a room, medication pass being slow on night shift, and concerns for showers. Under new business shower schedule was listed. * 11/06/2019: Showed under old business- concerns for call lights being answered. Under New business showed call light concerns related to answering both residents in the room and not turning off call light without answering needs. Other new business concerns were medication pass being slow, personal issues with call lights, and shower schedules. * 12/04/2019: Showed under announcements- shower schedule addressed. New Business showed concerns for call lights- reminding staff to put within reach for residents * 12/18/2019: Under old business it showed concerns for call lights being in reach of residents. Under New Business it showed personal issue with shower schedule. * 01/08/2020: Showed under addressed prior concerns- of fixed time on call lights and showers are being done .Under New Business for Nursing it showed a complaint about time length left on the commode. * 02/12/2020: Showed under new business for nursing- concern for average call light response was 20 minutes to an hour long. Residents requested that there were two CAN's (Certified Nursing Assistant) on the floor at all times for both wings, and more communication between residents and their care programs. *02/19/2020: Showed under Nursing- concerns for being short staffed, nurses running behind on their cares and passing out medications. Concerns for residents not getting enough showers, one resident stated, I've gone over a month without a shower. Showed residents are entitled to get two showers a week, and most residents stating they were only getting one a week. Review of the grievance log, dated 08/07/2019 through 01/30/2020, showed the following: 08/07/2019: concerns for not getting showered. 08/14/2019: concern for staffing. 09/10/2019: three concerns from three different residents for not getting showered. 09/13/2019: concern for not getting showered. 09/16/2019: concern for not getting showered. 09/18/2019: concern for not getting showered and wearing the same socks for three days. 09/23/2019: concern for long call light response. 09/24/2019: concern for long call light response. 09/25/2019: concern for a 3.5 hour long wait for pain medications. 09/27/2019: concerns for not getting showered regularly. 09/27/2019: concern for long call light response and not getting showered. 10/04/2019: concern for call light response. 10/04/2019: concern for call light response. 10/16/2019: concern for call light response. 10/17/2019: concern for not getting showered. 10/19/2019: concern for not getting showered. 10/21/2019: concern for call light response. 11/06/2019: concern for call light response. 11/14/2019: concern for not getting needed Activity of Daily (ADL) care related to oral care. 11/15/2019: concern for call light response. 11/16/2019: concern for not getting showered. 11/19/2019: concern for not getting showered. 11/20/2019: concern for not getting medication timely. 12/04/2019: concern for receiving insulin medication late. 12/06/2019: concern for call light response. 12/06/2019: concern for not getting showered. 12/12/2019: concern for not getting showered. 12/12/2019: concern for call light response. 12/26/2019: concern for call light response. 01/03/2020: concern for not getting ADL care related to oral care. 01/03/2020: concern for not getting showered. 01/17/2020: concern for not getting ADL care. 01/24/2020: concern for call light response and customer service. 01/20/2020: concern for call light response. CALL LIGHT OBSERVATIONS: The following call light observations were made: 02/07/2020 4:59 AM: room [ROOM NUMBER] call light on. Call light answered at 5:20 AM. 02/07/2020 5:33 AM: room [ROOM NUMBER] call light on. Call light answered at 5:53 AM. 02/07/2020 6:20 AM: room [ROOM NUMBER] call light on. Call light answered at 6:52 AM. 02/07/2020 6:50 AM: room [ROOM NUMBER] call light on. Call light answered at 7:05 AM. 02/07/2020 7:00 AM: room [ROOM NUMBER] and 123 call lights on. At 7:13 AM, rooms 123 & 160 were still on, unanswered. 02/10/2020 1:12 PM: room [ROOM NUMBER] call light on. Staff were observed in the area and not answering the call light. At 1:31 PM, the call light was answered. 02/12/2020 at 8:20 AM: room [ROOM NUMBER] call light on. At 8:35 AM the call light was answered. 02/13/2020 at 8:21 AM: room [ROOM NUMBER] bathroom light on. No staff were observed to be in the area. Call light answered at 8:30 AM. 02/18/2020 at 1:33 PM: room [ROOM NUMBER] and 161 call lights on. The call lights were answered at 1:52 PM. 02/18/2020 at 3:00 PM: room [ROOM NUMBER] call light on. At 3:23 PM, the call light was answered. 02/19/2020 at 10:09 AM: room [ROOM NUMBER] call light on. At 10:32 AM, the call light was answered. 02/19/2020 at 11:33 AM rooms [ROOM NUMBERS] call light on. room [ROOM NUMBER] call light was answered at 11:58 AM. room [ROOM NUMBER] call light was answered at 12:04 PM. Residents waited 20-30 minutes before their call lights were answered. STAFF INTERVIEWS: In an interview on 02/07/2020 at 6:01 AM, Staff OO, NAC, stated last night he had 30 residents on his assignment, and stated this happened a lot of time on A-wing. Staff OO stated managing fall risk patients and caring for residents was overwhelming. Staff OO stated it was frustrating with only 2-3 staff members for 60 residents. Staff OO stated he had worked alone as the only NAC on B wing with 37 residents. In an interview on 02/07/2020 at 6:30 AM, an anonymous staff member stated that night shift can be overwhelming if something goes wrong. The anonymous staff member stated that they had to often work late to get through the medication pass on A-wing for the long term care residents. The anonymous staff member stated night shift could use another staff member as the staff member stated they felt they were spread thin. Staff stated last night they had one aide on the hall. In an interview on 02/07/2020 at 6:46 AM, Staff PP, RN, stated staffing could be better in the evening as evening shift could be tightly staffed. Staff PP stated they had asked for another nursing staff but there had been turn over. Staff PP stated last night, they had up until 3:30 AM, 3 aides for A wing with 55-57 residents, two aides on the floor and one doing one to one. Staff PP stated after 3:30 AM the one to one staff left. Staff PP stated they did not know why the aide left at 3:30 AM as Staff PP stated they were busy dealing with a patient in acute respiratory distress. Staff PP stated they thought the 1:1 resident could be in line of sight and was not aware the resident continued to require 1:1 supervision. In an interview on 02/07/2020 at 7:12 AM, Staff QQ, Nursing Assistant Registered (NAR), stated on night shift staffing was sparse in the amount of nursing aides working. Staff QQ stated it was stressful working night shift with only two aides instead of three. Staff QQ stated it was hard when people called out and someone had called out last night. In an interview on 02/07/2020 at 7:25 AM, Staff FF, RN, stated for night shift after 10:30 PM, there was usually only one nurse scheduled. In an interview on 02/14/2020 at 6:08 AM, Staff T, Registered Nurse (RN), stated Resident #32 had a heel wound that was bleeding last night and the dressing came off, so Staff T changed the dressing. Staff T stated she had been rushing all night with 40 patients on A-wing, and stated she did not feel like she did good wound care because the dressing wasn't really fitting the wound at all. Staff T stated she failed to put the resident's sock back on after the wound care. When asked why Staff T did not put on the resident's sage boots after the wound care as reqired, Staff T stated she relied on the NAC's for that, and stated she didn't put on the sage boots because she didn't think about it. Staff T stated she felt she needed further training in wound care. Staff T

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	505296	A. BUILDING _____ B. WING _____	**03/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST FRANCIS OF BELLINGHAM	**3121 SQUALICUM PARKWAY BELLINGHAM, WA 98225**

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F 0725 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 20) stated there was just so much to do, and when one thing happens it throws everything off and she could not get everything done. Staff T stated she was supposed to change the resident's coccyx wound dressing last night but she did not get to it with everything going on. In an interview on 02/14/2020 at 11:00 AM, Staff RR, NAC, stated there were not enough staff to provide residents with needed care. Staff RR stated in the mornings they only have about 10 minutes to provide resident's care and it was not enough time as some residents can take longer such as 25-40 minutes. Staff RR stated managing 10-12 residents was hard, and stated they did not feel they could do a good job for the residents. In an interview on 02/14/2020 at 11:58 AM, Staff NN, Shower Aide, stated she worked Thursday, Friday, and Sunday. Staff NN stated she did come in and do extra shifts. Staff NN stated she was the only shower aide on A-wing. Staff NN stated she did 17 showers on Thursdays, 10 showers on Fridays, and 10 showers on Sundays. Staff NN stated she did not know if someone did showers on the days she was off work, and stated she did not think there was anyone else scheduled to give showers that she knew of. Staff NN stated she had snow days and missed work on 01/10/2020 and 01/17/2020, and stated she did not know who did showers for the residents in her absence. Staff NN stated she also had to help with meals. She stated she had only gotten to three showers for the day and it was slow going because she could not find staff help for Hoyer transfers that take two people. Staff NN stated she would likely have to stay late to try and get showers done. In an interview on 02/14/2020 at 12:23 PM, Staff SS, RN, stated often times the NAC's were stretched very thin. Staff SS stated the NAC's try very hard but was hard when there was 3-4 call lights on at once. Staff SS stated it was very frustrating. In an interview and observation on 02/18/2020 at 1:39 PM, Staff TT, NAC, was observed passing hall trays on A wing. Staff J, RN, stated hall trays were delivered at 1:15 PM. When asked about staffing, Staff J, stated he only had 3 aides when they try to have 5 aides and a shower aide. Staff J stated staffing was hard and it made him want to pull his hair out. In an interview and observation on 02/18/2020 at 1:52 PM, Staff UU, NAC, was observed to still be passing lunch trays. Staff J, asked Staff UU for assistance to lay down a resident, and Staff UU stated she was told she couldn't help until all the trays were passed and picked up. In an interview on 02/19/2020 at 10:08 AM, Staff J, RN, stated he only had four aides for today. Staff J stated he was not sure about a shower aide and stated his residents were itchy from not being showered. In an interview on 02/20/2020 at 1:59 PM, Staff K, NAC, stated he only had four aides today but had started with five aides and a shower aide. Staff K stated the fifth aide had to be sent home because they were a Nursing Assistant Registered (NAR) that was over the 120 days and the NAR did not have an active license yet. In an interview/observation on 02/21/2020 at 8:36 AM, Staff K, NAC, was the only staff present at the dining room table with five other residents in need of meal assistance. He said the restorative aide came on at 10 AM and helped at lunch but he just had to do his best to help at breakfast. In an interview on 02/21/2020 at 11:46 AM, Staff VV, NAC, stated there was not enough staff. Staff VV stated they often had three staff members split between the two halls instead of 5 due to call offs. Staff VV stated they get caught up in situations and it was difficult to provide equal care for each resident. Staff VV stated it was overwhelming then they were constantly pulled in all different directions. Staff VV stated it was overwhelming when on the floor to provide care for people who needed assistance. In an interview on 02/21/2020 at 12:55 PM, Staff NN, NAC, stated she did not think there was enough staff. Staff NN stated she sometimes comes in and pick up additional shifts. Staff NN stated shower aides absolutely needed another person on B-wing as the shower aide often was pulled to the floor and the aides were too busy to realistically get all showers done. In an interview on 02/21/2020 at 1:05 PM, Staff WW, Activity Assistant, stated there were not enough staff, and stated they would benefit from additional staff. Staff WW stated if during an activity a resident wanted to leave, they would have to stop the activity and assist the resident back to their room. In an interview on 02/24/2020 at 10:54 AM, Staff J, RN, stated that, Today, I have 4 aides and one training. No shower aides. In an interview on 02/24/2020 at 1:48 PM, Staff J stated there were not enough aides at times. Staff J stated he had to stop medication pass to go help a resident as they might fall. Staff J stated he knew the aides were tired. For further information regarding staffing Refer to F 600 Refer to F 677 Refer to F 684 Refer to F 686 Refer to F 688 Refer to F 689 Refer to F 692 Refer to F 838 This is a repeat citation from complaint survey on 08/14/2019 and Annual survey on 12/04/2018. Reference: (WAC) 388-97-1080 (1)
F 0732 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**Post nurse staffing information every day.** Based on record review and interview, the facility failed to post the actual nursing staffing hours. This failed practice prevented the residents, family members and visitors from knowing the facility's actual number of available nursing staff. Findings included . Review of the facility's posted Daily Staffing Report showed only projected nursing staffing hours. The report did not have the actual adjustments documented to reflect the nursing staff absences on each shift due to call-offs or illness. In an interview on 02/14/2020 at 10:37 AM, Staff H, Receptionist, stated the Daily Staffing Hours sheet had not been adjusted when staff call off. The posting was of the scheduled projected nursing hours, not the actual current hours. No reference WAC.

