STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505400	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENUMCLAW HEALTH & REHAB CENTER	2323 JENSEN STREET ENUMCLAW, WA 98022

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 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to allow three (#s 25, 45, & 165) of four residents reviewed for choices and two supplemental residents (#s 44 & 13), the right to make choices regarding important daily routines and health care, including accommodating preferences for the frequency and/or type of bathing. The facility's failure to accommodate resident choice placed these residents at risk for a diminished quality of life. Findings included . RESIDENT #44 According to the 1/31/2020 Quarterly Minimum Data Set (MDS - an assessment tool) the resident was assessed with [REDACTED]. In an interview on 02/25/2020 at 1:38 PM, when asked if she received bathing as frequently as she wished, Resident #44 replied, No, I am suppose to get it (bathing) once a week, it doesn't always happen. According to the Self Care Deficit Care Plan (CP) dated 11/13/2019, the resident, prefers 1 shower/week . Review of bathing records showed Resident #44 showed no bathing was provided from 10/31/2019 through 11/13/2019 (13 days), from 11/14/2019 through 11/25/2019 (11 days), and from 01/31/2020 through 02/20/2020 (10 days). In an interview on 03/04/2020 at 9:20 AM, Staff B, Director of Nursing (DON), reviewed the bathing records and confirmed the resident was not, but should be, offered bathing at least once a week. RESIDENT #25 A review of the baseline plan of care dated 05/13/2019, showed the resident preferred to be bathed three times per week. A review of the bathing documentation provided by the facility revealed the resident received a bath/shower November 11/11(bed bath), 11/12 and 11/27 (shower). In December, the resident was showered on 12/09, 12/12, 12/15, 12/17 and 1[DATE]19. On 01/02, 01/12, 01/20, and 01/28/2020, 02/01, 02/05, and 02/20/2020. In an interview on 02/25/2020 at 10:18 AM, Resident #25 was asked how frequently she preferred to bathe/shower. Resident #25 said, I'd like to shower daily, but I understand that may not be possible sometimes, when one of the bath aides gets pulled to the floor to take care of residents we only have one bath aide. When the resident was asked what did the staff say when they missed her scheduled bath day, she replied, they just say, sorry . I got pulled to the floor to work we usually get at least two showers in ten days. On 02/28/2020 at 9:25 AM, Staff D, LPN-RCM (Licensed Practical Nurse-Resident Care Manager), acknowledged the facility failed to meet the resident's preferences as it related to the frequency of bathing/showers. RESIDENT #45 According to the 01/22/2020 Quarterly MDS, the resident was cognitively intact, choices related to bathing were very important, and the resident was not bathed during the seven day assessment period. During an interview on 02/25/2020 at 10:06 AM, when asked if she could choose her frequency of bathing Resident #45 stated, They (staff) asked me if I was ok with two a week, and seen as it took three weeks for the first shower, I said yes. At home I showered daily. I would actually like three a week here, but if I can't (even) get the two (that are scheduled), how can I ask for more they always pull the shower aides. According to the .baseline plan of care CP, revised 02/05/2020, the resident was to be bathed two times per week. Review of the bathing flowsheets for January and February 2020 showed from 01/16/2020 through 01/31/2020 (16 days), and from 02/12/2020 through 02/27/2020 (15 days) the resident was only offered/ provided two showers. During an interview on 03/03/2020 at 10:29 AM, Staff B, DON, explained that resident bathing preferences were obtained upon admit and care planned. When asked those identified bathing preferences should be honored, Staff B stated, Yes. When asked if Resident #45 was consistently being provided two showers a week, as care planned Staff B stated, No. RESIDENT #165 Resident #165 admitted to the facility on [DATE]. According to the 02/19/2020 Admission MDS, choices related to bathing were very important and no bathing was provided during the seven day assessment period. In an interview on 02/26/2020 at 8:24 AM, Resident #165 indicated she was supposed to receive two showers a week, but they were not consistently provided and stated, .It varies depending on how much time they (shower aides) got. Review of the February 2020 shower flowsheet on 02/27/2020, showed from 02/12/2020 through 02/27/2020 (16 days) the resident had only been offered/provided two showers. During an interview on 03/03/2020 at 10:21 AM, Staff B acknowledged Resident #165 had an identified preference of two showers per week. When asked if staff were consistently offering/providing two showers a week Staff B stated, No. RESIDENT #13 According to the Assistance for ADLs (Activities Of Daily Living) and Transfers CP, initiated on 03/18/2019, Resident #13 preferred showers three times a week. A review of bathing records revealed Resident #13 received only 5 showers in the month of February 2020. During an interview at 1:45 PM on 03/02/2020, when asked how the facility determines how often residents receive assistance with bathing, Staff C replied resident preference. Asked if Resident #13 had received showers per his preference, Staff C stated No. REFERENCE: WAC 388-97-0900(1)-(4). .
F 0569 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure funds were conveyed to the state Office of Financial Recovery within 30 days of resident discharge or death for two (#s 265 & 266) of seven discharged residents whose trust accounts were reviewed. This failure caused delays in reconciling resident accounts. Findings included . A review of resident trust fund records on [DATE] at 8:46 AM with Staff O, Business Office Manager, revealed that Resident #265 continued to have a balance in a trust account despite being identified as deceased on [DATE]. Staff O acknowledged that the funds were not transmitted within the required 30 day window. Further record review of six other deceased or discharged residents revealed that Resident #266, identified as deceased on [DATE], also continued to have a balance as of [DATE]. REFERENCE: WAC [DATE](4)(5). .
F 0582 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** Based on interview and record review, the facility failed to provide accurate Advanced Beneficiary Notices (ABN: a notification used when services provided may not be reimbursed by Medicare) for one (#44) of one residents reviewed who required the notification. Failure by the facility to issue accurate ABNs placed residents at risk of not having adequate

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505400	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENUMCLAW HEALTH & REHAB CENTER	2323 JENSEN STREET ENUMCLAW, WA 98022

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 0582 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) information to make care and financial decisions during their continued stay. Findings include: RESIDENT #44 Record review showed Resident #44 received Medicare Part A Skilled Services starting 09/12/2019 with a last covered day of 09/30/2019. In an interview on 03/02/2020 at 1:18 PM. Staff O, Business Office Manager, stated Resident #44 remained in the facility after the cessation of Medicare Part A services. At this time, Staff O confirmed Resident #44 did not, but should have, received an ABN. REFERENCE WAC 388-97-0300(1). .
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 ensure, at the time of transfer for hospitalization or therapeutic leave, the resident and the resident representative received written notice which specified the duration of the bed-hold policy for one (#42) of five residents reviewed. Findings included . RESIDENT #42 Review of Census documents and progress notes showed Resident #42 transferred to the hospital on [DATE], where she resided for over 24 hours. Record review showed no indication bed-hold notification was provided to either the resident, or the resident's Power of Attorney (POA). In an interview on 02/27/2020 at 12:34 PM, Staff L, Medical Records, stated that Admissions Staff did bed-hold notification for hospital transfers and discharges. In an interview 02/28/2020 at 8:54 AM, Staff Q, Admissions Coordinator, indicated she provided bed-hold information within 24 hours of transfers/discharges and this information was, scanned in (to the record). When asked to provide information to support bed-hold notification was provided for Resident #42's 09/19/2019 hospitalization , Staff L replied, I don't think I have one on her. In an interview on 03/02/2020 at 8:36 AM, Staff B, Director of Nursing, and Staff C, Resident Care Manager, were asked to provide documentation to support bed hold information was received by the resident/POA. No information was provided. REFERENCE WAC 388-97-0120(4). .
F 0637 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident when there is a significant change in condition** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a Significant Change in Status Assessment (SCSA) MDS was completed, including Care Area Assessments (CAAs), for one (Resident #42) of one residents whose completed Minimum Data Set (MDS - an assessment tool) reflected decline . Failure of the facility placed the resident at risk of not receiving the care and services the resident may have been assessed to require. Findings included . RESIDENT #42 According to the Quarterly 11/07/2019 Minimum Data Set (MDS-an assessment tool), Resident #42 was assessed to be independent with bed mobility, require two person supervision for dressing, toilet independently with set up, and always continent of urine. According to the Annual MDS dated [DATE], staff identified Resident #42 with a significant weight loss of 5% or greater, now required two person limited assistance with bed mobility, extensive one person assistance for dressing and toileting, limited two person assistance for bed mobility, and was now occasionally incontinent of urine. According to RAI (Resident Assessment Instrument) manual (instructions for completing the MDS), a Significant Change (SC) MDS should be done when a resident's condition has changed from his/her baseline as indicated by comparison of the resident's current status to the most recent assessment. Based on the changes from the 11/07/2019 to 01/28/2020, the 01/28/2020 MDS met the significant change guidelines, but was not coded as a Significant Change MDS. Record review showed the facility failed to document the identification of a significant change in the resident's status in the clinical record. Observations on 03/03/2020 at 11:45 AM showed the resident independently ambulate the hall to the dining room. Additional observations showed the resident exited the dining room after eating approximately 50% of the lunch meal. Observation of the lunch tray and tray card showed the resident was supposed to, but did not receive, ice cream as directed. This observation was confirmed by Staff G, Dietary Service Manager. In an interview on the morning of 03/02/2020 Staff F, MDS Coordinator, stated that the MDS was not coded as a Significant Change assessment because the resident's condition was determined by the Interdisciplinary Team to be temporary and expected the resident to return to baseline within two weeks of the assessment. The RAI manual states, The final decision regarding what constitutes a significant change in status must be based upon the judgment of the IDT (Interdisciplinary Team). MDS assessments are not required for minor or temporary variations in resident status - in these cases, the resident's condition is expected to return to baseline within 2 weeks. However, staff must note these transient changes in the resident's status in the resident's record. However, record review showed no indication facility staff identified: the areas of decline qualified as a Significant Change event, the reason for the decline, or any rationale explaining why the resident was expected to return to baseline. Staff F acknowledged staff failed to address these issues in the resident record. Additionally, review of the resident ADL (Activity of Daily Living) records showed the resident continued to require extensive assistance with toileting, bed mobility and dressing in the two weeks after the ARD (Assessment Reference Date). REFERENCE: WAC 388-97-1000(3)(b) .
F 0645 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**PASARR screening for Mental disorders or Intellectual Disabilities** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR) assessments were accurately completed prior to or upon admission to the facility, or updated to accurately reflect resident's mental health status for three (#s 14, 11 & 23) of seven residents reviewed for PASRR compliance. This failure placed residents at risk for inappropriate placement and/or not receiving timely and necessary services to meet their mental health care needs. Findings included . RESIDENT #14 Resident #14 admitted to the facility on [DATE]. According to the most recent Quarterly Minimum Data Set (MDS - an assessment tool), staff assessed the resident had multiple diagnoses, including dementia, and did not require the use of antidepressant, antipsychotic or antianxiety medications. Record review revealed a Level I PASRR dated 12/06/2018 indicated the resident had [DIAGNOSES REDACTED]. In interview on 03/03/2020 at 8:50 AM and 03/04/2020 at 11:03 AM, Staff B, Director of Nursing (DON), stated the resident was no longer treated for [REDACTED]. RESIDENT #11 Resident #11 admitted to the facility on [DATE]. According to the Annual MDS dated [DATE], the resident had [DIAGNOSES REDACTED]. Record review showed a Level I PASRR dated 08/28/2017 which indicated the resident had [DIAGNOSES REDACTED]. In an interview on 03/02/2020 at 1:49 PM, Staff E, Social Service Director (SSD), said, after reviewing the resident's clinical diagnosis, the PASRR Level I should have been updated to reflect current diagnoses. RESIDENT #23 Resident #23 admitted to the facility on [DATE]. According to the 12/18/2019 Admission MDS, the resident was cognitively intact, had a [DIAGNOSES REDACTED]. Record review showed Resident #23 was referred to a psychiatry in February 2020 for increased impulsiveness, anger/agitation, verbal outbursts towards staff, and worsening depression. The resident was seen by Staff S, Psychiatric Advanced Registered Nurse Practitioner, on 0[DATE]. According to the practitioner's note the Resident reported feeling depressed and anxious due to acute pain and medical concerns. Under Impression Staff S documented Situational depression and anxiety with unstable mood due to acute stressors. Staff S recommended a trial of [MEDICATION NAME] (an anxiolytic) as needed for anxiety (which was denied by the primary care physician), and [MEDICATION NAME] (an anxiolytic) twice daily, as an adjunct to [MEDICATION NAME] (an antidepressant). In an interview on 03/03/2020 at 11:58 AM, Staff S, clarified that the [MEDICATION NAME] order was for, depression with situational anxiety. According to an undated Level I PASRR the resident had a diagnosis (dx) of depression but not anxiety. During an interview 03/03/2020 at 12:39 PM, Staff C, Resident Care Manager, stated that Resident #23 was being treated for [REDACTED]. REFERENCE: WAC 388-97-1915(1)(2)(a-c). .
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure care plans were accurate and/or implemented for 13 (#s 42, 165, 4, 34, 15, 52, 63, 23, 13, 3, 14, 44, & 18) of 24 sampled residents whose comprehensive care plans were reviewed. Failure to establish care plans that were individualized, with identified goals, that accurately

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505400	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENUMCLAW HEALTH & REHAB CENTER	2323 JENSEN STREET ENUMCLAW, WA 98022