F 0756 **Level of harm -** 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 interview and record review, the facility failed to ensure they had effective Medication Regimen Review (MRR) processes for 7 of 10 residents (#32, #29, #12, #20, #30, #3, and #68) reviewed. The failure: 1) to ensure all residents had MRRs conducted monthly, 2) to ensure medical providers documented rationales for declining Gradual Dose Reductions (GDR), 3) to ensure the consultant pharmacists conducted comprehensive MRRs to ensure pertinent resident issues and irregularities were addressed in the MRRs, 4) to ensure GDRs were done or considered, as required by regulation, 5) to ensure irregularities were acted on in a timely manner, and 6) to ensure adverse side effects of medications were accurately detected, documented, reported, and appropriately resolved in a timely manner, all placed residents at risk for medication-related adverse outcomes. Resident #32 was harmed when the facility and/or pharmacist failed to identify polypharmacy of multiple psychoactive medications, identify somnolence and lethargy as possible side effects of psychoactive medications, and when the pharmacist did request GDR, the facility did not provide rationale of why GDR did not occur. After several months of treatment with multiple [MEDICAL CONDITION] and opioid medications, the resident was no longer able to walk, feed herself, communicate effectively, and became incontinent of bowel and bladder. These declines led to heel and coccyx pressure injuries, left hand/wrist contracture, weight loss and she had multiple falls. Findings included . RESIDENT #32 The resident admitted to the facility on [DATE]. The resident had [DIAGNOSES REDACTED]. According to the resident's admission Minimum Data Set (MDS) assessment, dated 05/23/2019, she had severe cognitive impairment, and for activities of daily living (ADLs) she required only limited assistance with bed mobility, transfers and personal hygiene and required only supervision with eating and walking. For bowel and bladder, the MDS indicated she was occasionally incontinent of urine and always continent of bowels. Review of the quarterly MDS, dated [DATE], revealed severe cognitive impairment, and for ADLs, she required extensive assistance of 1-2 persons with bed mobility, transfers, and personal hygiene. Walking did not occur during this MDS time period. For bowel and bladder, the MDS indicated she was always incontinent of bowel and bladder. Review of the Admission Nursing Data Base (nursing assessment), dated 05/16/2019: -weighed 153.8 lbs -was always continent of bowel and bladder, -had no pressure ulcers, -had a pleasant mood. Review of the May 2019 Medication Administration Records (MARs), revealed in May, she had been started on [MEDICATION NAME] (an antipsychotic medication) for unspecified [MEDICAL CONDITION], [MEDICATION NAME] (an antidepressant medication)for [MEDICAL CONDITION], and she was receiving [MEDICATION NAME] (an opioid pain medication) for pain. Review of the June 2019 MARs revealed the resident's [MEDICATION NAME] got re-ordered, the [MEDICATION NAME] dosing was increased (multiple times), and [MEDICATION NAME] (mood stabilizer/anticonvulsant medication) was added for unspecified [MEDICAL CONDITION], and the [MEDICATION NAME] was continued. Review of the MARs for 2019 and 2020 revealed ongoing treatment with [MEDICAL CONDITION] medications and [MEDICATION NAME] as follows: -[MEDICATION NAME] 50 mg (milligrams) daily at 9 AM - 06/20/2019 - 01/03/2020 -[MEDICATION NAME] 100 mg daily at 3 PM - 06/21/2019 - 01/03/2020 -[MEDICATION NAME] 100 mg daily at 9 PM - 06/20/2019 - 01/03/2020 -[MEDICATION NAME] (multiple dose changes, starting in June 2019) 250 mg twice daily at 9 AM & 1 PM - 07/25/2019 - ongoing as of 02/06/2020 -[MEDICATION NAME] 500 mg daily at 9 PM, 07/24/2019 - ongoing as of 02/06/2020 -[MEDICATION NAME] 25 mg daily at 9 PM - 05/29/2019 - 02/12/2020 -[MEDICATION NAME] PRN (as needed) - 06/25/2019 - 01/03/2020 A Nurse Practitioner note, dated 06/06/2019 indicated Resident #32 had dementia with hallucinations and behaviors, exit seeking, wandering and sundowning, and going into other resident's rooms. The resident was diagnosed with [REDACTED]. Pain is controlled, stable for now. A Nurse Practitioner note, dated 07/31/2019 stated that Resident #32 had late Alzheimer's

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F 0756

Level of harm - Actual harm

Residents Affected - Some

(continued... from page 21)
dementia, behavior problems, wandered a lot, was getting into people's room, a little agitated occasionally, needed frequent redirection and occasionally one-on-one supervision. Also evaluating for fracture of left wrist with routine healing. Independent with feeding, assist with dressing and hygiene, mixed incontinent of bowel and bladder. She had a large blister on heels, she is independent with ambulation, no concerns with that. She looks well-nourished, no evidence of pain. Plan: Late Alzheimer's dementia, associated with increased anxiety, frequent agitation and frequent redirection, very confused, wandering around, sundowning and occasionally one-on-one supervision, patient has been seen by psych nurse, currently on [MEDICATION NAME], no change. She is at her baseline. The note did not indicate that the resident's Seroquesl doses had already been increased several times, and did not explain what necessitated the treatment with [MEDICATION NAME] Resident #32 was now on. In a Nurse Practitioner note, dated 09/20/2019, it stated that Resident #32 was lethargic, not real responsive, more wheelchair bound, and had dementia with behavioral disturbance. Patient appears to be stable on [MEDICATION NAME] and [MEDICATION NAME] at this time. Continue [MEDICATION NAME] 50 mg tab once daily as well as [MEDICATION NAME] 500 mg once daily. The note did not mention anything about the ongoing treatment with [MEDICATION NAME] (that had side effects of drowsiness/sedation) and [MEDICATION NAME] (which the resident was taking to aid sleep). The note did not address potential side effects of [MEDICATION NAME] (side effects included drowsiness, tiredness, lack of energy) or [MEDICATION NAME] (side effects of extreme drowsiness, dizziness, weakness) either. According to a Nurse Practitioner note, dated 09/25/2019, Resident #32 was still not ambulating as the resident had been in the past. According to a doctor note, dated 10/17/2019, Resident #32 was going to receive ongoing medical management for chronic pain, and a history of psychiatric disorders. [MEDICATION NAME] and [MEDICATION NAME] were to be continued. Although nurse practitioners notes dated 10/30/19, 11/29/19, and 12/04/19 indicated the resident was lethargic, had low blood pressure, had increased sleepiness throughout the day, and had overall decline, weakness, low energy, and decline in cognition, the nurse practitioner did not address the potential side effects of medications, and the resident remained on Seroqel, [MEDICATION NAME], Trazadone, [MEDICATION NAME]. The sleep monitored showed Resident #32 was sleeping 8-13 hours every day. In a nurse practitioner note, dated 01/07/2020, it was identified the resident had increased sleepiness, and weight loss, and was on [MEDICATION NAME] three times every day. The note indicated pain medications were made routine. Adjustments to [MEDICATION NAME] have been ineffective and patient remains extremely tired. Will discontinue midday [MEDICATION NAME]. We will also down titrate [MEDICATION NAME] to twice daily dosing. This nurse practitioner started the resident on a second antidepressant to stimulate the appetite, as the resident was already on an antidepressant as a sleep aid. Nurse Practitioner notes, dated 01/14/2020 and 02/04/2020 identified the need to reduce medictations to help improve extreme sleepiness and change in condition, and now the resident had pressure injuries along with weight loss. A 01/09/2020 Nursing Care Note by Nurse Manager showed that Resident #32 had a change in condition as follows: The resident was unable to sit upright in her wheelchair, speech therapy had difficuletу evaluating the resident due to the resident's lethargy and difficulty staying awake during meals. When awake, the resident had difficulty eating and swallowing her food. Report from NOC (night) nurse resident sleeps throughout the night with zero difficulty. Resident mobility has declined drastic where she is now w/c (wheelchair) bound and hoyer transfer lift and dependent with feeding. Noted even with a decrease of her medications, resident is still very sleepy with difficulty staying awake. .Reached out to social services to get in contact with son POA (Power of Attorney) to discuss changing current POLST (Physician order [REDACTED]). Nurse manager called this day with no answer and will follow up with son again to discuss and review current POLST status and possibly hospice as an option. Primary care provider aware of resident change and declining condition. Passed on report and care plan updated r/t resident decline in condition. Resident added on alert charting for decline in condition. CONSULTANT PHARMACIST MONTHLY MEDICATION REGIMEN REVIEW (MRR) REPORTS REVIEWED Dated 08/20/2019 - an irregularity was identified by the pharmacist related to [MEDICATION NAME] for sleep she was on since 05/19, the pharmacist notified the physician that a gradual dose reduction (GDR) should be considered, the resident's physician/nurse practitioner continued the medication with no change, the required rationale was left blank. Dated 09/26/2019 - an irregularity was again identified related to the ongoing treatment with [MEDICATION NAME] for sleep, and a recommendation was made to consider a GDR. The rest of this form was blank, there was no documentation the resident's physician/nurse practitioner had ever even seen it, it was never acted on. Dated 10/25/2019 - the resident's name was on a list of other residents that were reviewed by the consultant pharmacist, but did not require any recommendations. The resident had been noted by her nurse practitioner/physician to be lethargic, not ambulating as she had in the past, more wheelchair bound, yet no recommendations/irregularities identified by the consultant pharmacist. November 2019 - No MRR found in clinical record. There was a note in PCC (PointClickCare (electronic health record)), Pharmacist Acknowledgement, dated 11/19/19, that no irregularities noted. Even though the past few months doctor/nurse practitioner notes reflect lethargy, not extremely responsive at this time, more wheelchair bound, somnolent (sleepy), yet there were no irregularities identified by the consultant pharmacist. Dated 12/23/2019: the pharmacist wrote resident was due a GDR for [MEDICATION NAME] and [MEDICATION NAME]. The pharmacist note indicated if current therapy was to be continued, please provide a brief risk vs benefit assessment for state survey. The nurse practitioner wrote we are down titrating for sleepiness, but did not state which medication/s were being down titrated. STAFF INTERVIEWS In an interview on 02/12/2020 at 12:28 PM, the Director of Nursing Services (DNS) and Staff B, Licensed Practical Nurse (LPN)/Resident Care Manager, and later Staff A, Social Services, Staff C, Registered Nurse (RN) and Staff FF, RN, joined the interview after the DNS left the room, were interviewed: -Staff B stated medication adverse side effects were to be documented in progress notes. When asked whether medications had been assessed to see if medication side effects were contributory to the resident being wheelchair-bound and lethargic, the DNS and Staff B did not answer that question, Staff A stated the resident was still having hundreds of behaviors. When asked about the 08/20/2019 MRR that had no rationale documented for the pharmacist's GDR request, the staff interviewed were unable to provide any information. When asked about the 12/23/2019 MRR that requested a risk vs benefits assessment for the current [MEDICAL CONDITION] medication regimen, they were unable to provide any information. When asked about the many doctor/nurse practitioner notes that listed somnolence and lethargy as a problem and the relative lack of documentation regarding this in nurse progress notes, staff interviewed were did not provide any information. The DNS stated that the facility documented the presence of adverse side effects by exception, Staff FF stated there was not a space to document adverse side effects in the behavior monitors. When asked about the resident's change in condition in late September 2019 when she needed more assistance with ADLs, Staff C stated it manifested with the resident not being ambulatory and needing more assistance with cares. Staff C stated they changed pharmacists about that time. When asked about the 12/23/2019 MRR that listed three medications, and the nurse practitioner wrote We are downtitrating for sleepiness, but it did not list what was being downtitrated, Staff were unable to provide any information what was being downtitrated. When asked if the physician had documented Lowest effective dose - No GDR order, for any of the resident's medications, staff were unable to provide any information. In an interview on 02/12/2020 at 3:23 PM Staff GG, Advanced Registered Nurse Practitioner (ARNP): Staff GG stated her medical group took over the resident's care in August/September 2019, and the resident was still ambulatory then. Staff GG stated that she thought the resident actually worked at the facility. She stated she thought the resident was typically a sleepy person, and she thought that was due to the resident's [MEDICAL CONDITION], then she transitioned over to long-term care, and she didn't need to be seen for 30-60 days, then 5-6 weeks ago she seemed more sleepy, so she took a look at her medications and started to make adjustments, but she didn't make any adjustments until just recently when she started to look at her stuff. Staff GG stated she kept the resident on her [MEDICATION NAME] for sleep, even when she was somnolent because she was not sleeping at night, and that she was considering sundowning (a symptom of [MEDICAL CONDITION] also known as late-day confusion, confusion and agitation can worsen in late afternoons and evenings). Staff GG stated she did not get a lot of reports on that (from nursing staff). She stated she worked closely with Staff CC (Mental Health Nurse Consultant)(who's last progress note was dated 08/27/2019). When asked if nursing staff had been reporting any side effects of the [MEDICAL CONDITION] medications, Staff GG stated No, I don't get a detailed report of that. When asked what the [MEDICATION NAME] was treating, Staff GG stated to treat the behaviors and [MEDICAL CONDITION] from the dementia, as she would refuse cares, and she had a distrust. When asked if [MEDICATION NAME] was known to be effective at treating behaviors and [MEDICAL CONDITION] from dementia, Staff GG stated she didn't like using it for that, but that the resident was already on a lot of [MEDICATION NAME] when she took over her care. Staff GG said if the facility needed her at the GDR meetings, then she should be invited to them. When asked about the 08/20/2019 MRR with no GDR being done, and no documented rationale for no GDR, Staff GG stated she went with the nursing input, that she had been getting better at documenting rationales. When asked about the pharmacist's request for a risk vs benefit assessment on the 12/23/2019 MRR, Staff GG stated she didn't do one, but she has started doing them recently. She stated she didn't do a GDR for the [MEDICATION NAME] because staff told