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) reflected the residents condition, and implement plans of care placed residents at risk for unmet needs. Findings included . RESIDENT #14 According to the 12/19/2019 Quarterly MDS, Resident #14 had no open [MEDICAL CONDITION] or wounds and required extensive assistance with personal hygiene. Observations on 02/27/2020 at 1:28 PM, showed the resident had chipped, long fingernails with scant amounts of fingernail polish, the majority of which was chipped off. At this time, a foot cradle was noted at the foot of the resident's bed but no side rails or assistive devices were noted on the bed. Additionally, observation at this time, with Staff B, Director of Nursing, confirmed the presence of a wound to the right second toe. According to a 07/16/2018 Recreation Care Plan (CP), the resident, enjoys getting her nails painted at mani's on Thursdays. In an interview on 03/03/2020 at 9:05 AM, Staff B stated it did not appear staff had implemented the intervention of mani's on Thursdays and confirmed there was no direction on the CP to implement a foot cradle. According to an ADL (Activities of Daily Living) CP, interventions included, Bilateral bed mobility bars. In an interview on 03/03/2020 at 9:20 AM, Staff B and C confirmed the resident had no bed mobility bars on the bed and the CP was inaccurate. According to a 07/08/2019 [MEDICAL CONDITION] CP with a goal of to maintain an adequate H & H (hemoglobin and Hematocrit) which directed staff to, Monitor labs per MD orders. A separate CP indicated Resident #14 was receiving Hospice benefits and should not have labs done. In an interview on 03/03/2020 at 8:16 AM, Staff B stated the CP should be clarified because there was no way to determine adequate H & H in the absence of lab testing. Review of CP documents showed no identification of the right toe wound, no goals and no interventions. In an interview on 03/03/2020 at 8:16 AM, Staff B stated the CP should reflect this information. RESIDENT #42 According to the 01/28/2020 Annual and 11/07/2019 Quarterly MDSs, Resident #42 did not display [MEDICAL CONDITION]. Review of the resident's 01/31/2019 Antipsychotic Medication CP, the resident had paranoia and staff should Review in Mood and Behavior Meeting quarterly or as needed. Record review showed no indication the resident demonstrated paranoia and staff did not review the resident quarterly in the Mood and Behavior Meeting. In an interview on 03/03/2020 at 8:16 AM, Staff B stated the resident did not demonstrate paranoia and the CP should be revised. Staff B confirmed the care planned quarterly reviews did not occur. According to a 01/31/2019 CP, the resident had Verbal behavior symptoms directed toward others .related to pain . According to an interview on 03/03/2020 at 8:16 AM, Staff B stated the CP should, but did not specify, the resident's pain was related to hemorrhoids, nor were there specific individualized interventions identified for the resident's [MEDICATION NAME] pain. An additional [MEDICAL CONDITION] CP dated 01/31/2019 indicated the resident experienced hallucinations. In an interview on 03/03/2020 at 8:16 AM, Staff B stated she was unable to find documentation in the record to support the resident demonstrated hallucinations and the CP should be amended. According to a Hypertension CP dated 05/09/2018, staff were directed to, Monitor for and document any [MEDICAL CONDITION]. In an interview on 03/03/2020 at 8:16 AM, Staff B indicated the resident didn't have any [MEDICAL CONDITION] and the CP should be updated. Review of a 12/23/2019 CP showed Resident #42 had an actual fall. In an interview on 03/03/2020 at 8:16 AM, Staff B stated the CP should have, but did not reflect, interventions identified to prevent the fall. According to the 01/28/2020 MDS, the resident was assessed as frequently incontinent of bowel. According to an At risk for constipation CP dated 11/13/2018, staff are to, Encourage (resident) to sit on toilet to evacuate bowels if possible. In an interview on 03/03/2020 at 8:16 AM, Staff B indicated the instructions were not clear as to when staff should attempt this intervention and the CP should be clarified. RESIDENT #44 According to the Vision CP dated 01/25/2019, the resident was identified as at risk for vision problems/pain related to old age. In an interview on 03/04/2020 at 10:22 AM, Staff B indicated the CP needed to be clarified as it would be unusual to have pain related to vision. According to a Respiratory CP dated 11/13/19, staff were to Monitor 02 sats (oxygen saturation) as per MD order and apply 02 as MD order. In an interview on 03/04/2020 at 10:22 AM, Staff B indicated the CP needed to be updated as the resident had no order for oxygen and staff were not monitoring oxygen saturation levels. During an observation and interview on 02/25/2020 at 1:44 PM, Resident #44 start crying spontaneously during the conversation, stating her head hurt related to a lesion located on the back of her head. The At risk for pain related to . CP dated 11/13/2019 did not identify the resident's pain related to the head lesion but directed staff to attempt non pharmaceutical interventions prior to administering pain medication. In an interview on 03/04/2020 at 10:22 AM, Staff B indicated the CP should, but did not identify potential pain and associated interventions related to the head lesion and that the interventions needed to be amended. According to a Pacemaker CP dated 09/24/2019, nursing staff should ensure follow up with cardiology. In an interview on 03/04/2020 at 10:22 AM, Staff B indicated the CP needed to be updated as the resident received Hospice services with no further cardiology follow up. RESIDENT #15 Resident #15 admitted to the facility on [DATE]. According to the 1[DATE]19 Admission MDS, the resident was cognitively intact, had [DIAGNOSES REDACTED]. Review of Resident #15's 02/04/2020 hospital discharge summary showed the resident had a open reduction internal fixation (ORIF) secondary to a distil left femur fracture. According to the hospital discharge paperwork the resident was non weight (wt) bearing to bilateral lower extremities (LEs) secondary to [MEDICAL CONDITION] and baseline of no motor function in LEs and recent left femur ORIF. The resident was also being treated with a 12 week course of IV antibiotics for underlying osteo[DIAGNOSES REDACTED]. According to a .requires assistance for transfers . CP, revised 02/21/2020, staff were directed to provide one person extensive assistance with transfers to maintain safety. There was no instruction to staff as to how to accomplish the transfer, given the residents [MEDICAL CONDITION] and non-weight bearing status. Review of the February 2020 activity of daily living charting, showed the resident required two person extensive assistance with transfers. During an interview on 03/04/2020 at 7:53 AM, when asked if the transfer CP was accurate Staff C, stated, No. A Post surgical intervention for right [MEDICAL CONDITION] ORIF CP, initiated 02/21/2020, had an intervention of Weight bearing and precautions per MD order. During an interview on 03/04/2020 at 7:53 AM, when asked what Resident #15's weight bearing status was Staff C looked at the CP and indicated she did not know, and and acknowledged the resident's specific weight bearing status and precautions should be identified on the CP. Additionally, Resident #15 had a Left femur ORIF, not a right hip ORIF as stated in the CP. When asked if the CP was accurate Staff C stated, No. Review of the February 2020 Medication Administration Record [REDACTED]. Review of the comprehensive CP showed no indication Resident #15 had a PICC, had a [DIAGNOSES REDACTED]. During an interview on 03/04/2020 at 7:53 AM, when asked if the resident's PICC line, osteo[DIAGNOSES REDACTED], and IV antibiotics should be identified on his comprehensive CP Staff C stated, Yes. When asked if they were Staff C stated, No. Record review showed Resident #15 was transferred to the hospital on [DATE], and readmitted to the facility on [DATE]. According to 02/12/2020 hospital progress notes the resident only had one kidney due to prior right nephrectomy, and was diagnosed with [REDACTED]. Review of the comprehensive CP showed: no indication the resident had a right nephrectomy; no CP, goals or interventions were developed addressing the resident's CKD, [MEDICAL CONDITIONS], or use of diuretics; and there was no CP developed directing staff to monitor for signs and symptoms of [MEDICAL CONDITION]. During an interview on 3/13/2020 10:40 AM, Staff C stated the above identified problems should have been, but were not, care planned. RESIDENT #4 During an interview on 02/25/2020 at 11:32 AM, when asked if she had any problems with her vision Resident #4 indicated she had just seen the facility optometrist and he had ordered her a new pair of glasses. The resident motioned to a pair of glasses on her table indicating they no longer worked well and stated, I had them for about five years. A Risk for vision problems .related to impaired/ poor vision CP, revised 12/11/2019, showed no indication the resident required glasses, and gave no instruction to staff to ensure glasses were clean and/or provided to the resident. Nor did it address that the resident had been seen by the facility optometrist and was awaiting new glasses. On 03/03/2020 at 7:31 AM when asked if her new glasses came in Resident #4 stated, Yes they did, I got two pair. During an interview on 03/04/2020 at 7:42 AM, when asked if a resident required the use of glasses, if it should be reflected on the CP Staff C stated, Yes. When asked if resident #4's glasses were CP'd, Staff C stated, No. A .dementia . CP, initiated on 12/09/2019, identified a target behavior (TB) for the resident's dementia as Choosing not to speak. Review of the comprehensive CP revealed that was the identified TB for the use of [MEDICATION NAME] (an anxiolytic) and [MED] (an antidepressant) for the treatment of [REDACTED]. During an interview on 03/04/2020 at 7:42 AM, when asked if the CP was accurate in identifying Choosing not to speak as a TB for dementia Staff C stated, No. According to the 12/06/2019 Admission MDS, the resident had an active [DIAGNOSES REDACTED]. CP, revised 02/21/2020, failed to identify [MEDICAL CONDITION] as a risk factor for falls. During an interview on 03/04/2020 at 7:42 AM, Staff C confirmed Resident #4 had a [DIAGNOSES REDACTED]. RESIDENT #165 In an interview on 02/26/2020 at 8:24 AM, Resident #165 indicated she was supposed to receive two showers a week, but they were not consistently provided. Review of Resident #165's comprehensive CP showed a 02/13/2020 Self care . assistance for ADLs . CP that directed staff to Shower per schedule. During an interview on 03/03/2020 at 10:21 AM, when asked where Resident #165's bathing preference could be found Staff B, Director of Nursing, explained that resident bathing preferences were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505400	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENUMCLAW HEALTH & REHAB CENTER	**2323 JENSEN STREET ENUMCLAW, WA 98022**

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) documented on the CP. When asked if Resident #165's bathing preferences for frequency were on the CP Staff B stated, No and indicated they should be. RESIDENT #63 Resident #63 admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. According to the 02/16/2020 Quarterly MDS, the resident transfers and walk in her room with supervision. A Post surgical intervention for right [MEDICAL CONDITION] CP, revised 0[DATE]20, lists a intervention of Weight bearing and precautions per MD order. During an interview on 03/04/2020 at 8:03 AM, when asked what the weight bearing restrictions were Staff C acknowledged the CP was not resident specific and needed to be updated, as the resident was 3 months post op and was walking with supervision. RESIDENT #23 A .[MEDICATION NAME] and [MEDICATION NAME] r/t (related to) [DIAGNOSES REDACTED]. Review of the January and February 2020 MARs showed no behavior monitors were present. During an interview on 03/03/2020 at 12:39 PM, when asked if the behavior monitors were on the MAR indicated [REDACTED]. When asked if the CP was accurate, Staff C stated, No. The .[MEDICATION NAME] and [MEDICATION NAME] r/t (related to) [DIAGNOSES REDACTED]. Record review showed Resident #23 was referred to psychiatry for .worsening depression, helpless, increased verbal agitation and impulsive behavior. According to the practitioner's 0[DATE] note the Resident reported feeling depressed and anxious due to acute pain and medical concerns. Under Impression Staff S, Psychiatric Advanced Registered Nurse Practioner, documented Situational depression and anxiety with unstable mood due to acute stressors. Staff S recommended a trial of [MEDICATION NAME] (an anxiolytic) as needed for anxiety (which was denied by the primary care physician), and [MEDICATION NAME] (an anxiolytic) twice daily, as an adjunct to [MEDICATION NAME] (an antidepressant). In an interview on 03/03/2020 at 11:58 AM, Staff S, clarified that the [MEDICATION NAME] order was for depression with situational anxiety. During an interview on 03/03/2020 at 12:39 PM, when asked if the CP was accurate in stating that the [MEDICATION NAME] was for depression and the TB were Crying /tearfulness Staff C stated, No and acknowledged the resident was given a [DIAGNOSES REDACTED]. RESIDENT #3 Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of February 2020 MAR indicated [REDACTED]. Record review revealed no CPs with goals or intervention regarding the resident's [MEDICAL CONDITION]. RESIDENT #34 According to the 01/15/2020 Annual MDS, Resident #34 was cognitively intact, understood by others and able to understand conversation. According to 04/02/2019 Smile Seattle dentures consult, Resident #34 was referred for X-rays, dental evaluation and extraction and was identified with temporomandibular joint TMJ (cheek bone) pain. Recommendation from this consult included a referral for new upper and lower dentures. Record review revealed no CP with goals or intervention regarding the resident's TMJ pain, dental referrals or recommendations. RESIDENT #35 Resident #35 was admitted to the facility on [DATE] with medically complex diagnoses, including hypertension and [MEDICAL CONDITION]. Review of February 2020 MARs revealed Resident #35 received [MEDICATION NAME] 40 milligrams (diuretic medication) for hypertension. Record review revealed no CPs with goals or intervention regarding the resident's diuretic medication RESIDENT #18 Resident #18 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].#18 received [MEDICATION NAME] (diuretic medication) every morning for [MEDICAL CONDITION] and [MEDICAL CONDITION]. Record review revealed no CPs with goals or intervention regarding the resident's diuretic medication In an interview on 02/28/2020 at 11:25 AM, Staff D, Resident Care Manager, (RCM) confirmed that there was no CP which addressed the Resident's #3's [MEDICAL CONDITION] and medication, Resident # 34's TMJ Pain, referral and recommendation, and Resident #35 and #18 diuretic medications. Staff D, further indicated the CP should be updated to reflect the resident's current care needs. On 03/02/20 at 11:10 AM, the above findings were shared with Staff B, who acknowledged the care plans were not updated and indicated RCMs were responsible to update residents care plans to reflect the current status of each residents. RESIDENT #13 Resident #13 was assessed to require an indwelling Foley catheter per the 12/19/2019 Annual MDS. A review of the Alteration in Elimination R/T Neuromuscular Dysfunction of Bladder CP initiated on 06/12/2018 showed it directed staff to Change catheter Q (every) month per MD orders. However, a physician's orders [REDACTED]. When asked in an interview on 03/03/2020 at 01:45 PM whether the CP or the PO was correct, Staff C, RCM, stated the order and further stated that the CP needed to be updated. RESIDENT #52 Resident #52 received a PO for a daily fluid restriction of 1500cc beginning 02/10/2020. However, Resident #52's Hypertension - risk for hypo/hypertension, risk for adverse side effects of fluid imbalance CP, revised 02/15/2019, states that Resident #52 is on a 2000cc/day fluid restriction. This CP also stated No water pitcher in room but Resident #52 was observed with a water pitcher on his over-the-bed table throughout the data collection period, including at 02/28/2020 at 09:10 AM and on 03/02/2020 at 10:33 AM When asked in an interview on 03/02/2020 at 01:45 PM which number was correct, Staff C affirmed that the 1500cc quantity was. When asked if the CP needed revision, Staff C stated, I'll have to ask and get back to you. Staff C provided no further clarification. REFERENCE: WAC 388-97-1020(1), (2)(a)(b). .

F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure services provided met professional standards of practice for six (#s 64, 63, 23, 52, 15 & 42) of 22 residents reviewed. Nursing staff failed to obtain, follow or clarify physicians orders (PO) when indicated for (#s 42, 64, 23, 63, 15), document for only those tasks completed for resident (#s 23). These failures placed residents at risk for medication errors, delayed treatment, and adverse outcomes. Findings included . RESIDENT #42 Review of January 2020 Medication Administration Records (MARs) showed staff were instructed to administer, Preparation H for Women pad .topically in the morning for hemorrhoids . According to the MAR, staff documented OO (On Order From Pharmacy) on 25 occasions, the resident received the medication on three occasions, and refused the medication twice. In an interview on 03/03/2020 at 8:40 AM, Staff N, Licensed Practical Nurse (LPN), stated Preparation H was a house supply medication that was always available, and was unsure why staff were documenting it was on order from the pharmacy. In an subsequent interview on 03/03/2020 at 8:50 AM, Staff B, Director of Nursing (DON), stated the nurses should have utilized the medication available and in the event any medication was unavailable, should have it satellited to the facility. Record review showed a PO for a TSH ([MEDICAL CONDITION] Stimulating Hormone) level, based on a pharmacy recommendation, to be drawn in November 2019. According to laboratory records dated 11/14/2019, the resident refused the blood test. Further record review showed additional blood tests were successfully performed on 02/04/20 and 02/11/20. In an interview on 03/03/2020 at 10:15 AM Staff C, Resident Care Manager (RCM), stated, We (nursing staff) should have rescheduled the TSH to be done with the (02/04 and 02/11/2020 blood tests). RESIDENT #64 Resident #64 admitted to the facility on [DATE] with multiple complex medical diagnoses. A review of the documentation on the POC (Point Of Care, charting software used by Nurse Aides) Response History: Bowel Monitor showed the resident had no documented bowel movement on 02/19, 02/20, 02/21, 02/23, 0[DATE], 02/25 and 02/26/2020. A review of the documentation on the February 2020 MAR indicated [REDACTED]. Administer milk of magnesia per physician order [REDACTED]. On 02/25/2020 staff documented a [MEDICATION NAME] suppository was administered on 02/25/2020 at 1:33 PM. Additionally, on 03/02/2020 at 8:46 AM, Staff D, RCM said, well, according to the documentation on the February MAR, he should've received MOM on 02/ 0. However, it doesn't look like the MOM was administered before the administration of the [MEDICATION NAME] on 0[DATE]. Also, the staff documented a Fleets enema was administered on 02/26/2020 at 6:30 AM before the administering of MOM or a [MEDICATION NAME] suppository on day four. According to Staff D, the facility's bowel protocol required the staff to administer MOM on the fourth day if the resident hadn't had a BM followed by a [MEDICATION NAME] suppository on the next shift if the suppository failed to produce a BM the staff was instructed to administer a Fleets enema. Staff D said, based on the documentation on the MAR, the staff failed to follow the facility's bowel protocol. PAIN MEDICATION RESIDENT #64 A review of the physician's orders [REDACTED]. Administer 1 tablet by mouth every 6 hours as needed for pain 7-10/10. On 02/11/2020 at 5:08 PM, Staff V- RN documented the resident had a pain score of 6, which she administered [MEDICATION NAME] 5-325 mg. On 02/12/2020 at 7:18 PM, the facility staff documented the administration of 1 [MEDICATION NAME] tablet for a reported pain scale of 4. On 02/13/2020 at 1:36 AM the resident received 1 [MEDICATION NAME] tablet with a documented pain scale of 4. Also, at 8:40 PM, the same day staff documented the resident received 1 [MEDICATION NAME] tablet for a pain score of 6. On 0[DATE] at 9:40 PM. The staff documented the resident's pain score was 6. On 0[DATE] at 3:51 AM, The resident's documented pain level was 2, at 3:09 PM. The same day the resident's reported pain level was 5. A review of the documentation on the February 2020 MAR indicated [REDACTED]. In an interview on 03/03/2020 at 8:44 AM, Staff B-DNS said, based on the documentation on the February 2020 MAR's, it appears the facility staff failed to follow the physician's orders [REDACTED].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505400	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENUMCLAW HEALTH & REHAB CENTER	2323 JENSEN STREET ENUMCLAW, WA 98022

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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) RESIDENT #23 Review of the February 2020 MAR indicated [REDACTED]. Nurses were also directed to Check to see what the previous wts have been. Review of the daily wts showed on 02/12/2020 Resident #23 weighed 255.8 lbs. On 02/13/2020 his wt was 263.4 lbs, showing a 7.6 pound wt gain in one day. Record review showed no indication the nurse identified the wt gain, or notified the physician. In an interview on 03/02/2020 at 10:10 AM, when asked if there was documentation nursing identified the wt gain, and notified the physician as ordered Staff B, DON, stated, No. Review of the February 2020 MAR indicated [REDACTED]. According to the MAR indicated [REDACTED]. During an interview on 03/04/20 at 08:42 AM, when asked if the nurses followed the PO on the above occasions Staff C stated, No. A 0[DATE] nurses note indicated the resident was found on the floor, and after being assisted back to bed became unresponsive. The resident's oxygen saturation (SP02) dropped into the 60's. Oxygen was placed the resident's SP02 went up to the 80's . Record review showed a 12/26/2019 order for Oxygen as needed to keep SPO2 greater than 90%. Review of the February 2020 MAR indicated [REDACTED]. During an interview on 03/03/20 at 07:03 AM Staff B explained it was the expectation that nurses sign off on the MAR for medications they administered, upon returning to the cart. On 03/03/2020 at 6:06 AM Staff X, Licensed Practical Nurse (LPN), was informed that Resident #23's 8:00 AM medication pass were going to be observed, to include Resident #23's intravenous (IV) [MEDICATION NAME]. Staff X indicated indicated it was too early and would pass the medciaitons later. At approximately 6:45 AM, Staff X was reminded that Resident #23'sthe medication pass was going to be observed. At that time Staff X reported that Resident #23's IV [MEDICATION NAME] (which was scheduled for 8:00 AM) had also already been administered by Staff R, Registered Nurse. Staff X explained the facility did not allow LPNs to give IV push medications. When asked why it had not been signed off on the MAR indicated [REDACTED]. When queried why it was administered if it was not due Staff X indicated Staff R had her own residents We kind have to work around her schedule. According to Staff X, Staff R administered the IV [MEDICATION NAME], before she administered Resident #23's 6-10 AM flex pass medications, which were time stamped as administered at 6:31 AM. During an interview on 03/03/20 at 07:03 AM, when asked if Staff R administered the IV [MEDICATION NAME] in accordance with the PO Staff B, stated, No. At 7:45 AM Staff X was asked if she was ready to give Resident #23 the rest of his 8:00 AM medications. Staff X stated she had already administered them. Record review showed a 12/26/2020 order for Calcium acetate, with instruction to give with meals. According to the MAR indicated [REDACTED]. During an interview on 03/03/2020 at approximately 10:30 AM, when asked if Resident #23 had his breakfast tray at 7:26 AM Staff X stated, Not yet, but I knew it was coming. When asked if the order specified to administer with meals Staff X stated, Yes and acknowledged she failed to administer the medication in accordance with the PO. Additionally, review of the MAR indicated [REDACTED]. During an interview on 03/03/2020 at 8:44 AM, when asked if nurse's should sign for medications they did not administer Staff X stated, No. and acknowledged Staff R administered the medication. When asked if the documentation that it was administered at 7:26 AM was accurate Staff X stated, No. RESIDENT #15 Review of the February 2020 Treatment Administration Record (TAR) showed a 0[DATE] Peripherally Inserted Central Catheter (PICC) maintenance order, that directed staff to Measure arm circumference 10 cm above external length. During an interview on 03/03/20 at 11:27 AM , when asked what the order meant Staff C stated, It is unclear and needs to be clarified. RESIDENT #63 A 12/19/2019 nutrition interdisciplinary team (IDT) note made a recommendation to increase the resident's Cal Dense (nutritional shake) from 60 cc TID (three times daily) to 90 cc TID. Review of the December 2019 MAR indicated [REDACTED]. However, the order for Cal Dense 60 cc TID did not get discontinued. Nurses documented daily that they provided, and the resident consumed, both the 60 cc and 90 cc of Cal Dense TID. During an interview on 03/04/20 at 08:11 AM, when asked if the order for 60 cc of Cal Dense TID should have been discontinued when the 12/23/2019 order for 90 cc TID was implemented Staff C stated, Yes and acknowledged that did not occur. When asked if subsequent nurses should have identified/questioned the duplicative order Staff C stated, Yes, and it should have been clarified. Additionally, on 01/31/2019 at 12:00 PM and 4:00 PM, nurses documented they, provided 120 cc of Cal Dense when the order was for 90 cc. During an interview on 03/04/20 at 08:11 AM, when asked if the nurses followed the PO Staff C stated, No. On 12/30/2019 Resident #63's wt was 153.6 lbs (-12.3%) from the resident's 11/22/2019 admission wt of 175 lbs, and (-7.36%) from her12/17/2019 wt of 165.8lbs, demonstrating significant wt loss. Record review showed no indication staff notified the MD. During an interview on 03/02/20 12:11 PM , Staff C stated nursing should have identified the wt loss, and notified the MD. When asked if that occurred Staff C stated, No. WEIGHTS RESIDENT #52 Resident #52 had a PO dated 01/27/2020 that directed staff to transcribe the post-[MEDICAL TREATMENT] weights every Monday, Wednesday and Friday. Resident #52's recorded weight on 02/28/2020 was 79.6 lbs. It was noted as 173.8 lbs on 02/26/2020. Review of Resident #52's [MEDICAL TREATMENT] transfer paperwork revealed that [MEDICAL TREATMENT] recorded weights in kilograms (Kg) rather than pounds. Further review of Resident #52's weight record showed four occasions in February 2020, where facility staff recorded the [MEDICAL TREATMENT] wt that was in Kg, as pounds without performing the conversion. In an interview at 09:24 AM on 03/02/2020, Staff C acknowledged the weight was inaccurately transcribed, and that this error did not meet professional standards of nursing. REFERENCE: WAC 388-97-1620(2)(b)(1)(ii), (6)(b)(i) .
F 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a discharge planning process to effectively transition the residents to a community for one residents (#27) of three residents reviewed for discharge planning. This failure placed the residents at risk for an unsafe discharge and diminished quality of life. Findings included RESIDENT #27 Resident #27 admitted to the facility on [DATE] for care needs related to [MEDICAL CONDITION]. According to the resident's 01/07/2020 Quarterly MDS (Minimum Data Set-an assessment tool), the resident was cognitively intact. Section Q of the MDS, Assessment and Participation in Goal Setting, showed no active discharge plan was in place for the resident to return to the community. In an interview on 02/25/2020 at 10:25 AM, Resident #27 said he wanted to be discharged to an assisted living community, and that the plans were in place before, but he didn't know what had changed. Review of 05/03/2019 Social Service (SW) progress notes showed, Resident had asked to speak to a SW. Resident's Power of Anthony informed him of the discussion at his care conference that he did not attend and after learning that he will no longer be allowed to take the entire room to himself, he asked for assistance in finding another place to live. Record review showed no indication the facility addressed the resident's identified and preferred discharge goals. In an interview on 03/02/2020 at 11:10 AM, Staff BB, Social Worker Assistant, revealed that she had contacted the local assisted living but it was full. When asked if she contacted other places, Staff BB said No. Staff BB, further acknowledged the discharge plans had not been implemented according to the resident's requests. In an interview on 02/07/2020 at 2:50 PM, Staff E, Director of Social Service, acknowledged that there was no discharge planning in place for Resident #27. REFERENCE: WAC 388-97-0080. .
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 observation, interview and record review, the facility failed to provide ADLs for dependant residents including bathing, nail care, oral care, hair care, and denture care for five (#8, 14, 44, 34 and 3) of ten residents reviewed for activity of dailiy living. Failure to provide the residents, who were dependent on staff for assistance for bathing, nail care, hair care,oral care and denture care placed the residents and others at risk for poor hygiene, unmet care needs and a diminished quality of life. Findings included . RESIDENT #8 Resident #8 admitted to the facility on [DATE] and according to the 12/11/2019 Admission Minimum Data Set (MDS -an assessment tool) the resident required extensive two person assistance with toileting and personal hygiene. According to this MDS, bathing did not occur during the assessment period and the resident experienced one sided impairment of upper extremity range of motion. Observation on 02/25/2020 at 10:18 AM showed the resident had copious amounts of white debris in the gumline and was noted with long fingernails which were also moderately soiled with brown debris on the left hand. The resident was unshaved with what appeared to be a few days of facial growth. The resident stated at this time his teeth were brushed maybe once a week and would like to be shaved, if they don't cut me up. Similar findings of long, soiled nails, debris in gumline and unshaven facial hair were identified on 02/26/2020 at 7:45 AM and 2:50 PM and on 02/27/2020 at 8:15 AM. In an interview on 02/27/2020 at 10:02 AM Staff B, Director of Nursing, stated that ADLs (Activities of Daily Living), including oral and nail care, occur, in the morning they do oral care, comb hair .nail care occurs when the shower aides do the nail care on the shower days. Staff B indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505400	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENUMCLAW HEALTH & REHAB CENTER	2323 JENSEN STREET ENUMCLAW, WA 98022