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F 0756 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 22) her the resident was awake all night, and sleepy during the day. When asked about the resident's current physical condition, unable to walk, unable to self transfer, needed a hoyer lift for transfers, couldn't feed herself, all things she could do when she admitted to the facility, Staff GG stated the resident was very deconditioned right now. When asked about the ongoing pain management with all of the [MEDICATION NAME] for so long, Staff GG didn't have any information to offer. When asked if the resident was still having postoperative wrist pain, Staff GG stated she didn't know for sure, she stated she thought the resident's pain was all over. She stated the resident wasn't really talking much. Staff HH, physician/Medical Director, joined the interview. Staff HH was asked about the facility's adverse side effect monitoring program, he stated they relied heavily on self-report from the nurses. Staff HH said they go by what the nurses reported to them. In a phone interview on 02/18/2020 at 10:01 AM, Staff R, Consultant Pharmacist, and Staff S, Consultant Pharmacy Clinical Manager stated we were notified of the IJs related to [MEDICAL CONDITION] medications and opioids, we made a 300+ page report, there were many responses to pharmacy recommendations, a lot of recommendations that were not addressed or responded to appropriately, we sent some back to the facility for review, we met over the weekend with the facility and two providers. We had repeated recommendations that weren't addressed appropriately, so we spoke with the nursing director and a corporate representative, they did not know why the MRRs were not responded to. If MRRs were not responded to, we may make a repeat recommendation, or we may speak with facility staff. -Staff R stated that the first month he did MRRs, he met with the DNS, but he didn't get follow up until the next month, so he had no trends, especially with recommendations that were not followed up on. Staff R stated we are now implementing a percentage rate for what recommendations that were followed up on. When asked asked what was done if there was a recommendation for a GDR and the physician declined without documenting a rationale, Staff R stated that he reminded the nurse managers that rationales need to include some kind of concrete details, especially related to behaviors residents exhibited. When asked if it's an expectation that rationales were completed, Staff S stated in their meetings, they emphasized that just saying no to a GDR was not good enough, that they encouraged concrete details in the documentation. He stated they tried to draw the line without being too intrusive, but at the same time they did need information, and Risk vs Benefit should also be specific and customized. When asked what was the facility's system for monitoring for potential adverse side effects of medications, Staff R stated unfortunately, I am not familiar with their systems, I haven't gotten to the details of where they track side effects. When asked if the facility had notified them of concerns with this resident, the pharmacist staff answered Yes, I looked into it, I reviewed her my first month in December, then I sent a GDR letter because of the multiple [MEDICAL CONDITION] she was on. Then in 01/20 it looked like the [MEDICATION NAME] was being changed and monitored by the provider, I can't speak to going back, but the providers response in 12/19 was downtitrating. Staff stated multiple [MEDICAL CONDITION] can trigger hypersomnolence, so that could be an impact, I can't speak to hypersomnolence. When asked if this combination of [MEDICAL CONDITION] and opioids could have contributed to the multiple declines in her functional abilities, Staff S stated Thank you for that question, antipsychotic medications and the other drugs may see some additive effects on side effects, it is difficult unless there is a cause/effect relationship, unless there is a timeline, it is best to withdraw one medication at a time, if they withdraw one at a time and a side effect comes up, then there might be evidence the medication was causing harm. In a phone interview on 02/21/2020 at 8:22 AM, Staff CC, Registered Nurse/Mental Health Nurse Consultant (Behavioral Health), when asked about all of the potential side effects the resident was exhibiting like lethargy, somnolence, wheelchair-bound, etc .Staff CC stated that those side effects were not brought to my attention. Staff CC stated The facility did not notify me of any side effects, I would have of course looked into it. Is it the fault of the medications, I can't say that, I just don't know if that decline was related to medications. I have no way of knowing if her decline was related to medications. There were many concerns of putting her on medications and continuing to increase the doses. I was still coming to the building, but no one ever asked me to see her again. In an interview on 02/26/2020 at 9:26 AM, Staff N, RN/Minimum Data Set nurse, was asked about the significant change back in 09/19, Staff N stated we noticed she needed more care, because when she first admitted she was walking around more, but then she wasn't, she went from mostly continent to frequently incontinent, then to incontinent, she started sleeping more, and she needed more extensive assistance. In summary, this facility's medication management program failed Resident #32. When the resident admitted to the facility she was able to communicate effectively, walk, feed herself, to get herself in/out of bed, usuallly continent of urine, and always continent of bowels, she had no skin injuries, and she had no contractures. After about six months in the facility, of [MEDICAL CONDITION] medications and opioid pain medications, she was no longer able to walk or communicate, she required staff assistance with eating, she was incontinent of bowel and bladder, she had two skin injuries, she had a contracture in her hand/wrist, and she had significant weight loss. There was an extended period of time where the resident was somnolent and lethargic, but staff did not recognize and respond timely to potential side effects of medications. There were issues with: 1) [MEDICAL CONDITION] Medications Reviews not being accurate and comprehensive, 2) a lack of GDRs for [MEDICAL CONDITION] medications, 3) MRRs that failed to flag and identify issues/irregularities pertinent to medication management, 4) physician/nurse practitioner failures in addressing MRR irregularities and documenting rationales for declining pharmacist recommendations, 5) inadequate facility medication adverse side effect monitoring practices, 6) a lack of physician involvement in addressing medication-related adverse side effects. Overall, the resident exhibited many signs of adverse side effects that went unaddressed for months. These issues were not identified and timely addressed by the facility, nor was there documentation that the consultant pharmacists were fulfilling their roles as consultants in improving facility medication management systems. RESIDENT #29 The resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to her quarterly MDS, dated [DATE] she was rarely/never understood, had delusions, got antipsychotic medications and opioids, and was on hospice care. CONSULTANT PHARMACIST MRR REPORTS REVIEWED: Multiple requests were made of staff for MRRs for this resident all the way back to 01/01/2019, the facility was unable to provide MRRs for 03/19, 04/19, 05/19, 06/19, and 09/19. If the resident's medication regimens were reviewed by a consultant pharmacist for those months, the reports were not made available to the survey team. -MRR dated 8/20/2019, the pharmacist notified the physician that the PRN [MEDICATION NAME] (antianxiety medication) order duration was limited by regulations to 14 days, the provider wrote a rationale the resident was very debilitated and near end of life care, and continued the order for an additional 90 days. -MRR dated 12/23/2019: the pharmacist notified the physician that the PRN [MEDICATION NAME] was limited to 14 days, the physician continued the order for 99 more days and wrote in hospice pt (patient). -MRR dated 12/26/2019, the pharmacist notified the physician the resident was on three [MEDICAL CONDITION] medications and was due for a GDR, the physician agreed with the [MEDICATION NAME] GDR and wrote for that, but did not address [MEDICATION NAME] or Quetiapine. A note on the form indicated the resident was averaging 10-12 hours of sleep a night. -MRR dated 02/14/2020, the pharmacist wrote the resident was on four [MEDICAL CONDITION] medications and required GDRs. The note indicated per behavior monitoring records: there has been no documented behaviors of anxiety (nervous agitation, excessive worry), being physically or verbally aggressive, or delusions and resistance to cares/meds, and that per IDT (interdisciplinary team) meeting on 02/17/2020 hospice resident, defer to hospice. Another form with the same date indicated: Please note, hospice may not be an adequate rationale for state survey purposes. Review of [MEDICAL CONDITION] Medication Review forms: -Dated 09/21/2019: revealed staff had documented the last GDR for [MEDICATION NAME] was 4/08/2019. Review of the April 2019 MARs for that date revealed the dose of [MEDICATION NAME] was actually increased on that date. On that same review, staff did not list any other potential contributing factors, like pain, or medication interactions, even though the resident was being treated with [MEDICATION NAME] and [MEDICATION NAME] (both opioid pain medications). The review had a note, under recommendations, that the pharmacist was going to write a letter requesting a decrease of [MEDICAL CONDITION] medications now that the resident was on hospice, the letter could not be located in the clinical record. Staff A was asked about the letter, she stated that would have gone to nursing, she stated she didn't know about the letter as it was pretty much out of my hands. In an interview on 02/21/2020 at 10:31 AM, Staff A confirmed there was not a [MEDICATION NAME] GDR on 04/08/2019, she stated I can fix that. Staff A reviewed the resident's clinical record and determined the last [MEDICATION NAME] GDR was 02/16/2019, so it had been over a year since the resident had a [MEDICATION NAME] GDR. Staff A stated we need to look at that again (the [MEDICATION NAME] for GDR). Staff A did not know if the resident's doctor had written an order that the [MEDICATION NAME] was at the Lowest Effective Dose. Staff A was asked about pain, and why was it not listed as a potential contributing factor, she stated I think I just need to slow down to make sure I do them right. We reviewed the 06/11/2019 [MEDICAL CONDITION] Medication Review, and it also did not have pain listed as a potential contributing factor. PROGRESS NOTE REVIEW -dated 12/24/2019, revealed on 09/25 pharmacist wrote a letter requesting decrease of [MEDICAL CONDITION] meds now that she was on hospice but it had yet to be initiated. Recommending decreasing [MEDICATION NAME] to 250mg twice daily. Review of this medication revealed [MEDICATION NAME] was not decreased until

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	505296	A. BUILDING _____ B. WING _____	03/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST FRANCIS OF BELLINGHAM	3121 SQUALICUM PARKWAY BELLINGHAM, WA 98225

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 0756 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 23) 01/08/2020. -06/11/2019 - [MEDICAL CONDITION] Med Review -IDT recommendation to continue to monitor and review next qtr. The quarterly review did not address adverse side effects of the medications, although it was identified that on two days the resident was leaning over in her wheelchair, tired PAIN EVALUATIONS REVIEWED Dated 03/18/2019: pain evaluation was incomplete, it did not list all of the pain medications Resident #29 was on, [MEDICATION NAME] (non-steroidal anti-[MEDICAL CONDITION] drug used to decrease pain and inflammation) was omitted. The evaluation did indicate the resident received scheduled [MEDICATION NAME] and [MEDICATION NAME], but it did not indicate whether they were effective or if there were side effects (per the form's instructions). The resident was also receiving PRN [MEDICATION NAME], but that medication was omitted from the pain evaluation. There were no comments regarding the overall pain evaluation and whether it was effective or not. On 06/13/2019: the pain evaluation was incomplete, it indicated she received scheduled [MEDICATION NAME], and [MEDICATION NAME], but it did not state if there were side effects. Summary: There was no documentation a consultant pharmacist had did MRRs for five months in 2019 for this resident. There was also a lack of consultant pharmacist documentation they had reviewed this resident's pain evaluations or [MEDICAL CONDITION] medication reviews done by nursing. The consultant pharmacist also failed to identify that the resident had not had a GDR for [MEDICATION NAME] for over one year. Additionally, the resident had potential medication related side effects, but this did not get identified on any monthly MRRs. RESIDENT #12 Review of the facility's pharmacy recommendations showed there were no recommendations for April 2019 through September 2019. A pharmacy recommendation, dated 10/21/2019, showed the pharmacist recommended decreasing [MEDICATION NAME] and [MEDICATION NAME]. On 12/10/2019, 50 days later, the recommendation was addressed. In an interview 02/25/2020 at 12:15 PM, the DNS confirmed there were missing reports and the 10/21/2019 recommendation was addressed late. RESIDENT #20 Review of the facility's pharmacy recommendations showed there were no recommendations for March 2019 through July 2019, October 2019 and November 2019. A pharmacy recommendation, dated 08/20/2019, showed the pharmacist recommended decreasing the [MEDICATION NAME]. The recommendation failed to include a rationale for no change, documenting stable only. RESIDENT #30 A pharmacy recommendation, dated 08/20/2019, showed the pharmacist recommended decreasing the Duloxetine. The recommendation failed to include a rationale for no change, documenting stable chronic condition only. In a similar 12/23/2019 recommendation to decrease the Duloxetine, the recommendation was not dated and did not include documentation as to why the recommedation was rejected. In an interview 02/25/2020 at 12:16 PM, the DNS confirmed there were missing reports and the 08/20/2019 recommendations did not include a rationale for no change and was addressed late. RESIDENT #3 Resident #3 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Annual Minimum Data Set assessment (MDS), dated [DATE], showed that Resident #3 was moderately cognitively impaired, suffered from delusions (misconceptions or beliefs that are firmly held, contrary to reality). During review of monthly pharmacy reviews for February 2019 through February 2020 revealed that there had not been monthly review completed for the months of September 2019 and November 2019. During a joint interview & record review on 02/27/2020, Staff BBB, Regional Director of Clinical Services verified that there were no pharmacy consults for September 2019 or November 2019 in the clinical record and was unable to provide any further information. RESIDENT #68 Resident #68 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of a Pharmacy recommendation, dated 01/11/2019, showed a pharmacist recommended that the discontinuation of Memantine ([MEDICATION NAME]) medication, Resident #68 was receiving for dementia. The physician acknowledged this recommendation and confirmed order to discontinue on 01/11/2019. Review of Medication Administration Records (MAR's), dated January 2019, February 2019, March 2019, April 2019 and May 2019, showed that Resident #68 received the Memantine medication for approximately 5 months after the order was discontinued. Review of Pharmacy acknowledgment in the clinical record, dated 02/11/2019, showed no irregularities noted. The resident was still receiving a medication that should have been stopped in January 2019. Further review showed that there were no pharmacy acknowledgments completed in the clinical record for 03/2019, 04/2019, 05/2019, 06/2019, 07/2019, 08/2019 or 09/2019. During a joint interview & record review on 02/24/2020 at 3:08 PM, the DNS confirmed that Resident #68 had a pharmacy recommendation from January 2019 that was not followed up on until May 2019. The DNS verified that the medication memantine for dementia should have been stopped 01/11/2019 and the resident continued to receive the medication until 05/09/2019. The DNS further stated that she would review this concern and follow up with me but was unable to provide any further information at time of interview and did not follow up with any additional information during survey. Reference: (WAC) 388-97-1300 (1)(c)(iii)(iv)(4)(c)(d) CFR 483.45 (d)(1-6): F757 - Drug regimen is free from unnecessary drugs. CFR 483.45(c)(3)(i-iv)(e)(1-5: F758
F 0757 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure two of seven residents (#32, #29) remained free of unnecessary drugs. Failure to: 1) ensure opioid pain medications were used for the shortest duration necessary, 2) to provide comprehensive medication side effect monitoring, 3) to evaluate the presence of adverse consequences which indicated opioid pain medications may need to be reduced or discontinued, 4) to respond timely to the presence of potential medication-related adverse side effects (ASEs), 5) to consider the impact of side effects of [MEDICAL CONDITION] medications in a resident who also experienced similar side effects of opioid pain medications, 6) to perform accurate and comprehensive pain evaluations, 7) to ensure the consultant pharmacist identified medication-related irregularities and performed monthly Medication Regimen Reviews (MRRs), 8) to ensure residents that received [MEDICAL CONDITION] medications had comprehensive [MEDICAL CONDITION] medication reviews that took pain management into consideration, and 9) to not increase opioid pain medications in a resident who was already identified as having somnolence/lethargy that was already adversely impacting her life. Resident #32 was harmed when the facility failed to respond when she exhibited potential medication-related ASEs and the facility continued to treat her with the same medications for several months. Then, even after the resident had been identified as being lethargic & somnolent, the facility increased her [MEDICATION NAME] (opioid pain medication) which resulted in even more sedation. On admission, the resident was able to walk, able to communicate effectively, able to feed herself, and she had no skin pressure injuries. After several months of treatment with multiple [MEDICAL CONDITION] and opioid medications, the resident was no longer able to walk, no longer able to communicate effectively, no longer able to feed herself, no longer able to get in/out of bed, she developed heel and coccyx pressure injuries, she developed a left hand/wrist contracture, she developed significant weight loss, she had declined in her bowel and bladder continence, she had decreased activity participation, and she had multiple falls. These failures resulted in an Immediate Jeopardy (IJ) related to multiple failures in medication management for Resident #32 and for other residents. An IJ was called on 02/13/2020 at 2:18 PM. The facility: -had the consultant pharmacist review each resident's medication regimens and meet with the Interdisciplinary Teams (IDTs) and physicians regarding irregularities, -had the nurse managers and Director of Nursing Services (DNS) review and complete comprehensive pain assessments on each resident on opioid medications and consulted with physicians for further review and medication adjustments, -had staff assess and evaluate each resident on opioid medications for appropriate [DIAGNOSES REDACTED]. This all resulted in removal of the IJ on 02/28/2020 at 12:45 PM. Findings included . DEFINITIONS: Adverse side effects/consequences of medications: [REDACTED]. It may include various types of adverse drug reactions or interactions (e.g. medication-medication, medication-food, and medication-disease). Side effects of opioid medications include: drowsiness, weakness or lack of energy, lightheadedness, dizziness, headache, constipation, nausea and vomiting, itching, dry mouth, and trouble falling or staying asleep. Side effects of Antipsychotic medications include: movement disorders, blood pressure fluctuations, drowsiness, elevated pulse, sedation, dizziness, blurred vision, [MEDICAL CONDITION], dry mouth, nausea, constipation, urine retention, blood disorder, headaches, weakness, jaundice, agitation, restlessness, slurred speech, anorexia, rash, confusion, unsteady gait, frequent falls, refusal to eat, difficulty swallowing, depression, [MEDICAL CONDITION], social isolation, diarrhea, fatigue, [MEDICAL CONDITION], loss of appetite, weight loss, muscle cramps, vomiting, behavioral symptoms not usual to the person. Side effects of antidepressant medications include: constipation, hand tremors, blood cell abnormalities, arrhythmias, sedation, confusion, excitement, blurred vision, rash, dry mouth, dry eyes, [MEDICAL CONDITIONS], jaundice, psychotic episodes, anxiety, [MEDICAL CONDITION], weight loss, nervousness, loss of appetite, suicidal ideation, mood change, change in normal behavior, hallucinations/delusions, social isolation, decline in ability to help with/do ADLs (activities of daily living), no voiding, rigid muscles, difficulty ambulating, balance problems, accidents, dizziness, falls, movement problems, tremors, diarrhea, fatigue, weight loss, muscle cramps. Side effects of mood stabilizer medications include: extreme drowsiness, fatigue, muscle aching or weakness, dry mouth, constipation or diarrhea, loss of appetite, nausea, skin