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 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) the bathing occurred minimally once a week. During an observation on 02/27/2020 at 10:06 AM, Staff B confirmed the resident had long soiled fingernails, was unshaven and had red inflamed gums with debris in the gumline. When asked if it appeared the resident had received oral care recently, Staff B replied, No, doesn't look like he's received oral care. The resident was again asked how often he received oral care to which he replied, once a week. When asked at this time if he would like to be shaved, the resident replied, That would be nice. On 02/27/2020 at 10:17 AM Staff B was unable to find oral care equipment for Resident #8 in his room or his bathroom. Review of bathing records for Resident #8 showed the resident was bathed three times in January (01/01/2020, 01/13/2020 and 01/28/2020) and February (02/03/2020, 03/12/2020 and 02/23/2020) 2020. On 02/27/20 at 10:25 AM, Staff B confirmed Resident #8 did not received ADL care as required. RESIDENT #14 According to the 09/28/2019 and 12/19/2019 Quarterly MDSs Resident #14 required extensive one person assist with personal hygiene and bathing did not take place during the assessment period. According to these MDSs the resident was assessed with [REDACTED]. Observations on 02/26/2020 at 8:25 AM showed Resident #14 lying in bed, the resident was noted with uncombed hair and teeth that had heavily crusted with white and pink bits. The resident stated she was wearing only upper dentures and she was unaware of when staff last brushed her dentures. The resident's right hand was noted with fingernails that were chipped, and had remnants of fingernail polish. The resident's left hand, was noted with fingers curled inward that hand very long nails extending significantly past the tips of the resident's fingers. In an interview on 02/27/2020 at 1:34 PM, Staff N, Licensed Practical Nurse, stated, She won't let anybody touch her left hand. During an observation on 02/27/2020 at 1:28 PM, Staff B confirmed the resident's left hand fingernails were, very long. When asked the significance of long fingernails in a hand with fingers curled down into palm, Staff B stated, It puts her at risk for skin issues. When asked if she would have expected someone to report the long nails, Staff B replied, Yes but indicated she was unaware they were long. Staff B also confirmed Resident #14's upper denture appeared soiled and was unable to find a denture cup for Resident # in the resident's room According to the February 2020 Treatment Administration Record (TAR) licensed staff did nail care on 02/08/2020 and 02/15/2020 and refused nail care on 02/22/2020. In an interview on 02/27/2020 at 1:32 PM, Staff B stated it did not appear the resident's left fingernails had been trimmed in, a while. In a further interview, when asked if she was able to find a brush or denture cup for the resident, Staff B replied, No. When asked if it appeared the resident received oral or nail care recently, Staff B replied, No. RESIDENT #44 Resident #44 admitted to the facility on [DATE] and according to the 01/31/2020 Quarterly MDS the resident required one person extensive assistance with personal hygiene. Observation on 02/25/2020 at 1:38 PM showed Resident #44 gesture to her fingernails stating, these are too long, they need trimmed, I want em like this one (resident gestured to the second finger of the left hand. At this time the resident indicated she didn't always get bathed once a week as she should. Review of bathing records showed the resident went from 10/31/2019 to 11/12/2019 without a bath and from 11/14/2019 to 11/25/2019 without a shower/bathing. According to these records, the resident went 10 days without bathing from 01/31/2020 to 02/10/2020. In an interview on 03/04/2020 at 9:00 AM, Staff B confirmed the resident did not receive assistance with bathing as required. During an observation on 02/27/2020 at 1:08 PM, Staff B confirmed the resident had long fingernails which she wanted trimmed. RESIDENT #34 According to the 01/15/2020 Annual MDS, Resident # 34 was cognitively intact and required one person assistance with personal hygiene. Review of Resident #34's Self-care deficit related to weakness at times Care Plan, revised 10/17/20, showed a goal of, Resident will be assisted by staff all needs she cannot complete on own, Staff to offer assistance frequently to ensure needs are met daily. On 02/25/2020 at 9:46 AM, Resident #34 was observed sitting in her bed, her hair was long, uncombed and tied in a pony tail. The Resident indicated she washed her hair but needed it to be trimmed short but she had no money to pay for the salon. When asked if she had notified the staff she wanted a hair cut, Resident #34 said, Yes. In interview on 02/28/2020 at 11:50 AM, Staff C, RCM confirmed that there was no indication that Resident #34 received a haircut. When asked what happens to the resident who are not able to pay for salon, Staff C indicated the facility is responsible to provide a basic haircut. I will get her haircut. RESIDENT #3 Resident #3 admitted to the facility on [DATE] with medically complex diagnoses, including diabetes, hypertension and [MEDICAL CONDITION]. According to the 11/29/2019 Quarterly MDS, the resident required extensive assistance with ADLs, including hygiene, grooming and dressing. Review of Resident #3's CP revised 06/05/2019 reflected, Risk for dental impairment related advanced age, upper denture use, and dental extraction of all lower teeth. Intervention: Ensure dentures are in good repair, staff to perform oral care/brushing teeth twice a day and as needed. On 02/25/2020 at 10:01 AM and on 02/26/2020 at 11:15 AM, Resident #3 was observed in his room. Dirty dentures were noted at the bedside table. Two denture cups were noted at the side. Staff N revealed that resident had two pair of dentures. When asked why the denture was left on the table and not placed on denture cup, Staff N indicated she will get the nursing assistant to clean and store them. When asked which dentures does the resident use between the two, Staff N said I am not sure. In interview on 03/02/2020 at 11:35 AM, Staff D, RCM Confirmed that resident had two pairs of dentures in his room, He had a new pair recently and indicated that the nursing assistant are responsible to clean and store them in a denture cup. When asked which dentures the resident uses, Staff D said I don't know. REFERENCE: WAC 388-97-1060(2)(c). .
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 seven (#s 8, 44, 45, 23, 52, 25 & 64) of 22 residents reviewed received the necessary care and services in accordance with professional standards of practice. The facility failed to ensure residents were assessed, monitored, and received the treatment they were assessed to require for two (#s 8, 44) of three sample residents reviewed for non-pressure skin; four (#s 64, 23, 45, 44) five reviewed for [MEDICAL CONDITION] management; one (#52) of one for fluid monitoring; and one (#s 23) of five residents reviewed for bowel management. These failures placed residents at a potential risk of decline in medical status and unmet care needs. Findings included . RESIDENT #8 Resident #8 admitted to the facility on [DATE]. According to the 12/11/2019 Admission Minimum Data Set (MDS, an assessment tool), Resident #8 was assessed to require extensive two person assistance with bed mobility and transfers and had one sided impairment of upper extremity Range of Motion. This MDS indicated the resident was at risk for, but had no MASD (Moisture Associated Skin Damage). According to the undated Kardex (care instructions for direct care staff) staff were directed to, Reposition frequently to avoid excess pressure to bony prominences, Turn/Reposition Routinely and CNA to inform LN of skin integrity daily during routine care . During an interview on 02/25/2020 at 10:24 AM, Resident #8 stated he had a foot wound but was unaware of any other skin issue. Similar observations of the resident lying on his back with no position changes were noted on 02/25/2020 at 11:59 AM and at 1:32 PM. Observation on 02/26/2020 at 7:45 AM showed the resident lying in bed on his back. Observation of a skin assessment with Staff B and C, on 02/27/2020 at 11:42 AM revealed the resident had an open area to the right inner buttock that was noted by staff as 2.2 cm (centimeters) x 1.4 cm with a wound base that was described as, superficial by Staff C. Staff C stated the wound base was red and blanchable, with distinct wound edges on one side of the wound, but not on the other. Per Staff C, the wound was oblong, looks like a half moon. A second, smaller open area was described as .5 cm x .3 cm with a red wound base that was shiny with no drainage. Staff C indicated the wounds appeared to be MASD. In an interview on 02/37/2020 at 12:10 PM, Staff B stated direct care staff should ensure the resident received frequent position changes and report any skin changes to the Licensed Nurse as directed in the plan of care. Staff B confirmed that the facility should have been, but was not, aware of the open areas prior to the requested skin assessment. RESIDENT #44 According to the 01/31/2020 Quarterly MDS, Resident #44 was assessed with [REDACTED]. A 01/15/2020 risk for impaired skin integrity CP indicated the resident had a history of [REDACTED]. According to progress notes dated 02/23/2020 the resident was assessed with [REDACTED].#44 lying in bed on her back with no significant position changes. At this time the resident was noted to reach down into her groin area with her left hand and scratch vigorously stating, ohhh, it itches. During a concomitant interview, the resident stated she had [MEDICAL CONDITION] or swelling in, my right foot. According to Medication Administration Records (MARs) staff administered [MEDICATION NAME] (an anti-itching medication) on 02/25/2020 at 4:04 PM. Record review showed no skin assessment was performed at this time. Observations on 02/27/2020 at 7:46 AM showed Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505400	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENUMCLAW HEALTH & REHAB CENTER	**2323 JENSEN STREET ENUMCLAW, WA 98022**

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 0684

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 6)

#44 lying in bed on her back, the resident indicated she continued to have itchy areas in her groin. Observation of a skin assessment with Staff B and C, on 02/27/2020 at approximately 2:05 PM revealed the resident had [MEDICAL CONDITION] to the right lower extremity as evidenced by indentations in the lower leg upon removal of a sock. Staff B described the [MEDICAL CONDITION] as, 2+ and extended from the foot to above the ankle area. When asked how staff monitored the resident's [MEDICAL CONDITION], In an interview on 02/27/2020 at 2:15 PM, Staff C indicated the resident was on Hospice and received services for comfort only. When asked if [MEDICAL CONDITION] might cause discomfort and what interventions might be implemented in the event the resident had lower extremity [MEDICAL CONDITION], Staff B replied, elevate on pillows for comfort. Failure of facility staff to identify and implement interventions for [MEDICAL CONDITION] placed the resident at risk for worsening [MEDICAL CONDITION] and discomfort. During this skin assessment, the resident's lower back was also identified as red blotchy. The resident declined further skin assessment at this time due to nausea. Record review showed no indication the resident had any current rash. A subsequent progress note dated 02/27/2020 at 4:26 PM showed, LN (Licensed Nurse) and MD reassessed resident's groin/buttocks in relation to nursing reports of worsening rash .area is very red and blotchy .MD .added [MEDICATION NAME] (an antifungal medication). In an interview on 02/28/2020 at 8:10 AM, Staff B indicated staff should have identified and reported the rash prior to the skin assessment performed on 02/27/2020 at 4:26 PM.

RESIDENT #64 In an interview on 02/25/2020 at 10:08 am, Resident #64 complained of feeling bloated and being unable to catch his breath. A review of physician's orders [REDACTED]. The resident also had orders dated 01/11/2020-02/08/2020 for [MEDICATION NAME] 20 mg twice daily related to [MEDICAL CONDITION]. On 02/25/2020, order for [MEDICATION NAME] was increased from 20 mg twice daily to 80mg daily. A review of the risk for fluid imbalance, [MEDICAL CONDITION], SOB CP, revision date of 0[DATE]20, had instructions for staff to monitor [MEDICAL CONDITION] and report substantial changes to MD. In an interview on 03/02/2020 at 9:30 AM, with Staff's B- DNS and Staff C, RN-RCM present Staff B reported, the had gained a substantial amount of weight due to [MEDICAL CONDITION]. When asked if the facility had been monitoring the resident's [MEDICAL CONDITION], Staff C said, We don't have a base line indicating how much [MEDICAL CONDITION] the resident was experiencing. However, there's a general note referencing upper extremity [MEDICAL CONDITION] and increased abdominal and scrotal [MEDICAL CONDITION]. Staff C said, we documented in a progress note on 02/12/2020, that the resident had [MEDICAL CONDITION]. Additionally, there is a note indicating he was seen on 02/19/2020, but we don't have a baseline regarding the specific amount of the [MEDICAL CONDITION] the resident had or where the majority of the [MEDICAL CONDITION] was located.
Staff C said, to be honest, the only documentation I was able to find was the progress note from 02/12/2020. But, there wasn't anything specific suggesting we performed ongoing [MEDICAL CONDITION] monitoring. RESIDENT #25 A review of the 02/27/2020 Physician' orders showed orders for a [MEDICAL CONDITION]/BIAP machine at 12-17 CM with 0 liters of O2. Staff were instructed to have the resident wear the [MEDICAL CONDITION] at night and remove in the morning. A review of the Respiratory-[MEDICAL CONDITION] Care plan revised on 07/09/18, showed a goal of wearing the [MEDICAL CONDITION] during the night and maintain optimal air movement, with no increase signs of SOB or weakness. Interventions included, assessing the resident for signs or symptoms of [MEDICAL CONDITION] including increased confusion. A review of the February 2020 MAR/TAR showed facility staff failed to document if they assisted the resident with the application of [MEDICAL CONDITION] at bedtime on 02/01, 02/05, 02/07, 02/10, 02/16, 02/18, 02/20 and 02/25/2020. In an interview on 02/25/2020 at 10:41 AM, the resident stated she used a [MEDICAL CONDITION] usually at night. During a subsequent interview on 02/28/2020 at 12:53 PM, the resident said, sometimes I have trouble sleeping. Well it's mostly when I don't wear my [MEDICAL CONDITION]. When the resident was asked why she didn't wear the [MEDICAL CONDITION] as often as she should, she replied, the head gear is too tight and needed to be adjusted. She said, The nurses will help me adjust the head gear, but most of the time I forget to ask them to adjust it for me. On 02/28/2020 at 11:37 AM, Staff B DNS said, The resident's orders for the use of a [MEDICAL CONDITION] were routine and should be applied each night and removed in the AM. According to Staff B the expectation was the evening shift nurse would assist the resident with the application of the [MEDICAL CONDITION] and the following morning the day shift nurse would ensure the [MEDICAL CONDITION] was removed and properly stored.

RESIDENT #23 Review of the February 2020 POs showed Resident #23 had the following as needed (PRN) bowel orders: Milk of Magnesia (MOM) PRN if no bowel movement for three days, administer on day four; and [MEDICATION NAME] Suppository as needed for constipation, if no results from MOM, administer on next shift, during waking hours. Review of the February 2020 bowel flowsheet revealed Resident #23 had no bowel movement (BM) from 02/09/2020 through 02/12/2020 (4 days). Review of the MAR indicated [REDACTED]. During an interview on 03/03/2020 at 12:58 PM, when asked if Resident #23 received MOM on day four of no BM as ordered, Staff C stated, No. RESIDENT #23 According to the 12/18/2019 Admission MDS, the resident had a [DIAGNOSES REDACTED]. On 02/25/20 at 12:27 PM Resident #23 was observed with bilateral lower extremity ([MEDICAL CONDITION]) with dark pigmentation noted to the the bilateral shins. No further observations were made during the survey secondary to UNNA boots being in place. Review of the February 2020 POs showed the resident had a 01/25/2020 order for [MEDICATION NAME] (a diuretic) 40 mg daily for acute on chronic [MEDICAL CONDITION]. On 02/12/2020 the [MEDICATION NAME] was discontinued and the resident was started on [MEDICATION NAME] 50 mg twice daily per nephrology recommendation. Additionally, the resident had a 12/31/2019 order for daily weights (wt), with instruction to staff to notify the physician if there was a wt change of greater than two pounds (lbs) in one day, or three pounds in a week. Nurses were also directed to Check to see what the previous wts have been. Review of the February 2020 Treatment Administration Record (TAR) showed that in the first 25 days of February, the resident either refused or staff failed to obtain a daily weight 16 times, rendering the daily weights an ineffective means to assess the effectiveness of diuretic therapy and fluid volume status.
A 01/01/2020 [MEDICAL CONDITION] risk for fluid imbalance, [MEDICAL CONDITION] . CP directed staff to Evaluate for increase in [MEDICAL CONDITION] .and report to MD as indicated. During an interview on 03/02/20 at 10:25 AM, when asked how staff evaluate the effectiveness of diuretic therapy for resident's with [MEDICAL CONDITION] and associated [MEDICAL CONDITION] Staff B, Director of Nursing, stated, At least daily there will be (nurses) notes grading the [MEDICAL CONDITION]. A 02/10/2020 wound care note assessed the periwound of left anterior ankle diabetic ulcer as [MEDICAL CONDITION]. Under additional orders the practitioner wrote compression- UNNA boot (compression dressing made by wrapping layers of specialized gauze around the leg and foot, used to improve blood flow and decrease [MEDICAL CONDITION]) three times weekly and PRN. On 0[DATE] Resident #23 was transferred to the hospital after an episode of non-responsiveness and his oxygen saturation dropping into the 60's. The resident returned to the facility the same day with a [DIAGNOSES REDACTED]. According to the 02/20/2020 and 02/23/2020 at 3:50 AM skilled nursing notes the resident's Leg has new sores and weeping .(Left) leg has multiple open sore (sic) and weeping (fluid leaking out directly from the skin, due to severe swelling/[MEDICAL CONDITION]). However, in the next line the nurse documented Resident does not have any [MEDICAL CONDITION]. A second skilled nursing note on 02/23/2020 at 10:19 AM, assessed the resident had open sores, blisters and weeping to his bilateral LEs. Again, in the next line the nurse documented No redness, swelling . resident does not have any [MEDICAL CONDITION]. Similar findings were noted for the 0[DATE]20 and 02/26/2020 skilled nursing notes, in which nursing documented multiple blisters, open sores, and weeping were present, but then assessed the Resident does not have any [MEDICAL CONDITION]. In an interview on 03/03/2020 at 7:12 AM, Staff C acknowledged that Resident #23 had weeping [MEDICAL CONDITION]. When asked if facility staff should assess the resident's [MEDICAL CONDITION] with each UNNA boot change to determine the effectiveness of the compression dressing and diuretic therapy Staff C stated, Yes. When asked if that occurred Staff C indicated the [MEDICAL CONDITION] was addressed in the skilled nursing notes. Staff C reviewed the skilled notes and identified in each note, after describing the blisters and weeping, the nurse documented Resident does not have any [MEDICAL CONDITION]. When asked if the [MEDICAL CONDITION] assessments were accurate Staff C stated, No.
RESIDENT #45 According to the 01/22/2020 Admission MDS, the resident was cognitively intact with clear comprehension, had a [DIAGNOSES REDACTED]. Review of the [DATE] readmission Nursing Evaluation showed the resident was assessed to have bilateral 1+ pitting pedal (foot/ankle) [MEDICAL CONDITION]. A 01/17/2020 [MEDICAL CONDITION] risk for fluid imbalance, [MEDICAL CONDITION] . CP, directed staff to Evaluate for increase in [MEDICAL CONDITION] .and report to MD as indicated. On 02/25/2020 at 10:28 AM, Resident #45 was observed with visible [MEDICAL CONDITION] to her bilateral feet/ankles. When asked about it, she stated, I take medication for excess fluid .this (amount of [MEDICAL CONDITION]) is normal for me .when it gets worse I (LEs) start weeping and get blisters. On 03/03/2020 the resident was again observed to have visible [MEDICAL CONDITION] to her bilateral ankles, as evidenced by persistent indentations on the ankle when her socks were removed. Review of the Daily skilled nursing notes revealed they were not done daily; and that they assessed Resident does

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505400	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENUMCLAW HEALTH & REHAB CENTER	2323 JENSEN STREET ENUMCLAW, WA 98022

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) not have any [MEDICAL CONDITION]. During an interview on 03/04/2020 at 08:20 AM, Staff C explained it was the expectation that there be a daily assessment of the resident's [MEDICAL CONDITION] in the progress notes. When asked if there was any indication that this occurred Staff C stated, No. When informed that the 03/03/2020 Daily skilled nurse's note assessed Resident does not have any [MEDICAL CONDITION]. Staff C was offered to accompany surveyor to assess the resident's [MEDICAL CONDITION], but Staff C declined and stated, I believe you (that the resident had bilateral pedal [MEDICAL CONDITION]). RESIDENT #52 Record review showed Resident #52 had a 02/10/2020 order for a 1500 milliliter (ml) fluid restriction. According to the February 2020 MAR, nurses were allotted 225 ml per medication pass over four medication passes for a total of 900 ml per day. The remaining 600 ml was to be provided with meals, and was recorded on the Nutrition-Fluids flowsheet. Review of the February 2020 MAR indicated [REDACTED]. The failure to tally the resident's 24 hour fluid intake, precluded staff from determining if the resident had exceeded the 1500 ml fluid restriction. When the fluid intake on the MAR indicated [REDACTED]. The daily total for 1[DATE] could not be assessed due to lack of documentation of fluids provided with meals. Record review showed no indication that nursing was recording daily totals. During an interview on 02/28/2020 at 11:20 AM, Staff C, RCM, confirmed that nurses should be totaling the resident's 24 hour fluid intake to determine if the resident is adherent to the restriction, and that there was no indication this occurred. Staff C also acknowledged that is necessary to inform an MD when a resident has exceeded a fluid restriction, and that there was no indication that this occurred with Resident #52. REFERENCE: WAC 388-97-1060 (1). .
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one (#8) of three residents reviewed for pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, and prevent new ulcers from developing. Failure to identify, monitor and/or implement preventative measures, such as consistent repositioning and off-loading of pressure areas, caused Resident #8 to experience deterioration in skin condition. Findings included . RESIDENT #8 Resident #8 admitted to the facility on [DATE]. According to the 12/11/2019 Admission Minimum Data Set (MDS, an assessment tool), Resident #8 was assessed to require extensive two person assistance with bed mobility and transfers, and had one-sided impairment of upper extremity Range of Motion. This MDS indicated the resident was at risk for, but had no Pressure Ulcers. According to the Increased risk for further impaired skin integrity related to limited mobility, tissue perfusion . Care Plan (CP) dated 02/25/2020, interventions included, Encourage off-loading (a method of floating the foot off of a pillow to alleviate pressure) of heels. According to the pressure ulcer right heel CP dated 02/20/2020, interventions included, Re-position frequently to avoid excess pressure to bony prominences and heel protector to R (ight) foot. During an interview on 02/25/2020 at 10:24 AM, Resident #8 stated, I have a foot wound. Observation at this time revealed the resident lying on his back, the right foot was in a blue boot, socks on both feet, both feet were splayed laterally on mattress causing pressure to the lateral heels. Neither foot was noted to be floated/off loaded. Similar observations of the resident lying on his back with feet unsupported, with lateral heels in direct contact with the mattress, were noted on 02/25/2020 at 11:59 AM and at 1:32 PM. Observation on 02/26/2020 at 7:45 AM showed the resident lying in bed on his back, both feet were resting directly on a pillow, (not floated) with a blue boot on the right foot. Observation with Staff B, on 02/27/2020 at 10:10 AM revealed the resident had a blue bootie on the right foot right foot and both feet were lying directly on a pillow, feet splayed outward so the heels were in direct contact with the pillow. Staff B described the right lateral heel with a previously identified and treated as, unstageable pressure ulcer .black, to the lateral heel. Observation of the left lateral heel revealed a previously unidentified wound, described by Staff B as, an SDTI (Suspected Deep Tissue Injury) .a dime sized SDTI, purple surrounded by redness. The wound was located exactly where the heel rested on the bed/pillow. When asked if the wound was blanchable, Staff B replied, No. When asked if the wound was a Pressure Ulcer, Staff B stated, Yes. At this time, Staff B confirmed the resident's heels were not floated, which would prevent healing of the right heel, and could contribute to the development of the left heel wound. REFERENCE: WAC 388-97-1060(3)(b). .
F 0687 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate foot care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide necessary foot care and treatment in accordance with professional standards for two (#s 34 & 52) of five residents reviewed for foot care. This failure placed the residents at risk for decreased quality of life and negative health outcomes. Findings included . RESIDENT #34 According to the 10/25/2019 Quarterly MDS (Minimum Data Set, an assessment tool), Resident #34 was cognitively intact and required one person assistance with personal hygiene. Review of the Resident #34's Care plan (CP) revised 10/17/2020, reflected Self-care deficit related to weakness at times. Goal: Resident will be assisted by staff all needs she cannot complete on own, Staff to offer assistance frequently to ensure needs are met daily. On 02/25/2020 at 9:50 AM, Resident #34 was observed sitting in bed while Staff N, Licensed Practical Nurse (LPN), removed the resident's shoes, and confirmed that the resident's toes were long and chipped, with great toenails thick and jutting medially. Resident #34 indicated they are longer than preferred, and that they needed to be cut. Staff N stated, I will put her on a podiatrist list to be trimmed. On 03/02/2020 at 11:08 AM, Staff B, Director of Nursing, confirmed that nurses and nursing assistants are responsible to trim resident's toenails and make referrals to podiatry. RESIDENT #52 Resident #52 had a [DIAGNOSES REDACTED].#52's Diabetic CP, initiated 05/30/2018, included the following directions: LN to do toenail/foot inspections weekly while checking feet & between toes (.) report any changes to the MD; refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails. According to the February 2020 MAR, Resident #52 did not receive weekly diabetic nail care on 02/16/2020 and 02/23/2020, with no assessment as to whether the nail care was needed or not. Observation of Resident #52's toenails on 02/28/2020 at 09:06 AM showed the resident's nails needed trimming, with the nail of the left big toe extending at least 0.5 cm past the nail base and beginning to curl down. Staff D, Resident Care Manager, acknowledged, in an interview at 11:01 AM on 02/28/2020, that there was no indication that Resident #52 received the nail care he was ordered to receive, and further acknowledged this left the resident at risk for complications such as in-grown toenails. REFERENCE: WAC 388-97-1060(3) (j) (viii). .
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 services were provided to preserve range of motion (ROM) for five (#s 27, 36 10, 14 & 25) of eight residents reviewed for limited ROM. This failure placed the residents at risk for decreased function and quality of life. Findings included . RESIDENT #27 Resident #27's Quarterly MDS (Minimum Data Set-an assessment tool), dated 07/28/2019, showed the resident admitted on [DATE] with multiple conditions including muscle weakness and hypertension. Resident #27's care plan (CP), last reviewed 02/04/2020, showed the resident had muscle weakness and obesity. The CP also showed the resident was to receive, active range of motion (AROM) Use # weights. 15 sets x2 reps. Walking Program: Resident will walk 150 feet with CGA and use of walker up to three times a week. In an interview on 02/25/2020 at 11:55 AM, Resident #27 indicated he used to get a Restorative program but staff were not coming to help him with AROM and walking program. Review of Restorative program progress note dated 02/04/2020: Evaluation of Response to Program Asked if he would now like restorative aide to visit and offer assistance with his program and he agreed that it will be good to have someone help keep him accountable. Review of the Task section of Resident #27's record on 03/02/2020 showed that for the previous 30 days, AROM exercises and walking program were only offered twice, on 01/03/2020 and 02/25/2020, and the resident refused. In a 30-day period, at three times a week, the resident should have had 12 AROM sessions and 12 walking program. This showed the resident missed 11 AROM exercise sessions and 11 Walking Program on January and February 2020 without explanation as to why. RESIDENT #36 A 01/15/2020 Quarterly MDS showed staff assessed Resident #36 had functional limitation in ROM to upper (UE) and lower (LE) extremities, and received Restorative ROM program. Resident #36's CP, last reviewed 02/28/2020, showed the resident had impaired mobility related to decreased UE and LE ROM. The CP also showed the resident was to receive AROM light green theraband 15 reps 3x/week. May alternate with arm bike for a total of 6 days a week of UE AROM. Review of January and February, 2020.restorative flow sheets showed no documentation staff provided AROM to Resident #36's upper and lower extremities from 01/01/2020 through

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505400	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENUMCLAW HEALTH & REHAB CENTER	2323 JENSEN STREET ENUMCLAW, WA 98022