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F 0757

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 24)

rash, headache, dizziness, tremors, abdominal pain, and upset stomach. RESIDENT #32 The resident admitted to the facility on [DATE] for rehabilitation after having a fall at home resulting in a left wrist fracture. On admission the resident had [DIAGNOSES REDACTED]. According to the resident's Admission Minimum Data Set (MDS) assessment, dated 05/23/2019, she had severe cognitive impairment, and for activities of daily living (ADLs) she required only limited assistance with bed mobility, transfers and personal hygiene. The MDS indicated she required only supervision with eating and walking. For bowel and bladder, the MDS indicated she was occasionally incontinent of urine and always continent of bowels. Review of the Quarterly MDS, dated [DATE], revealed severe cognitive impairment, and for ADLs, she required extensive assistance of 1-2 persons with bed mobility, transfers, and personal hygiene. Walking did not occur during this MDS time period. For bowel and bladder, the MDS indicated she was always incontinent of bowel and bladder. Review of the Admission Nursing Data Base (nursing assessment), dated 05/16/2019 found the following: -Resident #32 had clear speech, -weighed 153.8 lbs -was always continent of bowel and bladder, -had no pressure ulcers, -had a pleasant mood. Review of a progress note, dated 05/17/2019 at 1:43 PM, revealed the resident stated she wanted to return home with her spouse. Review of a progress note, dated 05/22/2019 at 3:37 AM, revealed the resident was on alert for inappropriate behaviors, exit-seeking, and for the fall. She could not recall events from the previous day, and was oriented to self, but not time, place or situation. She denied pain and had constant episodes of confusion. Review of a progress note, dated 05/28/2019 at 2:30 PM, revealed the resident was very mobile and had difficulty following tasks and cueing safely. Resident #32's son reported she had been living with her significant other alone in an apartment and had a history of [REDACTED]. The facility discussed with the resident's family that it was felt she would not be safe to return home, and the recommendation was for 24/7 care and she would benefit from placement in an adult family home or in a memory care setting. Review of the May 2019 Medication Administration Records (MARs), revealed in May, she was started on [MEDICATION NAME] (an antipsychotic medication) for unspecified [MEDICAL CONDITION], [MEDICATION NAME] (an antidepressant medication) for [MEDICAL CONDITION], and she was receiving [MEDICATION NAME] (an opioid pain medication) for pain for 10 days. Review of the June 2019 MARs revealed the resident's [MEDICATION NAME] got re-ordered, the [MEDICATION NAME] dosing was increased (multiple times), and [MEDICATION NAME] (mood stabilizer/anticonvulsant medication) was added for unspecified [MEDICAL CONDITION], and the [MEDICATION NAME] was continued. Review of the MARs for 2019 and 2020 revealed ongoing treatment with [MEDICAL CONDITION] medications and [MEDICATION NAME] as follows: -[MEDICATION NAME] 50 mg (milligrams) daily at 9 AM - 06/20/2019 - 01/03/2020 -[MEDICATION NAME] 100 mg daily at 3 PM - 06/21/2019 - 01/03/2020 -[MEDICATION NAME] 100 mg daily at 9 PM - 06/20/2019 - 01/03/2020 -[MEDICATION NAME] (multiple dose changes, starting in June 2019) 250 mg twice daily at 9 AM & 1 PM - 07/25/2019 - ongoing as of 02/06/2020 -[MEDICATION NAME] 500 mg daily at 9 PM, 07/24/2019 - ongoing as of 02/06/2020 -[MEDICATION NAME] 25 mg daily at 9 PM - 05/29/2019 - 02/12/2020 -[MEDICATION NAME] PRN (as needed) - 06/25/2019 - 01/03/2020 -[MEDICATION NAME] changed from PRN, to a scheduled basis, three times daily on 01/03/2020. PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN'S ASSISTANT NOTE REVIEW: A hospital discharge summary, dated 05/16/2019 revealed the pain management plan included orders for [MEDICATION NAME] as needed for pain X 10 days with a physician note stating patient does require opioid pain medicine for this hospital diagnosis, pain medicine to be managed upon discharge by PCP (primary care physician), the usual duration of need for opioid pain medicine for this condition is 4-5 days. The discharge rders did not include [MEDICAL CONDITION] medications. A doctor note, dated 05/20/2019 stated patient was readmitted (to the hospital) for altered mental status and her pain was well-controlled with [MEDICATION NAME]. As per PT and OT (physical therapy and occupational therapy), patient was transferred to skilled nursing rehab for deconditioning and unsteady gait. Denies any pain. Assessment: presented with left wrist fracture, status [REDACTED]. A Nurse Practitioner note, dated 05/22/2019 stated dementia, anxiety, pleasantly confused, she seems to be very comfortable with her pain scale. She did not manifest any pain on assessment. Continent of bowel and bladder. A Nurse Practitioner note, dated 06/06/2019 stated chief complaint: routine follow-up [MEDICAL CONDITION], dementia with hallucinations and behaviors. Assessment: late onset [MEDICAL CONDITION], [MEDICATION NAME] will be initiated, she has been seen by psychiatry. [MEDICATION NAME] and adjust her regimen and follow-up with psych's recommendation if need be. Pain is controlled, stable for now. A Nurse Practitioner note, dated 06/10/2019 stated objective: left hand swelling with pain, Review of systems: psychiatric: positive for agitation, behavioral problem, confusion, decreased concentration, depressed mood, hyperactive and memory loss, Assessment: Late onset [MEDICAL CONDITION]. According to a Nurse Practitioner note dated 07/31/2019, Resident #32 had no evidence of pain, yet the resident continued to receive [MEDICATION NAME]. The resident continued on pain medication, although there was no indication the resident was assessed to require pain management. The previous provider note was six weeks prior. A Physician Assistant note, dated 08/01/2019 did not address treatment with [MEDICATION NAME], the provider did write to start [MEDICATION NAME] 400 mg every eight hours, however, review of the August 2019 MARs revealed it did not get started. Progress notes review revealed, there was no documentation in the progress notes to explain why the [MEDICATION NAME] was not initiated. In a Nurse Practitioner note dated 09/20/2019, there was no mention about the ongoing treatment with [MEDICATION NAME] (that had side effects of drowsiness/sedation) and [MEDICATION NAME] (which Resident #32 was taking to aid sleep). The note did not address potential side effects of [MEDICATION NAME] (side effects included drowsiness, tiredness, lack of energy) or [MEDICATION NAME] (side effects of extreme drowsiness, dizziness, weakness) either. According to Nurse Practitioner notes dated 09/25/19, 10/30/19, 12/04/19, and 01/03/2020 and a doctor note dated 10/17/19, Resident #32 was lethargic, hypersomnolent, not ambulating, wheelchair bound, with pressure ulcers, and had significant weight loss, and a general decline was noted. Although the resident's pain was not assessed in these notes, one note stated the resident did not ask for pain medication, however, [MEDICATION NAME] was increased. Although side effects from Ocycodone use included drowsiness, dizziness, nausea/vomiting and lack of energy, this resident's dosage was increased from PRN doses in 12/19 to routing at 3X daily. In addition, Nurse Practitioner notes dated 01/14/2020, 01/22/2020 and 02/04/2020 described the resident's general decline to include weight loss and pressure injury, lethargy, wheelchair bound, there were no pain assessments, yet the resident remained on narcotic pain management regime, along with antipsychotic medications. Further reviews of facility progress notes, on 08/14/19 a note indicated [MEDICATION NAME] was now being used for unresolved back pain, although there was no evidence of a pain assessment. In a Social Services note describing the interdisciplinary team (IDT) recommendations for the resident's care plan, side effects to medications was not addressed. The 08/29/2019 progress note stated that the resident was showing signs and symptoms of pain, however the resident was unable say where the pain was. It wasn't clear how the pain was assessed. The resident was on multiple antipsychotice drugs, was weak, and had general decline needing more assistance, sleeping more and was lethargic and there were some reported falls (see 09/01/19, 09/17/19, and 10/28/19 progress note). Further review of progress notes indicated staff attempted to give the resident Tylenol as well. According to a 11/29/19 note, the resident complained of pain and was unable to say where the pain was, there was no documentation to show how the resident was assessed to have pain. Further progree note reviews showed that on 12/20/19 Resident #32 was found on the floor, and on 12/25/19 was noted as refusing to wake up for medication. According to progress notes dated 01/04/2020 and 01/05/2020, Resident #32 had [MEDICATION NAME] held for increased sleepyness and the staff documented that there were no adverse side effects to the medications. In addition, the 01/06/2020 progress note stated Resident #32 was now on an increased dose of [MEDICATION NAME], although the note also stated that the resident was sleeping most of the time and staff documented no adverse side effects. There was no indication the resident required [MEDICATION NAME] for pain management. In a progress note dated 01/06/2020 at 9:52 PM, it stated [MEDICATION NAME] give 5 mg by mouth three times a day for pain, hold for hypersomnolence. Resident has been sleeping since dinner time. According to the January 2020 MARs, [MEDICATION NAME] was given although Resident #32 had been sleeping. After [MEDICATION NAME] was held, a 01/07/2020 at 12:47 PM showed that the resident was able to bet up in a wheel chair, was awake and more alert. However, after taking her medications was put back to bed at 10:00 AM that morning. The note further stated that Resident #32's medications were held at noon time including [MEDICATION NAME] and that the ARNP was to be notified for possibly reducing the [MEDICATION NAME]. According to progress notes dated between 01/08/2020 and 01/15/2020, Resident #32's [MEDICATION NAME] was held related to increased sleepiness. On 01/16/2020, an order was written to discontinue the AM dose of [MEDICATION NAME] related to the resident's sleepiness throughout breakfast meal. The resident was more alert and awake after the narcotic pain medications were held according to the p;rogress notes, and the documentation showed there was no breakthrough pain. According to 01/21/2020 progress notes, Resident #32 was given Tylenol for pain. Review of consultant pharmacist monthly medication regimen review (MRR) for reports between August and September 2019 showed that there was no documentation to address the ongoing treatment with [MEDICATION NAME], even though it was originally prescribed for acute pain related to the wrist fracture on admission in May 2019. On 10/25/2019, the resident's name was on a list of other residents reviewed by the consultant pharmacist, and did not require any recommendations. The resident had been noted by