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 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 8) 01/10/2020 and 02/21/2020 through 02/25/2020. On 03/03/2020 at 11:54 AM, the above findings were shared with Staff K, Restorative Supervisor. Staff K confirmed that the restorative program was not offered as care planned. When asked why, Staff K indicated she was new in the department and did not know why the program was not offered or provided for the two residents. The expectations are all restorative programs to be provided as scheduled and any refusal to be reported to the nurse or department Supervisor. RESIDENT #10 According to the 12/16/2019 Annual MDS assessment, Resident #10 was cognitively intact and was assessed with [REDACTED]. This MDS showed the resident participated in a walking Restorative Nursing program on four of seven days of the assessment. Observation on 02/25/2020 at 11:20 AM showed the resident transfer independently to a wheelchair with the aid of a walker kept at the bedside. The resident indicated at this time she had a Walk to dine restorative program, but did not perform three times a day consistently. Review of the restorative records showed, from 02/01/2020 to 02/26/2020, the resident was offered the walk to dine program only 35 times out of 77 opportunities. In an interview on 02/27/2020 at 8:45 AM Staff K, Restorative Coordinator, confirmed staff did not offer the walking program three times a day as the program was coded only as PRN (as needed), and should have been coded as three times a day in association with meals. In an interview on 02/27/2020 at 8:45 AM, after review of Resident #10's restorative documents, Staff B concurred restorative aides were not offering the program as directed. RESIDENT #14 According to the 09/28/2019 and 12/19/2019 Quarterly MDSs Resident #14 was assessed with [REDACTED]. Observations on 02/26/2020 at 8:25 AM showed Resident #14 lying in bed. The resident's left hand, was noted with fingers curled inward that hand very long nails extending significantly past the tips of the resident's fingers. Record review showed the resident had a surgery to release tendons in the left hand on 12/28/2018. The surgical report showed, The left middle and ring finger were contracted at the MP (joint in hand) and PIP (joints in fingers) joints .There were minor Dupuytren's changes in the palm but these in no way contributed to the severe flexion contracture of the middle or ring fingers. According to a ADL (Activities of Daily Living) self-care performance deficit CP, target date 04/08/2020, the resident had a history of [REDACTED]. A 07/08/2019 CP identified the resident as, At risk for pain related to .contractures to L(eft) fingers. There were no goals listed to prevent further decline in ROM to the left hand or any of the left sided joints. There was no identification of any other contractures besides the left fingers. During observations on 03/03/2020 at 1:18 PM Staff B confirmed Resident #14's left elbow and the third and forth finger of the left hand did not fully extend and were described as tight, confirming that none of the fingers fully extend. Staff B described the third and fourth fingers as contracted and was unable to fully extend the left knee. While an Occupational Therapy (OT) summary dated 03/25/2019 showed, Patient also participated with ROM (Rang of Motion) and therapeutic exercises t improve ROM .Patient does not tolerate splinting (secondary to) pain, patient does tolerate thin digit abduction between right and small finger which will improve skin integrity as well as digit alignment to neutral. The summary of care included, Recommendations to nursing provided for maintaining joint, tissue and skin integrity. Discharge recommendations included, Nursing to manage skin integrity and positioning foam or gauze between fingers when up in chair. While the OT summary indicated the resident did not tolerate left hand splinting, there was no indication facility staff attempted to implement interventions to prevent contractures of the other joints on the affected left side. In an interview on 03/03/2020 at 1:20 PM, Staff B was asked to provide documentation to support nursing implemented the OT recommendations for positioning foam to the left hand, or any assessment to contraindicate ROM to the elbow or knee joints. No information was provided. RESIDENT #25 According to the 01/03/2020 Quarterly MDS the resident was cognitively intact and assessed with [REDACTED]. Resident #25 CP, last revised 12/10/2019, showed the resident had impaired mobility related to muscle weakness obesity and chronic wounds. The CP showed the resident was to receive active ROM to LE. And a walking program: walk to dine using SBA (stand by assist) with a gait belt and 4ww (4 wheel walker). At least one meal six times each week. A review of the December 2019, restorative documentation showed the resident received ROM services on 12/15/2019, 12/12/2019, 12/16/2019, 12/19/2019, 12/22/2019 and 12/23/2019. According to Staff I, Restorative Aide, in an interview on 02/27/2020 at 1:48 PM, the resident wasn't currently participating with the walking program due to a wound on her heel. On 02/28/2020 at 9:42 AM, Staff D LPN-RCM said, No, the resident isn't non weight bearing. She wears an off loading shoe, but she's able to participate in an ambulation program. In an interview on 02/28/2020 at 10:35 AM, Staff I said, The resident told me she was none weight-bearing so I haven't been performing the walk to dine task. Staff I was asked how long the resident's walking program had been on hold . Staff I replied, at least a month or so. On 02/28/2020 at 11:04 AM, Staff D said, the program was not on hold the resident was supposed to ambulate using an off loading shoe. REFERENCE: WAC 388-97-1060 (3)(d), (j)(ix). .
F 0689 **Level of harm -** Immediate jeopardy **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 accurately assess and monitor facility water temperatures to ensure safe water temperatures. The likelihood of serious injury [MEDICAL CONDITION] to elevated water temperatures, constituted a situation of Immediate Jeopardy (IJ) on 02/26/2020. Additionally, the facility failed to thoroughly investigate accidents to determine the circumstances of resident accidents and implement measures to prevent reoccurrence for two (#23 & 42) of four residents reviewed for falls. These failures placed the residents at a potential risk of harm related to avoidable incidents. Findings included . REGULATION Water Temperature - Water may reach hazardous temperatures in hand sinks, showers, tubs, and any other source or location where hot water is accessible to a resident.[MEDICAL CONDITION] to hot water/liquids may also be due to spills and/or immersion. Many residents in long-term care facilities have conditions that may put them at increased risk [MEDICAL CONDITION] by scalding. These conditions include: decreased skin thickness, decreased skin sensitivity, [MEDICAL CONDITION], decreased agility (reduced reaction time), decreased cognition or dementia, decreased mobility, and decreased ability to communicate. According to regulatory guidance, based upon the time of the exposure and the temperature of the water, the severity of the harm to the skin is identified by the degree of burn, as follows: First-[MEDICAL CONDITION] the top layer of skin (e.g., minor sunburn). These may present as red and painful to touch, and the skin will show mild swelling. Second-[MEDICAL CONDITION] the first two layers of skin. These may present as deep reddening of the skin, pain, blisters, glossy appearance from leaking fluid, and possible loss of some skin. Third-[MEDICAL CONDITION] the entire thickness of the skin and permanently destroy tissue. These present as loss of skin layers, often painless (pain may be caused by patches of first- and second-[MEDICAL CONDITION] third-degree burns), and dry, leathery skin. Skin may appear charred or have patches that appear white, brown, or black. CMS provides the following guidance for the amount of time which would cause a third degree burn at the following temperatures: 15 seconds at 133F (Fahrenheit), one minute at 127F, three minutes at 124F, and five minutes at 120F. CMS advises,[MEDICAL CONDITION] occur even at water temperatures below those identified in the table, depending on an individual's condition and the length of exposure. FACILITY POLICY The degree of injury depends on factors including the water temperature, the amount of skin exposed, and the duration of exposure. According to the facility Preventative Maintenance Manual dated July 2008, Washington State Water Temperature Regulations reference, The facility must ensure: The hot water system maintains water temperatures at one hundred ten degrees Fahrenheit, plus or minus ten degrees F, at fixtures used by residents and staff. OBSERVATIONS Observation on 02/26/2020 at 8:05 AM, showed room [ROOM NUMBER] with water temperatures of 126 F, rooms #517/518 with water temperatures of 121 F; and at 9:40 AM room [ROOM NUMBER] was noted with a temperature of 125.8 F. During observations and interview on 02/26/2020 at 9:40 AM, Staff M, Maintenance Director, was noted to use a laser thermometer to test the water temperatures. Staff M pointed the laser through the running streams of water from the faucets, with the laser dot placed on the back of the sink. Using this method, at 9:45 AM, Staff M, confirmed a temperature of 117 F in room [ROOM NUMBER]. Upon changing the angle of the laser, Staff M obtained different water temperatures, confirming a temperature of 123 F, when aiming the laser at the bottom of the sink. According to the Raytek Minitemp MT2 Infrared Thermometer manufacturer's specification indicated the infrared thermometer allows user to accurately measure surface temperatures. An infrared thermometer measures the surface temperature of an object. Steps you need to take to measure the temperature of water using an infrared thermometer were identified as: Prepare a vessel with a strip of electrical tape on its side to prevent reflected infrared energy, which can to skew your readings; Pour the water

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505400	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENUMCLAW HEALTH & REHAB CENTER	**2323 JENSEN STREET ENUMCLAW, WA 98022**

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 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 9) that you want to get a temperature reading on into the vessel; Point the laser end of the infrared thermometer toward the strip of electrical tape at the side of the vessel; the temperature will be displayed in the digital screen; To verify the results, take at least two readings. Review of facility temperature monitoring logs showed that for January and February 2020, temperatures averaging 114-117 F. In an interview on the morning of 02/26/2020, Staff M stated he pointed the gun at the water and let it heat up to 117 and turn the gun off. According to facility provided documents, no water temperatures were monitored in December 2019. In an interview on 02/26/2020 at 9:52 AM, when asked if Staff M failed to accurately measure water temperatures, Staff B stated, I don't think you are wrong. Subsequent observations with Staff B, Director of Nursing, confirmed temperatures of 123.4 F in room [ROOM NUMBER] at 10:11 AM. At 10:14 AM, Staff M noted temperatures of 122.7 F in the 500 unit shower room and a temperature of 123.4 F in room [ROOM NUMBER] at 10:21 AM. In an interview on 02/26/2020 at 11:46 AM, Staff T, a facility contractor staff, stated that he altered the boiler that serviced the 500 hall and stated, The factory setting for the boiler says 120 degrees, that's the target, I turned it down to 115 degrees . When asked what the factory settings were, Staff T explained, It usually means (the boiler should be) set to 120 plus or minus. When asked, based on the manufacturers recommendations, what the boiler temperature should be set at, Staff T replied, I'd always set it at 120 degrees, that is what it comes (set) at. Staff T confirmed the boiler temperature should have been set at 120 degrees F, rather than 130 degrees F, the temperature at which facility maintenance staff had set the boiler. Observations on 02/27/2020 at 9:54 AM showed the boiler temperature for the 1-400 unit was set at 125 F. In an interview at 10:10 AM, Staff A, Administrator stated the staff method for testing water was, We are putting a cup in the bottom of the sink and putting in a submersible thermometer .Everybody's been in-serviced on that way .that's how (Staff T) does it. Maintenance staff failed to provide monitoring to ensure safe water temperatures. Maintenance staff utilized a temperature gun which assessed the surface temperature of the side of the sink, rather than the actual water temperature. Staff failed to document the location and times the temperatures were assessed. In an interview on 2/26/2020 at 10:26 AM Staff B, DNS, indicated the system for checking water temperatures was flawed and confirmed water temperatures, exceed regulation. RESIDENT INTERVIEWS In an interview on 02/26/2020 at 11:21 AM, Resident #63, in room [ROOM NUMBER], when asked if she had concerns with water temperature stated, Yes, it is hot. You have to turn the cold on and be careful. If you just turn the hot on, you better be ready. In an interview on 02/26/2020 at 11:38 AM, Resident #12, residing in room [ROOM NUMBER], stated, It's (water) damn hot, when asked about water temperature concerns. When asked why the resident thought the water was hot, Resident #12 stated, Well, when I put my hand under it, I couldn't hold it there. In an interview on 02/26/2020 at 11:29 AM, Resident #54, in room [ROOM NUMBER] stated, its hot (water), you have to do cold water with it. When asked how he determined the water was hot, the resident stated, I stuck my hand in it and said Oh[***] In an interview at 11:35 AM on 02/26/2020, Resident #45, in room [ROOM NUMBER], stated, It (water) tends to be rather warm. You have to be careful. I think it would take the hair off a pig. I would hesitate to let others here use it. When asked if she told staff about the hot water, the resident stated, No, I personally didn't (tell anyone) but they are aware it (hot water) happens. When asked about the showers, the resident stated, They are hot. They (staff) told me to be careful and temper it down. When asked how she knew it was hot, the resident stated because I use it. The fact that: 1. the facility failed to ensure water temperatures were below 120 degrees, 2. four cognitively intact residents had stated concerns about hot water. 3. five cognitively impaired residents were identified with the physical ability to have unsupervised access to water with unsafe temperatures. 4. According to the regulatory time and temperature relationship to serious burns, harm was likely. FALLS RESIDENT #42 According to the 11/07/2019 Quarterly Minimum Data Set (MDS - an assessment tool), staff assessed Resident #42 as independent with toileting, and two person extensive physical assistance with personal hygiene. According to a 12/22/2019 accident report, Resident #42 was found on her knees in her room with the walker in front of her and her pants were down around her knees and shoes were untied. There was urine on the floor. The plan to prevent recurrence was, get her Velcro shoes and updated care plan to offer assistance with toileting after meals and at bedtime routinely. Observations on 02/26/2020 at 11:50 AM showed Resident #42 ambulating down the hall to the dining room. A sock was noted hanging out of the back heel of the left shoe. The shoes were noted to be laced, not Velcro. Review of the resident's care plan revealed no interventions regarding the use of Velcro shoes or toileting after meals and at bedtime. In an interview on 03/02/2020 at 10:35 AM, Staff C, Assistant Director of Nursing, reviewed the resident's CP and confirmed the interventions identified on the 12/22/2019 fall investigation were not, but should have been, care planed and implemented. RESIDENT #23 According to the 01/01/2020 5-day MDS, the resident was cognitively intact, had [DIAGNOSES REDACTED]. During an interview on 02/25/2020 at 12:25 PM, Resident #23 indicated he had fallen multiple times since admission. According a 0[DATE] 05:52 AM nurse's note, at approximately 5:30 AM the nurse heard Resident #23 yelling for help. Upon entering the room, Resident #23 was observed lying on his stomach on the floor near his sink. Resident #23 reported he was trying to go to the bathroom but didn't make it, and indicated he felt weak and his legs gave out. After being assisted back to bed Resident #23 .started to seize. When the .[MEDICAL CONDITION] activity stopped, he became unresponsive. He was still breathing but was non-responsive to sternal rub and voice commands. The resident's oxygen saturation (Sp02) dropped into the 60s. Oxygen was placed and the resident's Sp02 went up to the 80s. The medics were called and Resident #23 was transferred to the hospital. Review of the 0[DATE] fall investigation showed on 0[DATE] at 5:30 AM, the resident was heard calling for help and was found lying on his stomach by the sink. The resident's walker and wheelchair were noted to be tipped over next to the resident. In the section that asked if Resident taken to the hospital staff documented No, despite a progress note written within 22 minutes of the incident indicating the resident was transferred to the hospital. Under Predisposing Physiological Factors staff checked the boxes for Gait imbalance and History of self-transfer. The boxes next to Recent change in medication/new, recent change in condition, hypotensive and weakness/fainted, were left unchecked. Although, the resident reported he fell due to feeling weak and his legs giving out. Review of the February 2020 Medication Administration Record [REDACTED]. Nurses were also directed to Check to see what the previous wts have been. Review of the daily wts showed on 02/12/2020 Resident #23 weighed 255.8 lbs. On 02/13/2020 (the day prior to the fall) his wt was 263.4 lbs, showing a 7.6 pound wt gain in one day. Record review showed no indication the nurse identified the wt gain, assessed the resident and/or notified the physician as ordered. In an interview on 03/02/2020 at 10:10 AM, when asked if there was any indication that nursing identified the wt gain, assessed the resident, and notified the physician of the change Staff B, Director of Nursing, stated, No. Review of the 02/13/2020 Complete Blood Count (CBC) showed the resident's Red Bloods Cells were 3.24 (low), Hematocrit-26.2 (Low) and Hemoglobin-8.1 (H&H, low) showing the resident was anemic (a condition in which you don't have enough healthy red blood cells to carry adequate oxygen to the body's tissues, with common symptoms of feeling tired and weak). Additionally, review of the 02/13/2020 BMP (Basic Metabolic Panel) showed then resident had a BUN (blood urea nitrogen) of -55 (high), creatinine- 2.84 (high), GFR (glomerular filtration rate) - 23 (low), and potassium level of 6.0 (high). This showed [MEDICAL CONDITION] and high potassium, both which have common symptoms of weakness and fatigue. Review of the fall investigation showed facility staff failed to identify, assess, or consider how the resident's clinically complex medical conditions and the multiple changes on 02/13/2020 (change in diuretic, 7.6 lbs wt gain in 24 hours, [MEDICAL CONDITION] requiring IV iron sucrate, [MEDICAL CONDITION], and [MEDICAL CONDITION]) may have contributed to the resident's fall. Facility staff did not identify the correlation of the residents reported symptoms of weakness/fatigue and his [MEDICAL CONDITIONS] and [MEDICAL CONDITION], or consider that the sudden onset of shortness of breath and oxygen desaturation, after being laid in bed, may have been related to [MEDICAL CONDITION] given his recent change in diuretic therapy and 7.6 lb weight gain in 24 hours. According to a 0[DATE] 3:10 PM nurses note Resident #23 returned to the facility from the emergency room at 10:00 AM, with a [DIAGNOSES REDACTED]. Plan was to educate and continue current plan of care. In an interview on 03/04/2020 at 8:42 AM, when asked if a fall investigation should include a record review to identify if the resident had any recent medication changes, a recent change in condition, or abnormal labs Staff C stated, Yes. When asked if the investigation identified on 02/13/2020 (the day before the fall) the resident had: new orders for diuretic therapy implemented; gained 7.6 lb in 24 hours; an elevated potassium level of 6.0; and an H&H of 8.1 & 26.2 Staff C stated, No. When asked if the fall was accurately and thoroughly investigated Staff C stated, No. 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 two (#s 42 & 63) of four sample residents reviewed for nutrition, received adequate weight monitoring, to determine whether their nutritional status was stable. This failure led to unintended weight loss for Resident #42 who experienced significant weight loss in the absence of timely

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505400	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENUMCLAW HEALTH & REHAB CENTER	2323 JENSEN STREET ENUMCLAW, WA 98022