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F 0757 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 25) her nurse practitioner/physician to be lethargic, not ambulating as she had in the past, more wheelchair bound, yet no recommendations or irregularities were identified by the consultant pharmacist, related to sedation or pain. On November 2019, no MRR was found in Resident #32's clinical record. There was a note in PCC (PointClickCare (electronic health record)), pertaining to a Pharmacist Acknowledgement, dated 11/19/19, that showed no irregularities noted. Although recent progress notes from doctor/nurse practitioner reflect lethargy, not extremely responsive at this time, more wheelchair bound, somnolent, yet there were no irregularities identified by the consultant pharmacist during November 2019. On 12/23/2019: the pharmacist wrote: resident was due a GDR for [MEDICATION NAME] and [MEDICATION NAME]. The pharmacist note indicated if current therapy was to be continued, please provide a brief risk vs benefit assessment for state survey. The nurse practitioner wrote we are down titrating for sleepiness, but did not state which medication/s were being down titrated. There was nothing documented about lethargy, somnolence, hypersomnolence, more wheelchair bound, not ambulating as was stated in the past provider notes. In the pharmacist note dated 08/20/2019 there was no mention of contributing factors like pain or medication interactions, even though there were spaces for this on the review. Resident #32 was started on Opioid pain medication for acute pain, then the opioids were extended for months. The IDT recommended no changes in [MEDICAL CONDITION] medications. In a note dated 11/16/2019, the facility marked No, under the question Are there signs/symptoms of medication side effects? Resident #32 was now wheelchair bound and not ambulating, somnolent, lethargic, and had four falls that quarter, yet no medication side effects were marked. Pain and medication interactions were not marked as potential contributing factors, and the IDT recommended no changes. In a note dated 02/21/2020 the facility documented as follows: -Medication side effects: Are there any signs/symptoms of medication side effects? Facility marked No, although the resident had experienced side effects since the November 2019 review, experienced significant weight loss, hypersomnolence, lethargy, was wheelchair-bound, could no longer walk, could no longer feed herself, and could no longer transfer herself, and the facility had been decreasing her [MEDICAL CONDITION] medications and her [MEDICATION NAME] for pain. The review said her weight is stable, and behaviors still consistent, when she had no behaviors because she was unable to do anything for herself anymore. PAIN EVALUATIONS REVIEWED: In a note dated 05/16/2019 the facility documented as follows: Question: Should pain assessment interview be conducted? No. There were no indicators noted of pain or possible pain. There were no comments noted. Resident #32 discharged from the hospital to the facility in May 2019 with an order for [REDACTED].? No. -Question: Over the past 5 days, has pain made it hard for you to sleep at night? No. -Question: Over the past 5 days, have you limited your day-to-day activities because of pain? No. -Pain intensity: Unable to answer. For pain management, there was very little information documented. The resident was on scheduled Tylenol every six hours, however, the pain assessment had no information whether that was effective. Resident #32 was also receiving [MEDICATION NAME] every six hours as needed, yet there was a section on the Pain Evaluation for PRN pain medications, but it was blank, the facility provided no information. This pain evaluation was lacking information to show why the resident was continued on [MEDICATION NAME] for pain, when she was admitted in May 2019 with acute pain related to her fractured wrist/surgery, and was to receive [MEDICATION NAME] for 10 days for the acute pain. Now according to the facility documentation, the resident required opioid pain medications for two months and it was continuing. In a note dated 08/21/2019 the facility documented as follows: -Question: Should pain assessment interview be conducted? No. -Received scheduled pain medication regimen, describe treatment? . the facility response was no side effects, The resident was taking Tylenol every six hours, but this information was not included in the pain assessment, and the effectiveness of the Tylenol was not addressed. Resident #32 received PRN [MEDICATION NAME] as needed every six hours, there was no side effect information documented regarding this in the assessment. In a note dated 11/14/2019 the facility documentation showed that Resident #32 was receiving [MEDICATION NAME] as needed every six hours, the pain evaluation form indicated side effects and effectiveness were to be documented regarding this PRN pain regimen, however, there was no documentation to indicate effectiveness of the pain medication, or of any side effects, although, the resident was experiencing somnolence, lethargy, and was wheelchair-bound, yet no assessment of potential side effects. OBSERVATIONS In random observations on 02/04/2020, the resident was observed asleep in bed. In an observation on 02/05/2020 at 9:46 AM, the resident was asleep in bed. In an observation on 02/05/2020 at 10:22 AM, the resident was asleep in bed. In an observation on 02/19/2020 at 8:41 AM, the resident was being fed breakfast by a staff member at the assisted table in the dining room. In an observation on 02/19/2020 at 12:37 AM, the resident was in the dining room, a staff member was helping her to drink by holding a glass to her mouth. In an observation on 02/20/2020 at 9:02 AM, the resident was in the dining room, a staff member was feeding her by bringing the silverware to her mouth. STAFF INTERVIEWS In an interview on 02/12/2020 at 12:28 PM, the Director of Nursing Services (DNS) and Staff B, Licensed Practical Nurse (LPN)/Resident Care Manager, and later Staff A, Social Services, Staff C, Registered Nurse (RN) and Staff FF, RN, joined the interview after the DNS left the room, were interviewed: Staff B stated medication adverse side effects were to be documented in progress notes. She stated the side effects to be monitored for medications were listed on resident care plans. In reviewing the resident's care plan (print date 02/06/2020), staff were to monitor for side effects of [MEDICATION NAME] and [MEDICATION NAME] (two medications the resident had not been on while in the facility), but none were listed for [MEDICATION NAME]. For [MEDICATION NAME], the only side effect listed on the care plan was constipation, it did not list any other side effects. Staff were asked whether medications had been assessed to see if medication side effects were contributory to the resident being wheelchair-bound and lethargic, the DNS and Staff B did not answer that question, Staff A stated the resident was still having hundreds of behaviors. Staff were asked about the lack of information documented on the 05/16/2019 Pain Evaluation, they were unable to provide any information. Staff were asked about the lack of information on the 08/21/2019 Pain Evaluation, they were unable to provide any information. Staff were asked about the lack of information on the 11/14/2019 Pain Evaluation, and what pain was being treated, they were unable to provide any information. Staff were asked about the many doctor/nurse practitioner notes that listed somnolence and lethargy as a problem and the relative lack of documentation regarding the nurse progress notes, they were unable to provide any information. The DNS stated that the facility documented the presence of adverse side effects by exception, Staff FF stated that there was not a space to document adverse side effects in the behavior monitors. Staff were asked about the four shifts in June 2019 with no pain assessment documented, they were unable to provide any information. Staff were asked about the resident not being able to ambulate anymore, Staff C stated when the resident first admitted she was ambulatory until about the end of October 2019, then she was moved over from rehab to the long-term care wing. Staff were asked about the resident's change in condition in late 09/19 when she needed more assistance with ADLs, Staff C stated it manifested with the resident not being ambulatory and needing more assistance with cares. Staff C stated they changed pharmacists about that time. Staff were asked about the limited nursing documentation in the progress notes related to the resident's lethargy and hypersomnolence, they were unable to provide any information. Staff were unable to provide any information about what pain was being treated or what necessitated the ongoing treatment with [MEDICATION NAME], even though she was admitted with a plan for [MEDICATION NAME] for only 10 days. to treat acute pain. In an interview on 02/12/2020 at 3:23 PM Staff GG, Advanced Registered Nurse Practitioner (ARNP): Staff GG stated her medical group took over the resident's care in August/September 2019, and the resident was still ambulatory then. Staff GG stated she thought the resident actually worked at the facility. Staff GG thought the resident was typically a sleepy person, and she thought that was due to the resident's [MEDICAL CONDITION], then she transitioned over to long-term care, and she didn't need to be seen for 30-60 days, then 5-6 weeks ago she seemed more sleepy, so she took a look at her medications and started to make adjustments. Staff GG stated she kept the resident on her [MEDICATION NAME] for sleep, even when she was somnolent because she was not sleeping at night, and that she was considering sundowning (a symptom of [MEDICAL CONDITION] also known as late-day confusion, confusion and agitation can worsen in late afternoons and evenings). She stated she did not get a lot of reports on that (from nursing staff). She stated she worked closely with Staff CC (Mental Health Nurse Consultant), whose last progress note was dated 08/27/2019. Staff GG was asked about the resident's current physical condition, inability to ambulate, unable to self transfer, needing a Hoyer lift for transfers, inability to feed herself, all things she could do when she admitted to the facility. Staff GG stated the resident was very deconditioned right now. Staff GG was asked if the resident was getting better from the treatment with all of the [MEDICAL CONDITION] medications, she stated the resident was the same, that she didn't see her very much because she went to long-term care, from rehab, and that she trusted the staff to know what to monitor for and what side effects to monitor for. Staff GG was asked about the ongoing pain management pertaining to the long term use of [MEDICATION NAME] for acute pain related to a wrist fracture and surgery, and she didn't have any information to offer. When asked if the resident was still having postoperative wrist pain, Staff GG stated she didn't know for sure, she stated she thought the resident's pain was all over. She stated the resident wasn't really talking much. Staff HH, physician/Medical Director, joined the

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	505296	A. BUILDING _____ B. WING _____	03/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST FRANCIS OF BELLINGHAM	3121 SQUALICUM PARKWAY BELLINGHAM, WA 98225

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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 0757 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 26) interview. Staff HH was asked about the facility's adverse side effect monitoring program, he stated they relied heavily on self-report from the nurses. He didn't offer much information except to state they follow what the nurses reported to them. Staff HH was shown the admission pain evaluation with nothing documented, he stated he thought the resident hurt all over, and that some residents have pain just sitting in bed or in their wheelchairs. In an interview on 02/14/2020 at 10:10 AM, Staff E, RN, stated the resident wouldn't open her mouth for breakfast or medications that morning. She stated that was too bad because when the resident resided on the rehab wing she had a voracious appetite and staff would even buy her chips and sodas between meals, but since she had been moved to the long term care wing she had not had much of an appetite. In an interview on 02/14/2020 at 10:41 AM, Staff II, Regional Consultant, stated the pain assessments lacked pertinent information, and that this resident should have had another pain assessment after the first 10 days of the [MEDICATION NAME]. She stated it didn't look like staff really put a lot of time into the pain assessments. She stated she had been investigating this resident's issues and there weren't many staff that had been there very long to know the residents very well. In a phone interview on 02/18/2020 at 10:01 AM, Staff R, Consultant Pharmacist, and Staff S, Consultant Pharmacy Clinical Manager stated: We were notified of the IJs related to [MEDICAL CONDITION] medications and opioids, we made a 300+ page report, there were many responses to pharmacy recommendations, a lot of recommendations that were not addressed or responded to appropriately, we sent some back to the facility for review, we met over the weekend with the facility and two providers. We had repeated recommendations that weren't addressed appropriately, so we spoke with the nursing director and a corporate representative, they did not know why the MRRs were not responded to. If MRRs were not responded to, we may make a repeat recommendation, or we may speak with facility staff. Staff R stated that that the first month he did MRRs, he met with the DNS, but he didn't get follow up until the next month, so he had no trends, especially with recommendations that were not followed up on. Staff R stated we are now implementing a percentage rate for the recommendations that were followed up on. Staff R stated typically I go there for meetings with staff monthly. Staff R and S were asked what was done if there was a recommendation for a GDR and the physician declined without documenting a rationale, he stated he typically reminded the nurse managers that rationales needed to include some kind of concrete details, especially related to behaviors residents exhibited. When asked if it's an expectation that rationales were completed, Staff S stated in their meetings, they emphasized that just saying no to a GDR was not good enough, that concrete details in the documentation was encouraged. He stated that pharmacist consultants tried to draw the line without being too intrusive, but at the same time they needed information, and Risk vs Benefit should also be specific and customized. Staff R and S were asked what was the facility's system for monitoring for potential adverse side effects of medications, and stated unfortunately, I am not familiar with their systems, I haven't gotten to the details of where they track side effects. Staff R and S were asked about the facility's system for monitoring side effects of opioids, and stated that the side effects of opioids were more subtle in older people, it's difficult to pinpoint ASEs, some places have a sticker that states what the ASEs are. For opioids there is a long list of ASEs and we rely on progress notes, they will put a little face, those are the things we look for in systems, but they are not always in place. I do look at progress notes to see what would trigger issues. Staff R and S were asked if the facility had notified them of concerns with Resident #32, Staff R answered Yes, I looked into it, I reviewed her my first month in December, (12/19) then I sent a GDR letter because of the multiple [MEDICAL CONDITION]'s she was on. Then in 01/20 it looked like the [MEDICATION NAME] was being changed and monitored by the provider, I can't speak to going back, but the providers response in 12/19 was downtitrating. Staff R stated multiple [MEDICAL CONDITION]'s can trigger hypersomnolence, so that could be an impact, I can't speak to hypersomnolenc
F 0758 **Level of harm** - Immediate jeopardy **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 eight of twelve residents (#32, #29, #21, #30, #12, #20, #38, and #3) remained free of unnecessary [MEDICAL CONDITION] medications. Failure to: 1) respond timely when a resident experienced potential [MEDICAL CONDITION] medication-related adverse side effects, 2) to have responsive systems in place to identify, monitor for, document, and respond to the presence of potential medication-related adverse side effects, 3) to ensure residents received Gradual Dose Reductions (GDRs), 4) to ensure residents received [MEDICAL CONDITION] medications for the shortest duration necessary and in the lowest dose necessary, 5) to ensure all residents had monthly medication regimen reviews done by the consultant pharmacist, 6) to consider the impact of side effects of opioid [MEDICATION NAME] on a resident who also experienced similar potential side effects of [MEDICAL CONDITION] medications, 7) to perform comprehensive [MEDICAL CONDITION] medication reviews, 8) to ensure medication-related documentation was done consistently and thoroughly, 9) to ensure doctor and nurse practitioner progress notes were accurate, 10) to ensure monthly medication regimen review (MRRs) irregularities were acted on timely, 11) to ensure the benefits of treatment with [MEDICAL CONDITION] medications exceeded the risks, 12) to ensure physicians/nurse practitioners provided progress notes reflecting treatments/goals/risks and benefits of treatment with [MEDICAL CONDITION] medications, and 13) to ensure PRN (as needed) [MEDICAL CONDITION] medication orders were limited to 14 days per regulations, all placed residents at risk for medication-related adverse side effects. Resident #32 was harmed when the facility failed to respond when she exhibited potential medication-related adverse side effects and the facility continued to treat her with the same medications for several months. On admission, the resident was able to walk, she was able to communicate effectively, she was able to feed herself, and she had no skin pressure injuries. After several months of treatment with multiple [MEDICAL CONDITION] and opioid medications, the resident was no longer able to walk, no longer able to communicate effectively, no longer able to feed herself, no longer able to get in/out of bed, she developed heel and coccyx pressure injuries, she had a left hand/wrist contracture, she developed significant weight loss, she had declines in her bowel and bladder continence, she had decreased activity participation, and she had multiple falls. These failures resulted in an Immediate Jeopardy (IJ) related to multiple failures in medication management for Resident #32 and for other residents. An IJ was called on 02/13/2020 at 2:18 PM. The facility: -had the consultant pharmacist review each resident's medication records and consulted with physicians/nurse practitioners on irregularities, -provided physician education, -had the physician review each resident's psychoactive medications and complete clinical assessments, -revised facility practice for reviewing side effect monitoring, progress note review, and alert charting, -revised psych review meeting processes to include nurse practitioners, physicians, and pharmacists, -reviewed residents that had recent change of conditions, -educated/trained nurses, nurse managers, nursing assistants, and the Director of Nursing Services (DNS) on pharmacy procedures/follow-ups, -implemented auditing and validation of [MEDICAL CONDITION] medication management procedures to include behavior monitoring, GDRs, and adverse side effects. This all resulted in the removal of the IJ on 02/28/2020 at 12:45 PM. Findings included . DEFINITIONS: Adverse side effects/consequences of medications: [REDACTED]. It may include various types of adverse drug reactions or interactions (e.g. medication-medication, medication-food, and medication-disease). Side effects of Antipsychotic medications include: movement disorders, blood pressure fluctuations, drowsiness, elevated pulse, sedation, dizziness, blurred vision, [MEDICAL CONDITION], dry mouth, nausea, constipation, urine retention, blood disorder, headaches, weakness, jaundice, agitation, restlessness, slurred speech, anorexia, rash, confusion, unsteady gait, frequent falls, refusal to eat, difficulty swallowing, depression, [MEDICAL CONDITION], social isolation, diarrhea, fatigue, [MEDICAL CONDITION], loss of appetite, weight loss, muscle cramps, vomiting, behavioral symptoms not usual to the person. Side effects of antidepressant medications include: constipation, hand tremors, blood cell abnormalities, arrhythmias, sedation, confusion, excitement, blurred vision, rash, dry mouth, dry eyes, [MEDICAL CONDITIONS], jaundice, psychotic episodes, anxiety, [MEDICAL CONDITION], weight loss, nervousness, loss of appetite, suicidal ideation, mood change, change in normal behavior, hallucinations/delusions, social isolation, decline in ability to help with/do ADLs (activities of daily living), no voiding, rigid muscles, difficulty ambulating, balance problems, accidents, dizziness, falls, movement problems, tremors, diarrhea, fatigue, weight loss, muscle cramps. Side effects of mood stabilizer medications include: extreme drowsiness, fatigue, muscle aching or weakness, dry mouth, constipation or diarrhea, loss of appetite, nausea, skin rash, headache, dizziness, tremors, abdominal pain, and upset stomach. Side effects of Opioid Medications include:

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F 0758

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 27)

drowsiness, weakness or lack of energy, lightheadedness, dizziness, headache, constipation, nausea and vomiting, itching, dry mouth, and trouble falling or staying asleep. RESIDENT #32 The resident admitted to the facility on [DATE] for rehabilitation after having a fall at home resulting in a left wrist fracture. On admission the resident had [DIAGNOSES REDACTED]. According to the resident's admission Minimum Data Set (MDS) assessment, dated 05/23/2019, Resident #32 had severe cognitive impairment, and for activities of daily living (ADLs) she required only limited assistance with bed mobility, transfers and personal hygiene. The MDS indicated the resident required only supervision with eating and walking. For bowel and bladder, the MDS indicated she was occasionally incontinent of urine and always continent of bowels. Review of the quarterly MDS, dated [DATE], revealed severe cognitive impairment, and for ADLs, Resident #32 required extensive assistance of 1-2 persons with bed mobility, transfers, and personal hygiene. Walking did not occur during this MDS time period. For bowel and bladder, the MDS indicated the resident was always incontinent of bowel and bladder. Review of the Admission Nursing Data Base (nursing assessment), dated 05/16/2019: -she had clear speech, -weighed 153.8 lbs -was always continent of bowel and bladder, -had no pressure ulcers, -had a pleasant mood. Review of a progress note, dated 05/16/2019 (day of admit) at 5:57 PM, revealed the resident had attempted to leave the facility, and was assessed to be a high elopement risk. Review of a progress note, dated 05/17/2019 at 1:43 PM, revealed the resident stated she wanted to return home with her spouse, and the spouse also had a poor memory and may not be able to meet resident's needs at home. Review of a progress note, dated 05/19/2019 at 2:57 PM, revealed the resident was alert and oriented, but had confusion and wandered around the hallways. Review of a progress note, dated 05/21/2019 at 5:12 AM, revealed the resident had an unwitnessed fall. Review of a progress note, dated 05/21/2019 at 2:27 PM, revealed the resident was placed on alert for increased behaviors and had increased agitation. She was exit-seeking and had set off the alarms to multiple emergency exit doors multiple times. Resident #32 had been walking into other residents' rooms and taking items out with her, and had frequent visual hallucinations. Review of a progress note, dated 05/22/2019 at 3:37 AM, revealed the resident was on alert for inappropriate behaviors, exit-seeking, and for the fall. The resident could not recall events of the previous day, and was oriented to self, but not time, place or situation. She denied pain and had constant episodes of confusion. Review of a progress note and a report titled View [DIAGNOSES REDACTED]. The nurse contacted the doctor and got an order for [REDACTED]. Review of the resident's Level 1 Pre-admission Screening and Resident Review (PASRR), dated 05/16/2019, revealed the resident had a [DIAGNOSES REDACTED]. Review of another Level 1 PASRR, dated 05/20/2019, revealed the facility had revised the Level 1 PASRR to now include the resident had a [MEDICAL CONDITION]. Review of a progress note, dated 05/26/2019 at 8:06 AM, revealed the resident was difficult to redirect, had been in another resident's room and was difficult to redirect out of that resident's room, and was confused and aggressive during cares. Review of a progress note, dated 05/28/2019 at 2:30 PM, revealed the resident was very mobile and had difficulty following tasks and cueing safely. Resident #32's son reported the resident had been living with her significant other alone in an apartment and had a history of [REDACTED]. The facility discussed with the resident's family that it would not be safe to return home, and the recommendation was for 24/7 care and the resident would benefit from a placement in an adult family home or in a memory care setting. Review of the May 2019 Medication Administration Records (MARs), revealed in May, Resident #32 was started on [MEDICATION NAME] (an antipsychotic medication) for unspecified [MEDICAL CONDITION], [MEDICATION NAME] (an antidepressant medication) for [MEDICAL CONDITION], and she was receiving [MEDICATION NAME] (an opioid pain medication) for pain for 10 days. Review of the June 2019 MARs revealed the resident's [MEDICATION NAME] got re-ordered, the [MEDICATION NAME] dosing was increased (multiple times), and [MEDICATION NAME] (mood stabilizer/anticonvulsant medication) was added for unspecified [MEDICAL CONDITION], and the Trazadone was continued. The target behaviors being monitored for [MEDICATION NAME] and [MEDICATION NAME] (behaviors not individualized, they were grouped together for these two medications) included agitation, refusals of care and verbal aggression towards others (no behaviors were being monitored for any hallucinations or delusions). Review of the MARs for 2019 revealed ongoing treatment with [MEDICAL CONDITION] medications and [MEDICATION NAME] as follows: -[MEDICATION NAME] 50 mg (milligrams) daily at 9 AM - 06/20/2019 - 01/03/2020 -[MEDICATION NAME] 100 mg daily at 3 PM - 06/21/2019 - 01/03/2020 -[MEDICATION NAME] 100 mg daily at 9 PM - 06/20/2019 - 01/03/2020 -[MEDICATION NAME] (multiple dose changes, starting in June 2019) 250 mg twice daily at 9 AM & 1 PM - 07/25/2019 - ongoing as of 02/06/2020 -[MEDICATION NAME] 500 mg daily at 9 PM, 07/24/2019 - ongoing as of 02/06/2020 -[MEDICATION NAME] 25 mg daily at 9 PM - 05/29/2019 - 02/12/2020 -[MEDICATION NAME] PRN (as needed) - 06/25/2019 - 01/03/2020 Review of Behavior Monitoring records dated May 2019 through January 2020 revealed: In May 2019 sleep monitoring for Trazadone use found the resident slept 8-11 hours a day. In June 2019, although antipsychotic behaviors were being monitored for use of [MEDICATION NAME], there were 10 shifts with no behavior monitoring, and no behaviors were monitored in June for [MEDICATION NAME] use. No sleep monitoring for the use of Trazadone was conducted between June 26, 2019 and June 30, 2019; and behaviors not listed as being associated with a medication included: exit seeking and attempting to go into others' rooms. In July 2019, there was no documentation of behavior monitoring for the use of [MEDICATION NAME] between 07/01 and 07/23/19. For [MEDICATION NAME] there was no behavior monitoring on 07/01 and 07/23/19. There was no sleep monitoring between 07/01 and 07/21/19 to validate use of Trazadone. In August 2019, there were 10 shifts with no behavior monitoring for [MEDICATION NAME] and [MEDICATION NAME] use. For July 2019 through September 2019 behaviors not associated with medication use were exit seeking and attempting to go into others' rooms. In October 2019 and November 2019, refusals of care was added to exit seeking and wandering into others' rooms as behaviors not associated with medication use. PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN'S ASSISTANT NOTE REVIEW: According to the hospital discharge summary dated 05/16/19, Resident #32 was alert and oriented to person, place and time. There were no orders for [MEDICAL CONDITION] medications. The orders did include [MEDICATION NAME] for 10 days for pain management related to wrist facture and surgery. The physician noted dated 05/20/19 indicated Resident #32's pain was well controlled and the resident denied any pain. The resident was ordered to have physical therapy (PT) and occupational therapy (OT). According to the note, Resident #32 was speaking in full sentences and was pleasant and appropriate in her demeanor, with normal affect and mood. According to the Nurse Practitioner note dated 06/06/2019, Resident #32 was placed on [MEDICATION NAME] (antipsychotic) for behaviors which included exit seeking, wandering, sundowning, and hallucinations, and had a [DIAGNOSES REDACTED]. This note stated that the resident was assessed to have late onset [MEDICAL CONDITION]. Although, [MEDICATION NAME] was already started on 05/24/2019. There were no physician notes explaining this, and Trazadone was already started for a sleep aid on 05/20/19 and there was no physician note explaining that either. In a nurse practitioner note dated 06/10/19, there was no mention of treatment with [MEDICATION NAME] or the plan or therapeutic goals of treatment [MEDICATION NAME]. In a nurse practitioner note dated 07/31/19, Resident #32's [MEDICATION NAME] had already been increased and it did not elaborate on what necessitated the treatment with [MEDICATION NAME] the resident was now on. The note stated the resident had no evidence of pain, however, the resident continued on [MEDICATION NAME] and the previous provider note was dated over six weeks ago. In a physician assistant note dated 08/01/19, the noted stated that Resident #32 was on a high dose of [MEDICATION NAME] and suggested reevaluating appropriate medication. The note also stated that the resident was on [MEDICATION NAME], and that no psychiatry notes were available. The physician assistant recommended following up with psychiatry for medication management. In a Nurse Practitioner note, dated 08/16/2019, it showed that Resident #32 was on [MEDICATION NAME] and [MEDICATION NAME], and it did not address the resident's behaviors ongoing between July 2019 and August 2019. In a nurse practitioner note dated 09/20/19, it showed the nurse practitioner was aware the resident was more wheelchair bound, however, it did not address why the resident may have been more wheelchair bound. The nurse practitioner did not address how the resident's medications may have contributed to the general decline in Resident #32's condition. Further, the nurse practitioner did not provide an accurate review of the September 2019 MARs related to the extremely high dosing of the antipsychotice medications, [MEDICATION NAME] and [MEDICATION NAME]. The nurse practitioner did not address the ongoing treatment with [MEDICATION NAME] and Trazadone, and the side effects of all the medications combined which may have contributed to the resident's overall decline and change in condition. The nurse practitioner note dated 09/25/19 mentioned the resident was more wheel chair bound at this time, however, did not indiate clinical concerns with the effects the medications may have had on Resident #32. In a physician note dated 10/17/2019, the physician did not address the effects of the antipsychotic drugs together with the pain medications on the resident related to the resident notably being more wheelchair bound. In addition, physician did not provide an accurate review of the October 2019 Mars which indicated the resident was on extremely high dosages of [MEDICATION NAME] and [MEDICATION NAME]. In a nurse practitioner note dated 12/04/19, the nurse practitioner noted the resident was generally lethargic with decline, somnolent (sleepy) throughout the day, experiencing decline in cognition and energy, however, there was no mention that side effects of the medications the resident was on may have contributed to the resident's change in condition. The resident was on [MEDICATION NAME] at elevated doses,

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F 0758

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 28)