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 0692 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 10) interventions. Findings included . FACILITY POLICY According to the facility Weight policy dated November 2012, guidelines for residents who may need to be weighed weekly include those residents who demonstrate slow trending of weight loss/gain, significant weight loss/gain of 5% in 30 days, 7.5 % in 90 days or 10% in 180 days. The policy specifies staff should re-weigh residents with, Any weight with a 5-lb (pound) variance is re-weighed within 24 hours. The policy directs, If a significant variance is actual after re-weigh, the nurse documents in the medical record, revises the care plan, refers to Nutritional Hydration Skin Committee and notifies the physician and resident/resident's authorized representative. These notifications are recorded in the nursing progress notes of the medical record. RESIDENT #42 According to the 02/27/2019 Annual Minimum Data Set (MDS - an assessment tool) showed Resident #42 required supervision and setup for eating and weighed 191 lbs. The resident's eating abilities remained the same with weights of 192 lbs, 183 lbs, and 174 lbs respectively for the 05/20/2019, 08/10/2019 and 11/07/2019 Quarterly MDSs. The 01/28/2020 Annual MDS showed no change in eating abilities, but a weight of 163 lbs, which was identified as a 5% or more weight (wt) loss. Observation of the lunch meal on 03/02/2020 showed the resident ate less than 50% of the meal and was not served ice cream or whole milk as indicated on the tray card. Interview on 03/02/2020 at 7:51 AM Staff G, Dietary Service Manager, stated the weight and skin (W & S) committee meet once a week for reasons including, if someone has wounds or is losing weight or gaining weight or [MEDICAL TREATMENT], anything they deem appropriate. Staff G explained that medical records ran the weight records and provided them to the RCM (Resident Care Manager) who determined if the resident required review by the W & S committee. Review of weight records showed the resident was assessed on 12/08/2018 to weigh 197 lbs, on 04/01/2019 to weigh 192.2 lbs and on 06/27/2019 to weight 183.2 lbs. A 05/13/2019 Nutrition Note identified the most recent weight was 04/01/2019 and the Registered Dietician (RD) documented, weight changes past 6 months not significant, po (oral intake) is adequate to prevent weight loss, request current weight. A 06/27/2019 NHSC (Nutrition Hydration Skin Committee) note showed, Res reviewed for weight loss .Weight loss is not significant. Resident usually refuses weights. Weight loss r/t (related to) normal fluctuations .no supplementation 76-100% (of meal intake) most of the time .Continue with POC (Plan of Care.) Review of meal intake monitors showed the resident ate less than 50% (including refusals) for 21 of the 90 meals offered in (NAME)2019. A quarterly RD nutrition note dated 07/29/2019 reflected, wt 6/27/2019 183.2 weight changes past 6 months not significant, po is adequate to prevent weight loss, request current weight. There were no weights obtained for Resident #42 for almost three months from 06/27/2019 to 09/19/2019 when the resident was assessed to weight 170.9 lbs, a loss of 12 lbs / a 6.7% wt loss. There was no documentation in the record the facility identified the significant delay in obtaining weights, or acted to obtain said weights. There was no indication facility staff provided a reweight after any five pound deviation was noted, as directed in the policy. A 09/26/2019 NHSC note showed weight 9/19 170.9 weight loss r/t past UTI (Urinary Tract Infection) and poor tolerance to care and food. Appetite has improved. No change at this time to be made .76-100% po intake . According to meal intake records, the resident ate less than 50% (including refusals and missing documentation) of 28 of the 87 meals offered in September 2019. A nutritional RD evaluation dated 09/30/2019 identified the previous weight as 183.2 lbs on 06/27/2019 and showed current, weight 09/26/2019 174.8 # was on ABT (antibiotic therapy) for UTI. Resident was out of the facility 09/19/2019 and returned on 09/20/2019 abnormal bleeding, resident was refusing care .has a confirmed UTI and is on antibiotics to treat. PO intake is still good per her norm. The listed goal was, no significant unplanned weight changes but offered no interventions to stem the identified weight loss of nine lbs from (NAME)2019 to September 2019. The note failed to identify how, if the oral intake was good, why the resident continued to evidence steady weight loss. Weight records showed that on 10/15/2019 the resident weighed 174.1 lbs. There were no further weights obtained for two months from 10/15.20/19 to 12/10/2019 when the resident was assessed to weigh 162.4 lbs, another 12 lbs / 6.72 % weight loss. There was no documentation in the record the facility identified the significant delay in obtaining weights, or acted to obtain said weights. There was no indication facility staff provided a reweight after any five pound deviation was noted, as directed in the policy. A 10/28/2019 Nutrition note documented, 1 month weight is stable. No 3 month weight available. 6 month weight shows 18.1 lbs weight loss, 9.4% weight change, borderline significant weight change .See NHSC note dated 9/26. PO intake is variable per her norm. 50-100% . No interventions were considered or implemented. A NHSC note dated 12/12/2019 showed, NHSC for weight loss .12.4 lbs weight loss, 7.1% weight change, not significant over 2 month window. Weight loss r/t recent bout with UTI she is currently on IV treatment where she had a bad appetite. No pressure ulcer per recent skin report .intake is 50-100% .No s/s (signs /symptoms) dehydration noted per nursing. Will follow up prn (as needed). However, according to the November 2019 meal intake records, the resident ate less than 50% (including refusals and missing documentation) of 45 of the 90 meals. On 12/16/2019 the resident weighed 163 lbs and was 163.2 lbs on 1[DATE]19. There were no weights obtained for over six weeks from 1[DATE]19 to 02/11/2020 when the resident was assessed to weight 150.8 lbs, a weight loss of over 7%. There was no documentation in the record the facility identified the significant delay in obtaining weights, or acted to obtain said weights. There was no indication facility staff provided a reweight after any five pound deviation was noted, as directed in the policy. According to NHSC records dated 06/27/2019, 09/26/2019 and 12/12/2019, Resident #42 was listed for review related to weight loss with No Change planned. While the NHSC failed to identify any interventions related to the continued identified weight loss, a provider visit on 12/12/2019 recommended the addition of NEM (Nutritionally Enhanced Meal, the addition of items such as butter and cream for the addition of calories). In an interview on 03/02/2020 at 12:55 PM, when asked why there were three consecutive quarterly reviews culminating in a 48 lb unplanned weight loss, with no change planned Staff B stated, We should have provided interventions. A physician order [REDACTED]. According to Medication Administration Records for December 2019 and January and February 2020, the resident consistently did not accept the HS snack. A 01/20/2020 Nutrition Evaluation documented the resident's most recent wt as 163.2 lbs obtained on 1[DATE]19. The evaluation identified, hs snack offered but failed to identify this intervention was ineffective as the resident was not receiving it. The evaluation indicated the resident consumed 50-100% of all meals, when according to the meal monitor records, the resident consistently (30% of the meals) ate less than 50% of the meals provided. There was no assessment of if the resident was offered or consumed any replacement meals for those meals for which 50% were consumed. This evaluation documented, 1 month weight is stable. 3 month weight shows 6.6% weight change, not significant.10.9% 20 lb loss in 6 months significant .Her PO intake is fair but adequate enough to maintain her weight over the past month. The documented goal was no significant unplanned weight changes but there were no interventions to prevent what was already identified as an unplanned significant weight loss. The resident continued to evidence further weight loss of 13 lbs when, on 02/11/2020, the resident was assessed to now weigh 150.8 lbs. It was not until 02/13/2020, that a nutritional supplement was ordered. A 02/19/2020 Practitioner note showed, She has continued with weight loss currently at 150 pounds, witch (sic) is down 48 pounds from one year ago. Supplementation added, however, she is most likely going to be resistant to accepting. In an interview on 03/02/2020 at 11:13 AM, when asked what staff were expected to review for the residents at the nutrition at risk meetings, Staff B, Director of Nursing (DON), replied, Weight loss, pressure ulcers, poor intake .our policy is trend able weight loss or significant weight loss. Staff B elaborated that the nutrition committee looked at meal intakes, weights . When asked if there were no weights, Staff B stated, Then we should attempt to get one. In an interview on 03/02/2020 at 11:13 AM, When asked the expectation if a resident refused weights for more than three weeks, Staff B and C, RCM, interviewed together on 03/02/2020 at 11:18 AM, stated, Reapproach, have different staff try, show her pictures of dogs. When asked if any additional interventions would be implemented, Staff C stated, Possibly. When asked if she expected interventions for someone who lost 58 lbs in a year, Staff B replied, Yes. When asked if 58 lbs was a normal fluctuation, Staff B replied, No. After reviewing the resident's weight records, Staff B confirmed that each time three to seven weeks went without a weight, Resident #42 demonstrated a significant unplanned weight loss. RESIDENT #63 Resident #63 admitted to the facility on [DATE]. According to the 02/16/2020 Quarterly MDS, the resident had [DIAGNOSES REDACTED]. A Nutrition Hydration problem . CP, revised 0[DATE]20, listed problems affecting nutrition as: Barret's esophagus, diverticulitis, depression, obesity, wt gain related to consistent supplement intake, and Variable oral intake/ poor appetite leading to wt loss. The goal was identified on 11/25/2019, as .will have No unplanned significant weight loss or gain. Interventions included: 2 handled cup with lid; NEM (nutritionally enhanced meals) diet; refer to RD (Registered Dietician) as appropriate; and Supplements per MD order. The CP did not identify or direct staff to monitor for symptoms of Barret's esophagus, functional dyspepsia,or diverticulitis such as: heartburn, difficulty swallowing food, vomiting, weight loss, bloating, belching, nausea, abdominal pain, feeling uncomfortably full, and loss of appetite. According to the 11/25/2019 Nutrition Evaluation Form (NEF) completed by the RD, Resident #63's wt was 175 pounds (lbs), she had no [MEDICAL CONDITION], and had an average intake of 25-50% for all meals. Under evaluation the RD stated, Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505400	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENUMCLAW HEALTH & REHAB CENTER	2323 JENSEN STREET ENUMCLAW, WA 98022

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 0692 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 11) wt has been stable since admit. Resident BMI (body mass index) is 32 which classifies her as obese. Gradual wt loss is desirable. Her po (oral intake) is not adequate to meet her needs . Recommend adding NEM to diet and adding Cal Dense 60 cc (nutritional supplement) BID (twice daily) . Record review showed a 12/11/2019 nurse's note stated Resident #63 Returned from an appointment with GI (gastrointestinal) MD. New order to increase [MEDICATION NAME] and plan EGD (Esophagogastroduodenoscopy, a test to examine the lining of the esophagus, stomach, and first part of the small intestine) in March. Indicating the resident was still experiencing some GI issues. Review of the resident's wts showed the following trend: 11/22/2019-175 lbs; 12/11/2019-166.4 lbs (-4.9%); and 12/17/2019-165.8 lbs (-5.26%). On 12/19/2019 Resident #63 was nutritional status was reviewed by the nutrition interdisciplinary team (IDT). The IDT identified Resident #63 had a significant wt loss of 5.3 % in less than 30 days. The MD and responsible party were notified and the wt loss was determined to be related variable intake. A recommendation to increase Resident #63's Cal Dense order to 90 cc TID (3x daily). The assessment did not include any indication that staff spoke with the resident to determine why her appetite was variable or if GI symptoms were affecting her appetite or intake. On 12/30/2019 Resident #63's wt was 153.6 (-12.3%) in approximately six weeks, and (-7.36%) from 12/17/2019 (two weeks), demonstrating continued significant and unplanned wt loss. Review of the meal monitor from 12/19/2019 (the last time the resident's nutrition was assessed) through 12/30/2019 revealed: of the 36 meals in the 12 day period, the resident refused or had no documentation of the meal 12 times (33% of meals). Of remaining 24 meals, 8 times the resident only ate 0-25%. Record review showed no indication that staff: identified the wt loss; notified the the MD/patient and/or responsible party; referred the resident to the RD for further evaluation; assessed the resident's meal intake; or assessed the resident to determine if she was experiencing GI symptoms, or if there were other factors affecting her intake. During a joint interview on 03/02/2020 at 12:11 AM with Staff B and C, it was explained that when a resident triggered for weight loss, the resident would be added to the weekly nutrition IDT meeting, and interventions would be implemented based off of the assessment. The resident would continue to be monitored weekly until stable. When asked if Resident #63 was monitored weekly until stable Staff C stated, No but acknowledged she should have been. When asked if there was any indication that staff reviewed the 12/30/2019 wt, identified the resident's continued significant and unplanned wt loss, assessed the resident's meal intake, spoke with the resident to determine factors contributing to her lack of appetite, notified the MD, referred the resident to the RD for further evaluation, and/or implemented nutritional interventions Staff C stated, No. On 01/06/2020 Resident #63's weight was 151.2 showing continued wt loss. On 01/08/2020 the a Physician Rectification note note stated the resident does report poor appetite and PO (oral) intake . the Physician then ordered [MEDICATION NAME] twice daily as an appetite stimulant. Resident #63's weights then stabilized between 151 and 154 lbs. REFERENCE WAC 388-97-1060(3)(h). .
F 0694 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide for the safe, appropriate administration of IV fluids for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure Intravenous (IV) treatments/services were provided consistent with professional standards of practice for two (#s 15 & 23) of two residents reviewed. The facility failed to provide appropriate treatment, monitoring, and maintenance of Peripherally Inserted Central Catheters (PICC), Central Venous Catheters (CVC) and extended dwell catheters (specialized intravenous access devices) as evidenced by failure to timely: identify the type of catheter the (valved vs non-valved); obtain and implement flushing, monitoring and treatment orders; accurately monitor external length; and discontinuing a peripheral IV catheter without validating the entire catheter without validating the catheter tip was intact. These failures placed residents who required IV services, at risk for loss of vascular access and complications related to IV therapy. Findings included . RESIDENT #15 Record review showed Resident #15 readmitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. The hospital Discharge Orders directed staff to provide CVC care per protocol, but did not identify what type (Valved vs non-valved) catheter it was in place. A 02/05/2020 facility nurse's note stated, Resident has orders for IV antibiotics via right chest PICC line. However, PICCs are inserted into peripheral veins in the arm, and the hospital provided clear documentation that it was a CVC. Review of the February 2020 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed the facility failed to obtain/implement orders for: CVC flushes, daily IV tubing changes, measuring external length, monitoring of the CVC insertion site, and weekly dressing changes upon admit. On 02/07/2020 (two days after admission) the facility identified the CVC as non-valved, and implemented orders to flush the CVC with 5 ml (milliliters) of NS (Normal Saline) before and after medication administration, and then flush with 5 ml of [MEDICATION NAME], (SASH). By that time the resident had already received: 5 doses of [MEDICATION NAME]; and 2 doses of [MEDICATION NAME], with no indication any flushes had been provided before or after medication administration. Additionally, an order to change the IV tubing every 24 hours was not obtained until 02/08/2020 (three days after admit), and no orders were obtained or implemented to perform weekly dressing changes, or measure external length to validate CVC placement, prior to the resident's re-hospitalization on [DATE]. During an interview on 3/13/2020 10:40 AM, Staff C, Resident Care Manager, confirmed the above findings and acknowledged all of the IV flushing, monitoring, and maintenance orders should have been obtained and implemented the day of admit. Review of the February 2020 MAR showed a 02/07/2020 order for two liters of NS IV at 100 ml an hour. On 02/07/2020 at 9:16 PM a nurse signed off on the MAR indicating the first bag was hung. There was no further direction or information on the MAR such as: direction to staff to document how many ml (milliliters) infused on their shift, a place for each shift to sign that the NS was infusing, or any indication that both liters were provided. Review of the nurse's notes from 02/07/2020 through 02/09/2020 showed no documentation that the resident ever had an order for [REDACTED]. During an interview on 03/03/2020 at 11:27 AM, Staff C, Resident Care Manager (RCM), stated that nurses should have, but did not, document mls infused each shift, when the second liter was hung, and when the two liters were completed. When asked how one could tell if the resident actually received the two liters of NS Staff C acknowledged you could not. Record review showed Resident #15 was transferred to the hospital on [DATE] and readmitted to the facility on [DATE] with a PICC to his right upper arm, and orders for Daily IV antibiotics. The admission progress note identified the PICC to the right upper arm, but there was no indication of what the external length was, and the PICC insertion report was not found. Review of the February 2020 TAR showed a 02/25/2020 order that directed nurses to weekly .Measure Upper Arm Circumference 10 cm above External Catheter Length . On 02/25/2020 the nurse documented the external length was 1 cm. In an interview on 03/03/2020 at 11:27 AM, when asked what the order meant (e.g. did mean to say measure the arm circumference 10 cm above the insertion site, and measure the external catheter length) Staff C stated that the order was unclear. Staff C then explained the facility measured external length From insertion site to the bottom of the needless injection cap to ensure the catheter had not migrated. When asked if the documented 1 cm external length was accurate Staff C stated, No. Additionally, when asked if there was documentation indicating what the external length of the PICC was when placed Staff C stated,No, and acknowledged not knowing what the initial external length was, would preclude staff from determining if the line had migrated. RESIDENT #23 According to the February 2020 MAR Resident #23 started on IV [MEDICATION NAME] (Iron Sucrate, used to treat [MEDICAL CONDITIONS] in people with kidney disease) IV daily for five days on 0[DATE]. A 0[DATE] IV Service Note indicated an extended dwell catheter was placed to Resident #23's left forearm. On 02/25/2020 12:24 PM Resident #23 was observed with a peripheral IV access to his left forearm. Review of the February 2020 MAR and TAR showed 0[DATE] orders that directed staff to flush the catheter with 10 ml NS before and after medication administration, and to monitor the IV insertion site for signs and symptoms of infection every shift. These orders were discontinued on 02/22/2020 with completion of the [MEDICATION NAME], despite the IV remaining in place. During an interview on 03/03/2020 at 07:19 AM, when asked if Resident #23 should have had an order for [REDACTED]. When asked if there should have been an orders for a weekly dressing changes (as the extended dwell IV was in place for 8 days)and monitoring of the insertion site Staff C stated, Yes. Additionally a 02/25/2020 2:06 PM progress note stated, Peripheral IV removed, tolerated procedure. During an interview on 03/03/2020 at 07:19 AM, when asked what a nurse should asses and document when discontinuing a peripheral IV Staff C stated, Tip intact .to ensure no pieces were left and acknowledged that did not occur. REFERENCE: WAC 388-97-1060(3)(j)(2) .
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 record review and interview, the facility failed to ensure two (#s 4 & 16) of five sample residents reviewed for unnecessary medication, received oversight of their total program of care by a physician, as frequently as required. This failure placed the residents at risk for unmet medical needs. Findings included . RESIDENT #4 Per the record, Resident #4 was admitted to the facility on [DATE] and had a documented comprehensive review by a physician on 12/09/2019. Subsequent visits by Advanced Registered Nurse Practioners (ARNP) and/or Physician Assistant Certified (PA-C) were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505400	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENUMCLAW HEALTH & REHAB CENTER	2323 JENSEN STREET ENUMCLAW, WA 98022