[MEDICATION NAME] at elevated doses, Trazadone, [MEDICATION NAME]. The resident's sleep monitor records indicated she was sleeping 8-13 hours a day. In a nurse practitioner note dated 01/03/2020, the nurse practitioner noted Resident #32 leaning forward in her wheelchair, poor oral intake and planned to reduce the antipsychotice dosaging. However, without a pain assessment, the narcotic pain medication was increased. The resident's weight had decreased 20 pounds since the 12/04/19 note. The nurse practitioner did not address the side effects of the pain medication such as nausea and vomiting, lack of energy, drowsiness, dizziness, and how it impacted the the resident's decline In a nurse practitioner note dated 01/07/2020, the nurse practitioner identified that the recent decrease in [MEDICATION NAME] did not change the resident's hypersomnolence (increased sleepiness) and planned to decrease [MEDICATION NAME] as well. According to this note, the nurse practitioner started another antidepressant to the resident's regime ([MEDICATION NAME] for appetite stimulation) in addition to Trazadone (for sleep). According to the nurse practitioner note dated 01/14/2020, the nurse practitioner identified that although [MEDICATION NAME] had been down titrated, the resident remained slelepy throughout the day, so futher decreased the [MEDICATION NAME] to encourage the resident to be more active during the day. In a note dated 01/22/2020, the nurse practitioner noted some improvement in the resident that day, although was now at risk for aspiration and choking. According to a nurse practitioner note dated 02/04/2020, the resident now had pressure injury related to being wheel chair bound and decreased nutrition and water intake. The nurse practitioner noted the resident's decline had worsened and that hospice was considered. Review of Resident #32's clinical record did not find psychiatry notes, however, there were notes from Staff CC, mental health nurse consultant. According to Staff CC's 06/11/19 note, the psychiatrist (medical doctor) was wondering if Resident #32 had a dementia workup. According to the note, [MEDICATION NAME] was increased. According to Staff CC's 06/18/19 note [MEDICATION NAME] was increased, was exit seeking, verbally and physically aggressive toward staff. In addition, Staff CC noted the resident's family stated that the resident did better when they had her at home over the weekend than in the facility. According to Staff Cc's 06/25/19 note, [MEDICATION NAME] was increased and [MEDICATION NAME] was started as well as Trazadone at bedtime. The 07/02/19 showed that the resident was getting around well and the resident's spouse took her on an outing. The note dated 07/23/19 showed Staff CC found the resident dozing at the nursing station. When awakened wanted to go back to sleep and after breakfast would nap until later in the day. The resident had behaviors of exit seeking and wandering and had a fall, sleeping a lot in the a.m. According to the 08/27/19 note, Staff CC found the resident was all over the place today. Staff CC stated in the note that the resident was on a list for a more appropriate skilled nursing facility . In progress note reviews for dates between June 2019 and January 2020, Resident #32 had increasing aggressive behaviors toward staff, that occurred more as noted in the progress notes when the resident was awake more. The facility provided interventions by increasing [MEDICATION NAME], and [MEDICATION NAME]. The resident experienced falls and pressure injuries requiring wound consultants, and the facility did not identify side effects of all the medications the resident was receiving that could have contributed to further decline in her condition including falls, decreased intake, and weakness. Instead, staff continued to document that there were no side effects of the medications in progress notes. Interdisciplinary team notes did not make any recommendations to change the resident's medication regime or care plan. There was no indication the facility attempted non drug intervention for the resident with a [DIAGNOSES REDACTED]. There was no indication the facility had the resident on an individualized activity program. Instead, the facility continued to increase antipsychotic drug dosaging, with antidepressants, and narcotic pain medication, although there were no pain assessments completed to warrant the need for narcotic pain medication. Review of Consultant Pharmacist Monthly Medication Regimen Review (MRR) reorts showed the following: On 08/20/2019, the pharmacist identified an irregularity related to [MEDICATION NAME] for sleep. Resident #32 on Trazadone, an antidepressant since 05/19. The pharmacist notified the physician that a gradual dose reduction (GDR) should be considered. However, the resident's physician/nurse practitioner continued the medication with no change, and the required rationale was left blank. On 09/26/2019, the pharmacist identified an irregularity related to the ongoing treatment with [MEDICATION NAME] for sleep, and a recommendation was made to consider a GDR. The rest of this form was blank, there was no documentation the resident's physician/nurse practitioner had ever even seen it, it was never acted on. Provider notes in 09/19 reflected the resident was more wheelchair bound and not ambulating as she had in the past, and was lethargic, and not extremely responsive. On 10/25/2019, Resident #32's name was on a list with other residents that were reviewed by the consultant pharmacist, but did not require any recommendations. There was no documentation the physician/nurse practitioner had ever addressed the [MEDICATION NAME] irregularity/GDR request, even though it had been made twice in recent months. The resident had been noted by her nurse practitioner/physician to be lethargic, not ambulating as she had in the past, more wheelchair bound, yet no recommendations or irregularities were identified by the consultant pharmacist during this review. In November 2019, no MRR was found in Resident #32's clinical record. Although the past few months doctor/nurse practitioner notes reflected lethargy, not extremely responsive at this time, more wheelchair bound, somnolent, there were no irregularities identified by the consultant pharmacist. There was a note in PCC (PointClickCare (electronic health record)), Pharmacist Acknowledgement, dated 11/19/19, that no irregularities noted. On 12/23/2019, the pharmacist documented that the resident was due a GDR for [MEDICATION NAME] and [MEDICATION NAME]. The pharmacist note indicated if current therapy was to be continued, please provide a brief risk vs benefit assessment for state survey. The nurse practitioner wrote we are down titrating for sleepiness, but did not state which medication/s were being down titrated. There was nothing documented about lethargy, somnolence, hypersomnolence, more wheelchair bound, not ambulating as Resident #32 had in the past, which was all reflected in provider notes in recent months. On 02/14/2020 (two notes to Attending Physician/Prescriber) the Pharmacist wrote the PRN [MEDICATION NAME] was limited to 14 days of treatment, as of 02/18/2020 it was not yet signed by the physician/nurse practitioner. There were no indications or [DIAGNOSES REDACTED]. On another form, there was a note Per IDT (interdisciplinary team) meeting on 02/17/2020 (with Social Services, Nursing, MD, Pharmacy): Previous substantial psych issues, followed by somnolence, 66% decrease in [MEDICATION NAME] and [MEDICATION NAME] has been d/ced. Resident was able to respond to MD since reduction of medications. Facility [MEDICAL CONDITION] Medication Reviews: On 08/20/2019, there was no mention of contributing factors like pain or medication interactions, even though there were spaces for this on the review. The IDT team recommended no changes in [MEDICAL CONDITION] medications. On 11/16/2019, the facility marked No, under the question Are there signs/symptoms of medication side effects? Although, Resident #32 had changes in condition that included wheelchair bound and not ambulating, somnolent, lethargic, had four falls this quarter, yet no medication side effects was marked. Pain and [MEDICAL CONDITION] medication interactions were not marked as potential contributing factors for the resident's changes in condition. [MEDICATION NAME] dosing was incorrect on the form, it only listed [MEDICATION NAME] 50 mg once daily, resident was also getting [MEDICATION NAME] 100 mg at 3PM and 100mg at 9PM. [MEDICATION NAME] dosing was also incorrect on that form, it incorrectly listed [MEDICATION NAME] 125 mg two times daily, she was actually getting 250mg daily at 9AM, 250mg at 1PM, and 500mg at 9PM. IDT recommended no changes, although Social Services and pharmacy noted medications contributed to the assessment, nursing and the physician/nurse practitioner did not. On 02/21/2020, the facility listed the incorrect dose of [MEDICATION NAME], the dose was listed as 7.5 mg, but review of the MARs revealed the resident was actually taking 15mg daily since 01/13/2020. Medication side effects: Are there any signs/symptoms of medication side effects? Facility marked No, even though Resident #32 had since the last review, experienced significant weight loss, hypersomnolence, lethargy, was wheelchair-bound, could no longer walk, could no longer feed herself, and could no longer transfer herself, and the facility had been decreasing her [MEDICAL CONDITION] medications and her [MEDICATION NAME] for pain. The review said the resident's weight is stable, and behaviors still consistent, when the resident had no behaviors because she was unable to do anything for herself anymore. The form indicated they should choose a [DIAGNOSES REDACTED]. OBSERVATIONS In random observations on 02/04/2020, the resident was observed asleep in bed. In an observation on 02/05/2020 at 9:46 AM, the resident was asleep in bed. In an observation on 02/05/2020 at 10:22 AM, the resident was asleep in bed. In an observation on 02/19/2020 at 8:41 AM, the resident was being fed breakfast by a staff member at the assisted table in the dining room. In an observation on 02/19/2020 at 12:37 AM, the resident was in the dining room, a staff member was helping her to drink by holding a glass to her mouth. In an observation on 02/20/2020 at 9:02 AM, the resident was in the dining room, a staff member was feeding her by bringing the silverware to her mouth. STAFF INTERVIEWS In an interview on 02/12/2020 at 12:28 PM, the Director of Nursing Services (DNS) and Staff B, Licensed Practical Nurse (LPN)/Resident Care Manager, and later Staff A, Social Services, Staff C, Registered Nurse (RN) and Staff FF, RN, joined the interview after the DNS left the room, were interviewed: the DNS stated Staff CC, Registered Nurse (RN)/Mental Health Nurse Consultant, was managing the resident's [MEDICAL CONDITION] medications. The DNS stated Staff CC consulted with her psychologist. The DNS was asked for Staff CC's notes, she was able to provide notes until 08/27/2019, which she said was the last time Staff CC saw the resident. The DNS stated the resident got the [DIAGNOSES

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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.

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F 0758 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 29) REDACTED]. Staff B stated medication adverse side effects were to be documented in progress notes. She stated the side effects to be monitored for medications were listed on resident care plans. Review of the resident's care plan (print date 02/06/2020) revealed, there were side effects listed for the [MEDICATION NAME], but none for the [MEDICATION NAME] REsident #32 had been taking since 06/19. The care plan indicated staff were to monitor for side effects of [MEDICATION NAME] and [MEDICATION NAME] (two medications the resident had not been on while in the facility), but none were listed for [MEDICATION NAME]. The care plan also did not list side effects of [MEDICATION NAME], which Resident #32 had been taking since 05/19. Staff were asked whether the [MEDICATION NAME] was for convulsions or a mood disorder, Staff B stated the resident did have a [DIAGNOSES REDACTED]. Staff were asked whether medications had been assessed to see if medication side effects were contributory to the resident being wheelchair-bound and lethargic, the DNS and Staff B did not answer that question, Staff A stated the resident was still having hundreds of behaviors. Staff were asked about the 08/20/2019 MRR that had no rationale documented for the pharmacist's GDR request, they were unable to provide any information. Staff were asked about the 12/23/2019 MRR that requested a risk vs benefits assessment for the current [MEDICAL CONDITION] medication regimen, they were unable to provide any information. Staff were asked about the many doctor/nurse practitioner notes that listed somnolence and lethargy as a problem and the relative lack of documentation regarding this in nurse progress notes, they were unable to provide any information. The DNS stated taht the facility documented the presence of adverse side effects by exception, Staff FF stated that there was no space to document adverse side effects in the behavior monitors. Staff were asked if they had performed a sleep assessment to see why the resident wasn't sleeping, they didn't know of one being done. Staff were asked about the 10 shifts in 06/19 with no documented behavior monitoring for the antipsychotic medication [MEDICATION NAME], Staff A stated that it looked like they (nurses) weren't charting. Staff were asked about the 02/20 [MEDICATION NAME] order with no end date, Staff B stated it was because the resident was on comfort care. Staff were asked about the seven shifts in 06/19 with no documentation in the sleep monitor, they were unable to provide any information. Staff were asked about the resident not being able to ambulate anymore, Staff C stated when the resident first admitted she was ambulatory until about the end of October 2019, then she was moved over from rehab to the long-term care wing. Staff were asked about the lack of documented behavior monitoring for the [MEDICATION NAME] from 07/01/2019 - 07/23/2019, Staff C stated they switched from eight hour shifts to 12 hour shifts and the nurses didn't know how to do that properly. Staff were asked about the 06/19 behavior monitoring being grouped together for [MEDICATION NAME] (antipsychotic medication) and [MEDICATION NAME] (mood stabilizer) medication, Staff A stated she changed that when she started working at the facility. Staff were asked about the resident's change in condition in late 09/19 when she needed more assistance with ADLs, Staff C stated it manifested with the resident not being ambulatory and needing more assistance with cares. Staff C stated they changed pharmacists about that time. Staff were asked about the 12/23/2019 MRR that listed three medications, and the nurse practitioner wrote We are downtitrating for sleepiness, but it did not list what was being downtitrated, Staff were unable to provide any information what was being downtitrated. Staff were asked if the physician had documented Lowest effective dose - No GDR order, for any of the resident's medications, staff were unable to provide any inform
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were dated, and/or stored at correct temperatures in accordance with current accepted professional standards in two of five medication carts and one of two medication rooms. These failures placed residents at risk to receive expired and/or compromised medications and biologicals. Findings included . Review of the facility's policy titled, Storage of Medications dated [DATE], The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses station or other secured location. Medication must be stored separately from food and must be labeled accordingly. Revied of the refrigerator temperature log present in medication room B, marked Payless Long Term Care Pharmacy labeled as 1213 revision, the refrigerator temperature should be checked twice daily if vaccines were present and that the refrigerator temperature should range between ,[DATE] degrees Fahrenheit (F). On [DATE] at 11:25 AM, Med room B was inspected. A bottle of Urinalysis test strips was found to be expired [DATE]. An open multi dose vial of [MEDICATION NAME] solution that was not dated. These findings were acknowledged by Staff E, Registered Nurse (RN). Review of the refrigerator temps log showed that temperatures were only checked once daily on fifteen out of nineteen days. The temperature range was below the recommended temperature of 36 degrees F on fifteen of 34 temperatures documented. When Staff E was asked when refrigerator temperatures should be done, she acknowledged it should be done twice daily with shift change. There were 3 boxes of Influenza vaccines in refrigerator. On [DATE] at 11:40 AM during an interview with Staff C, Resident Care Manager (RCM), regarding the observations of the temperature log, she acknowledged that the readings were outside of the recommended range and that there didn't appear to be any adjustment when out of range. On [DATE] at 11:53 AM during inspection of medication cart 2, an open bottle of Health Smart brand Acidophilus was found. The label stated,refrigerate after opening. Staff Y, RN, acknowledged that the medication was not in the refrigerator and replied she wasn't aware of it needing to be refrigerated after opening until pointed out by surveyor. On [DATE] at 1:15 PM during inspection of medication cart 3, an open bottle of Health Smart brand Acidophilus was found. Staff J, RN acknowledged that it should be in the refrigerator after opening. Also located was an open bottle of [MEDICATION NAME] ophthalmic drops with a sticker on it marked date when opened. When asked how long the eye drops were good for after opening, Staff J replied he didn't know exactly but there was a list somewhere he could check. No additional information was provided. Reference: (WAC) [DATE] (2)
F 0802 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.** Based on observation, interview and record review, the facility failed to ensure there was sufficient dietary support personnel to serve meals on time. Failure to have sufficient dietary support personnel to be able to serve meals on time placed residents at risk for frustration due to having to wait on scheduled meals. Findings included . In an interview on 02/10/2020 at 8:35 AM, Anonymous Resident #1 stated breakfast in the main dining room was 20 minutes late to start and this resident felt it was disrespectful of the facility to not serve scheduled meals on time. In an observation on 02/10/2020 at 1:13 PM, the B-wing hall tray cart went out of the kitchen. Review of the Meal Schedule form, undated, revealed the B-wing cart was scheduled for 12:45 PM. The B-wing cart was 28 minutes late. In an observation on 02/10/2020, the A-wing hall tray cart left the kitchen at 1:34 PM. Review of the Meal Schedule form, undated, revealed the A-wing lunch meal service was scheduled to start at 1:00 PM. The A-wing cart was 34 minutes late. In an interview on 02/10/2020 at 3:33 PM, Staff DDD, Dietary Manager, stated they recently had to terminate the employment of two kitchen staff, and that day they were down one staff member, which is why she thought lunch was late. Reference: (WAC) 388-97-1160
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, interview and record review, the facility failed to ensure to store food in a sanitary manner in two of two nourishment refrigerators reviewed and to ensure handwashing supplies were available in the dishwashing area. These failures placed residents at risk of food borne illness. Findings included . HANDWASHING SUPPLIES In an observation/interview on 02/04/2020 at 8:55 AM, the handwashing sink in the dishwashing area had a paper towel dispenser that was out of paper towels. Staff EEE, Dietary Aide, was asked how he dried his hands, he answered by shaking his hands

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 30) in the air. NOURISHMENT REFRIGERATORS In an observation on 02/04/2020 at 10:33 AM, the A-wing nourishment refrigerator and freezer units were soiled with sticky food debris and hair. In an observation on 02/06/2020 at 8:51 AM, the B-wing nourishment refrigerator and freezer units were both soiled. The temperature monitoring logs for the freezer and refrigerator were reviewed for January and February 2020. The February 2020 log had no temperatures documented since 02/02/2020. The January 2020 logs had 40+ shifts without documentation that temperatures were monitored. Review of the logs revealed the acceptable temperatures were not appropriate, the refrigerator temperatures indicated safe temperatures were between 36-46 degrees Fahrenheit, these were not safe refrigerator temperatures. The freezer temperature logs had a reference of 59-77 degrees Fahrenheit, these temperatures were also not safe temperatures. In an interview on 02/06/2020 at 10:59 AM, Staff DDD, Dietary Manager, stated the nourishment refrigerator/freezer temperatures were monitored by nursing services. When Staff DDD was asked about the unsafe temperature ranges listed on the logs, she stated she didn't know where they got those logs, she agreed the listed temperature ranges were not safe for food storage. Staff DDD, stated kitchen staff were responsible for cleaning the nourishment refrigerators. Reference: (WAC) 388-97-1100(3) & -2980
F 0835 **Level of harm** - Actual harm **Residents Affected** - Some	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's Administration failed to take action to reports of deficient practice and did not investigate all allegations of abuse or elopement that they had knowledge of. Failure to take action for reported allegation of Rape/abuse, failure to reassess a resident with [DIAGNOSES REDACTED]. FAILURE TO INVESTIGATE ALLEGATIONS OF ABUSE: Review of facility's policy titled, Abuse Prevention Policy and Procedure, revised 08/11/2017 showed each resident had the right to be free from abuse. Investigations- As soon as a report of alleged or suspected abuse was received, the investigation shall begin in order to rule out or identify abuse. During a joint record review/interview on 02/05/2020 at 5:15 PM, the Director of Nursing Services (DNS) confirmed multiple notes documenting reports of sexual allegations were in Resident #3's clinical record, however she was unable to provide any further information regarding the notes and stated that there were no incident reports completed for these allegations because the resident had a history of [REDACTED].#3) had a past history of sexual trauma as a young person and she often would state that someone raped her, that's normal for her. RESIDENT REQUIRING emergency room VISITS: Resident #3 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of a progress note entered by Administrator in Training (AIT) on 02/05/2020 at 5:02 PM, documented: Clarification to note made on 01/30/2020 at 6:17 PM. Facility was aware that resident had gone out shopping, they had checked in with the front desk at 10:30 AM and got a ride at the bus stop. Later the resident called around 12:30 PM to main phone line asking to be picked up, she was able to provide the address of her location. She did not wait and had decided to walk back. Upon arrival staff was notified that EMS has picked up resident and she was located at the emergency room . During a joint interview/record review on 02/05/2020 at 5:41 PM, the DNS (director of nursing services) stated that on 01/30/2020, Resident #3 went to the front desk and told receptionist she was going out of the facility. The DNS confirmed that the resident ended up at the emergency room , but was unaware of exactly how she got there. The DNS stated she did not complete an investigation related to this issue because the resident always went out and came back, stating I asked the Administrator and he told me it wasn't an investigation. Follow up interview/record review on 02/06/2020 at 10:28 AM, revealed the DNS confirmed Resident #3 did go to theER on [DATE], but was unable to provide any further information regarding that. The DNS stated that she hadn't actually received or reviewed the paperwork from the hospital encounter. Review of the ER notes dated 01/30/2020 showed: Resident's chief complaint was dizziness. Per triage notes the resident stated she went on the bus today to go shopping and then decided to walk back to the facility but got lost, was then picked up by EMS and noted that she felt dizzy and tired. Per ER Doctor (MD) he suspects the majority of the resident's symptoms were due to overexertion. Review of the care plan showed that Resident #3 had been identified as a High Elopement Risk resident in August 2019 and was being monitored for making unplanned, unsafe trips out of the facility since November 2019. The care plan also showed that the resident needed assist to set up outings and required a staff member to assist with shopping needs (initiated 08/30/19). Administration staff knew resident was leaving the building unsupervised despite having had [DIAGNOSES REDACTED]. PHARMACY RECOMMENDATIONS: In a phone interview on 02/18/2020 at 10:01 AM, Staff R, Consultant Pharmacist, and Staff S, Consultant Pharmacy Clinical Manager: We had repeated recommendations that weren't addressed appropriately, so we spoke with the nursing director and a corporate representative, they did not know why the monthly Medication Regimen Reviews (MRR) were not responded to. Staff R stated that the first month he did MRRs, he met with the DNS, but he didn't get follow up until the next month, so he had no trends, especially with recommendations that were not followed up on. Staff R stated we were notified of concerns related to [MEDICAL CONDITION] medications and opioids, we made a 300+ page report. There were many responses to pharmacy recommendations; a lot of recommendations that were not addressed or responded to appropriately, we sent some back to the facility for review. In addition, Staff R stated we are now implementing a percentage rate for what recommendations that were followed up on. Summary of Consultant Pharmacist's Reviews, dated February 13-15, 2020, showed: -MD follow up rate from previous months: 40% -Nursing follow up rate from previous months: 10% This is a repeat deficiency from 02/13/2019. Reference: (WAC) 388-97-1620 (1)
F 0838 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.** Based on interview and record review, the facility failed to thoroughly and completely evaluate its resident population in order to develop, evaluate, and implement a Facility Assessment which addressed and incorporated all required components to meet each resident's care and service needs. This failure placed all residents at risk of unidentified and/or unmet care needs. Findings included . On 02/04/2020 during the entrance conference, Staff F, Administrator in Training (AIT), and the Director of Nursing provided a notebook that included the Facility Assessment. Review of the assessment showed it was incomplete. The assessment lacked a thorough review of the residents with dementia, bariatric care including staffing in case of emergencies, cultural and religious needs and evaluation of the care and service needs of the resident population served by the facility, the services, equipment, staff/personnel competencies needed, the required training and education, and facility resources including all buildings,vehicles, and medical and non-medical equipment. Additionally, the facility assessment did not include a comprehensive list of contracts, memorandums of understanding, and/or other agreements with third parties to provide services and/or equipment to meet residents' needs during both normal operations and emergencies. During an interview on 02/28/2020 at 11:30 AM, Staff AA, Regional Director of Operations (RDO), stated Facility Administration completed the facility assessment Staff AA stated when the facility completed the facility assessment they were expected to review things like: -Quality measures the facility triggered high in -Changes in patient acuity -Need for new equipment -Physical plant improvements that may need done -New leadership staff needed -Resident diagnoses, different nationalities, hearing impaired Staff AA, further stated that trends were identified through system reports, mock surveys, audits and regional nurse onsite tool visits. She stated that they finished up in May 2019 helping the facility get on track and prepare for survey and we honestly thought everything was running smooth. Staff AA continued to say, since the identification of these current concerns and so many repeat citations we are immediately changing the way we do QAPI. We will be completing 2 full mock surveys a year (instead of 1 previously), holding monthly QAA meetings (instead of every 3 months previously), 2 full system reviews and we are having a 2nd party review progress notes to see if the facility is able to identify concerns independently. Staff AA stated that as a company we are moving from a PPD (price per day) model to a ratio model, we are looking at staffing differently based on a ratio status. Staff AA stated that the governing body investigated concerns due to so many repeat issues and are pretty sure where the ball was dropped and would be looking at the facility administration for answers. The assessment lacked identification of the bariatric residents who resided in the facility had. (see staffing) The assessment failed to identify competencies of staff that was needed to care for the residents. No applicable WAC reference.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.**

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F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 31) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a consistent Quality Assurance and Performance Improvement (QAPI) Program, failed to put forth effort of Good Faith attempts to identify and correct own identified deficiencies, and failed to develop/implement effective plans of action to sustain plan of corrections for previous deficiencies. Failure to recognize deficiencies in care and services that were identified during survey and/or for previously cited deficiencies that resulted in the severity of harm, immediate jeopardy (IJ), as well as a potential for a pattern of resident harm. Findings included . Review of the facility's Quality Assurance and Performance Improvement (QAPI) Plan dated 08/21/2017, stated, This facility shall develop, implement, and maintain an ongoing program designed to monitor, evaluate the quality of resident care, pursue methods to improve quality care and to resolve identified problems. Purpose: 1. To track & trend performance in critical clinical situations and adverse resident events, develop root cause analysis and implement preventative actions and an analysis of preventative plan. 2. To establish and provide a system whereby a specific process, and the documentation relative to it's maintained to support evidence of ongoing QAPI, encompassing all aspects of quality care, including safety, infection control and quality of life applicable to all residents. 3. To develop the facility's self-assessment & QAPI plan. Authority: 1. The Governing body of the facility shall be ultimately responsible for the QAPI program. 2. The Administrator is delegated responsible for assuring the QAPI program of the facility is in compliance with federal, state, and local regulatory agency requirements. Focus: 2. The quality and appropriateness of patient care, including identification of trends in performance, are monitored and evaluated in the following areas: - Adverse events, quality indicators, 5 star rating trends, falls, med errors, facility acquired pressure ulcers tracking/trending reports, consults reports, pharmacy reviews, survey management (trend identification), customer satisfaction, employee satisfaction, infection control and other issues identified by facility or regional team for the facility. Committee Actions: 1. The committee will develop and implement action plans to correct adverse events, which can include educational training programs, staffing changes, equipment changes, and enhancement of services. During an interview on 02/28/2020 at 11:30 AM, Staff AA, Regional Director of Operations (RDO), stated the facility current had QAPI meeting quarterly, every 3 months and the meetings were intended to track and trend issues/concerns that were identified through system reports, mock surveys, audits and Regional nurse onsite tool visits. She stated in May 2019, we completed a mock survey and wrapped things up to get the facility on the right track, I honestly thought everything was running smooth. Staff AA continued to say, since the identification of these current concerns identified during survey, the facility was immediately changing the way we do QAPI. The facility will be completing 2 full mock surveys a year (instead of 1 previously), holding monthly QAA meetings (instead of every 3 months previously), 2 full system reviews and we are having a 2nd party review progress notes to see if the facility is able to identify concerns independently. Staff AA stated that the governing body investigated concerns due to so many repeat citations to identify where the ball was dropped and would be making changes as indicated. The RDO agreed that the following facility-wide areas of concerns were not identified as quality deficiencies by the facility until brought to their attention by the survey team: A. Falls and accidents, including timely investigations and follow-ups. B. Abuse and Neglect concerns from residents. C. Showers, Self-Determination and choices. D. Insufficient staff/staffing concerns from residents and staff. E. Unnecessary [MEDICAL CONDITION] medication use and evaluation F. Unnecessary drug use and monitoring and reviews. G. QAPI H. Administration Repeat Citations from annual survey concluding 12/04/2018, are as follows; F550-Resident rights/Exercise of Rights F584-Safe/Clean/Comfortable/Homelike Environment F657-Care Plan Timing and Revision F679-Activities Meet Interest/Needs of Each Resident F684-Quality of Care F688-Increase/Prevent Decrease in ROM/mobility F689-Free of Accident Hazards/Supervision/Devices F692-Nutrition/Hydration Status Maintenance F700-Bedrails F725-Sufficient Nursing Staff F758-Free from Unnecessary [MEDICAL CONDITION] Meds/PRN use F880-Infection Prevention and Control F947- Required In-Service Training for Nurse Aides Reference: (WAC) 388-97-1760(1)(2)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility failed to implement an effective Infection Prevention and Control Program (IPCP) with monitoring to demonstrate ongoing data analysis with trending and tracking of residents' infectious organisms for three of thirteen months reviewed for the IPCP, to include not completing annual review of IPCP policies and goals, and infection prevention practices to prevent the contamination of clean environments. This failure can lead to spread of disease/illnesses to all residents. Findings included . Tracking and Trending: Review of the Infection Control logs, Dated January 2019- January 2020 showed that a monthly assessment of data to evaluate for trends and/or failed practices were not completed for January 2019, February 2019 and January 2020. In addition, there were several different line listings for the month of January 2019 with conflicting data, making it difficult to determine how many infections had occurred. On 02/26/20 at 02:50 PM, Staff D, Infection Preventionist, stated that he did not know why there were so many different line listings for January 2019 as he has only been in this role one month. He also stated that he had not yet completed monthly report for January 2020 to evaluate infection trends or failed practices. He also was unaware if the facility had reviewed its IPCP policies within the last year. On 2/27/2019 at 11:37AM, the Director of Nursing Services (DNS) stated that last year they did not have anyone in the role to manage IPCP and that is why there were no monthly reports for January and February 2019. The DNS was unable to state the expectation for the time frame that previous month's reports should be completed. She also did not know if they had reviewed the IPCP policies last year and would have to check, but no additional information was provided. Infection Prevention Practices: On 02/19/20 at 11:21 AM, Staff E, Registered Nurse (RN), was observed to check a blood glucose level of a resident using a glucometer (machine to monitor glucose level within blood). The nurse brought the glucometer out of the room and placed it on top of the medication cart without a barrier, prior to disinfecting the machine. Staff E, stated that she hadn't thought about infection control before when she placed the contaminated machine on top of the medication cart. RESIDENT #29 In an observation on 02/20/2020 at 3:24 PM, Staff ZZ, Nursing Assistant, was observed doing incontinent care for the resident. During the cares Staff ZZ continued to wear contaminated gloves after cleaning the resident's groin/buttocks and while putting supplies away in the closet. At the end of the procedure contaminated items included the closet, the clean briefs, and the resident's clothing and bedding. This is a repeat deficiency from 02/13/2019. Reference: (WAC) 388-97-1320(1)(a)(2)(a)(c)
F 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the resident call light system was working in two of two resident rooms (144-2 & 152). Failure to ensure call lights were working properly placed residents at risk for unmet care needs. Findings included . In an observation and interview on 02/07/2020 at 8:19 AM, the call light for room [ROOM NUMBER]-2 came on, the light was working but the sound was not audible at all. Staff FF verified the call system was not audible for that room and she stated she would put in a maintenance request. In an interview on 02/20/2020 at 4:30 PM, Staff II, Consultant stated they had done extensive call light audits today. She said, These residents are just constantly on their call lights. It's just the type of residents we have. In an observation on 02/21/2020 at 10:55 AM, Staff DDD, Dietary Manager informed the nurse the call light in room [ROOM NUMBER] was not working. She stated I will put in a tels (maintenance request). Maybe they (staff) need to do Q (every) 15 minute checks? Reference: (WAC) 388-97-2280(1)(a)
F 0947 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.** Based on interview and record review, the facility failed to provide at least 12 hours of in-service education and/or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505296	A. BUILDING _____ B. WING _____	**03/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST FRANCIS OF BELLINGHAM	**3121 SQUALICUM PARKWAY BELLINGHAM, WA 98225**

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 0947 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 32) failed to maintain individual records to track training requirements therefore they were unable to verify that four of six nursing assistants certified (NAC) (Staff V, W, G, P), reviewed had required In-Service training. This failed practice had the potential to negatively affect the competency of these NAC's and the quality of care provided to the residents. Findings included . Review of the education record for Staff V, Nursing assistant (NA), provided by facility showed 3.2 hours of required education. Review of the education record for Staff W, NA, provided by the facility showed 8.45 hours of required education. Documentation of in service for above staff was provided on a sticky notes with multiple entries of numbers with a total hours documented. There was no date of training listed, nor was there any content of information documented. During a joint interview/record review on 02/20/2020 at 10:40 AM, Staff U, Regional Nurse Consultant (RNC), confirmed that Staff V and Staff W did not have the required 12 hours of in-services completed. Staff U reported that the facility did not have a good tracking system in place to manage in-service training/hours. During an interview on 02/27/2020 at 10:15 AM, Staff D, Staff Development Coordinator, stated that Staff G and Staff P did not have a record of current education hours and he would have to go through each in-service to determine how many hours of education each staff had during the previous year. The facility did not provide any additional information on training requirements for these two staff members. This is a repeat deficiency from 02/13/2019. Reference: (WAC) 388-97-1680 (2)(a-c)