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 0712 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 12) documented on 01/08/2020, 01/29/2020 and 02/07/2020. A physician visit was due by 02/08/2020 +/- 10 days but did not occur. In an interview on 03/03/2020 at 10:18 AM, Staff C, Resident Care Manager, indicated it was the facility's understanding that any physician visit counted as a physician visit, including outside consults of podiatry, psychiatry, or neurology, not a Primary Care Provider (PCP). RESIDENT #16 Similar findings were identified for Resident #16 who admitted to the facility on [DATE] and seen by the PCP on 12/25/2019. The resident had an Osteopathic consult on 01/23/2020 and was seen by a Psychiatric ARNP on 02/04/2020 and a PA-C on 02/07/2020. The resident should have, but was not seen by, the primary PCP physician on 01/25/2020 +/- 10 days. REFERENCE WAC 388-97-1260(4)(b). .
F 0725 **Level of harm** - Minimal harm or potential for 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.** Based on interview and record review, the facility failed to have sufficient staff to provide and supervise care as evidenced by information provided in 10 (#s 64, 4, 27, 34, 10, 15, 36, 45, 25 &165) of 22 resident interviews, one grievance (#s 45), Resident Council (#s 34), and staff interviews. The facility had insufficient staff to ensure residents received assistance with Activities of Daily Living (ADL) including showers, Restorative services, and call light response in accordance with established clinical standards, care plans, and preferences. These failures placed residents at risk for unmet care needs and negative outcomes. Findings included: Refer to CFR: 483.10(f)(1)-(3)(8), F-561, Self Determination 483.24(a)(2), F-677, ADL Care Provided For Dependant Residents 483.25(c)(1)-(3), F-688, Increase/Prevent Decrease in ROM/Mobility RESIDENT INTERVIEWS DURING INITIAL ROUNDS RESIDENT #64 On 02/25/2020 at 09:58 AM when asked if the facility had adequate staffing Resident #64 stated No .They need more help, if you ask for something it takes a half hour, or if you holler for them they don't come . they only got one girl taking care of two halls, it makes me feel bad, especially around lunch, they never come to see if you're ok because they don't have enough help. RESIDENT #4 On 02/25/2020 at 11:29 AM when asked if there enough staff Resident #4 stated, No .I have had to wait three hours before (for her call light to be answered), meal times is worst meal time is worst, (when staff finally come) they always say there was an emergency .I have told staff about it (long call light response times), I don't remember who . whoever comes in. RESIDENT #27 On 02/25/2020 at 10:44 AM Resident #27 indicated there was not enough staff and stated, It takes about 45 minutes for staff to respond to a call light. RESIDENT #34 On 02/25/2020 at 10:03 AM Resident #34 stated, The facility does not have enough CNA (Certified Nursing Assistant) staff .it takes long to get the call light answered. RESIDENT #10 On 02/25/2020 at 11:41 AM when asked if the facility had adequate staffing Resident #10 stated, So long as everybody show up for their shift .(but) they don't always show up .they (staff) are stressed due to staffing (issues). RESIDENT #15 On 02/25/2020 at 10:51 AM when asked if there was enough staff to meet his needs Resident #15 stated, Yes, except for weekends, they are something else. Resident #15 clarified that meals are sometimes late, and call light response is prolonged on weekends. RESIDENT #36 On 02/25/2020 at 1:40 PM Resident #36 expressed call lights were not answered promptly on all shifts. RESIDENT #45 On 02/25/2020 at 10:16 AM Resident #45 stated, When I need assistance it could take quite a while, I had to use the bed pan when I first got here, sometimes I would be left on the bedpan for 20-30 minutes, especially in the morning, you get a little sore . it is not comfortable being on a bed pan for that amount of time. RESIDENT #25 On 02/25/2020 at 10:43 AM Resident #25 stated that the facility needed more staff .They are under staffed .a lot of them work double shifts because they don't have enough staff GRIEVANCES RESIDENT #45 A grievance summary report dated 11/25/2019 showed the resident expressed concerns about not receiving any showers since admission on 11/07/2019 (19 days). According to the grievance a incident report was generated and the it was called into the state agency as an allegation of neglect. RESIDENT COUNCIL During a Resident Council meeting held on 03/02/2020 at 9:07 AM, the following concerns were discussed related to staffing. Although six residents were present, five residents were unable/unwilling to participate. When asked if there were enough staff, Resident #34 stated, No and indicated call lights were not answered timely on graveyard and stated, Sometimes there are so few people in the building, if there were a emergency, it would be a calamity. My neighbor (roommate) had fallen off the bed, and I put the call light on because she needed help to get off the floor, nobody came. I put my robe on and went down the hall, they know if I show up in the hall it's hell to pay .(it was a) 10-15 minute wait. When asked about provision of showers Resident #34 stated, They pull the shower aide when they are short on the floor . it's appalling, standing and waiting for the showers .at least weekly they get pulled. When asked about Restorative services Resident #34 voiced no concerns. RESTORATIVE SERVICES During an Interview on 03/02/2020 at 02:06 PM Staff AA Restorative aide, revealed that she was pulled to work on the floor as a nursing assistant when they are short staffed. When asked what happens to the programs when she get pulled, staff stated they are not done. SHOWERS RESIDENT #45 On 02/25/2020 at 10:06 AM, when asked if she could choose her frequency of bathing Resident #45 stated, They (staff) asked me if I was ok with two a week, and seen as it took three weeks for the first shower, I said yes. At home I showered daily. I would actually like three a week here, but if I can't (even) get the two (that are scheduled), how can I ask for more they always pull the shower aides. RESIDENT #165 In an interview on 02/26/2020 at 8:24 AM, Resident #165 indicated she was supposed to receive two showers a week, but they were not consistently provided and stated, .It varies depending on how much time they (shower aides) got. RESIDENT #25 On 02/25/2020 at 10:18 AM, when asked if she could choose her frequency of bathing Resident #25 said, I'd like to shower daily, but I understand that may not be possible . Resident #25 then indicated was supposed to receive three showers a week but they were not consistently provided. When one of the bath aides gets pulled to the floor to take care of residents, we only have one bath aide. When asked what staff say when they miss her scheduled bath day, Resident #25 replied, They just say sorry .I got pulled to the floor to work . During an interview on 03/03/2020 at 06:16 AM Staff P, Shower Aide, explained that the facility had two shower aides, he worked Sunday-Thursday and Staff U, Shower Aide, worked Monday-Thursday. When asked what occurred if the facility was short staffed on the floor Staff P stated, They take us (Shower Aides) and put us on the floor, so no showers get done. When asked if the floor aides were then assigned the showers that were due Staff P stated, No, they don't do showers. Staff P indicated in December 2019 (Staff U was pulled) 2-3 times a week and me 1-2 times (per week). Staff P indicated they were still being pulled to the floor on occasion, but it was improving as the facility now used agency staff, but noted that he was the only shower aide yesterday and today (03/03/2020), as Staff U was out on emergency leave. When asked if being short staffed had affected his ability to provide showers at the resident's desired frequency Staff P stated, Yes. During an interview on 03/03/2020 at 10:29 AM Staff B, Director of Nursing, acknowledged that Staff U was out on leave and she was unable to replace her on 03/02/2020 but indicated she found someone to work a half shift on 03/03/2020 and was working on 03/04/2020. After reviewing Staff P's responses with Staff B she stated, I don't think we pulled them that frequently in December (2019), I think it may be true for November (2019). When asked if she was aware that staffing (although reportedly improved) had affected the provision of showers/bathing for residents Staff B stated, Yes. STAFF INTERVIEWS In an interview on 03/03/2020 at 2:05 PM, when asked if there was enough staff to ensure residents got their care needs without having to wait long periods, Staff W, Certified Nursing Assistant (CNA), stated It depends. Staff CC, CNA explained, Usually we run at five or six (CNAs), but sometimes it's four .sometimes from 4-5-6 it depends on the day. When asked how the facility fixed it when CNAs called off on dayshift, Staff CC replied, They don't. When asked if the Restorative Aides were pulled to work the floor when direct care staff called off, Staff W stated, Sometimes but not on the weekend generally .on the weekend she (Restorative staff) comes in at 10:00 AM. Staff W indicated we've had five (CNAs) lately but indicated four CNAs on dayshift was a frequent occurrence, a couple of months ago. REFERENCE: WAC 388-97-1080(1). .
F 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Observe each nurse aide's job performance and give regular training.** Based on interview and record review, the facility failed to ensure a system which provided for annual performance reviews for three (Staff U, Y & Z) of five Certified Nursing Assistants (CNAs) reviewed. Failure to provide an annual performance review for all nurse aides, and provide sufficient in-service education based on the outcome of the reviews, placed residents at risk for unmet care needs related to under-qualified care staff. Findings included . Performance reviews for a sample of five CNAs were requested from Staff J, Staff Development Coordinator, on 03/03/2020. On 03/03/2020 at 2:42 PM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505400	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENUMCLAW HEALTH & REHAB CENTER	2323 JENSEN STREET ENUMCLAW, WA 98022

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 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 13) Staff J acknowledged that she could not produce performance reviews for Staff U, Y & Z. REFERENCE: WAC 388-97-1680 (1), (2)(a-c). .
F 0745 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide medically related social services for two (#s 10 & 42) of five residents reviewed who demonstrated refusals. This failure placed residents at risk of unmet care needs related to refusals of care. Findings Included . Refer to CFR 483.259(g)(1), F-692, Maintain Nutritional Status RESIDENT #10 According to the 12/16/2019 Annual MDS (Minimum Data Set, an assessment tool), Resident #10 was cognitively intact and was assessed with [REDACTED]. This MDS showed the resident participated in a walking Restorative Nursing program on four of seven days of the assessment and no rejection of care. Observation on 02/25/2020 at 11:20 AM showed the resident transfer independently to a wheelchair with the aide of a walker kept at the bedside. The resident indicated at this time she had a Walk to dine restorative program, but did not perform three times a day consistently. Review of the restorative records showed, from 02/01/2020 to 02/26/2020, the resident was offered the walk to dine program refused the restorative program two of seven offered opportunities in January 2020 and 19 times out of 25 offered opportunities in February 2020. In an interview on 02/27/2020 at 8:45 AM, after review of Resident #10's restorative documents, Staff B, Director Of Nursing, confirmed the resident was refusing restorative services. When asked what staff were suppose to do when residents refuse services, Staff B stated, Put it (refusal) in the refusal binder and then Social Services will look at it and come up with alternatives for refusals to see if they (residents)would be more inclined to participate Upon review of the refusal binder, staff reported only two refusals in January and February, on 02/01/2020 and 02/04/2020' with staff documenting, resident said that she over did it again, and resident refused because she did it the day before. In an interview on 02/27/2020 at 8:52 AM, when asked if he provided any interventions to determine the cause of Resident #10's refusals (21) or alternative approaches to increase participation, Staff E, Social Services (SS), stated, I don't think I documented on refusals for her .she doesn't refuse all that much. In an interview at this time, Staff B confirmed the refusal binder did not reflect the resident's frequency of refusals and indicated SS should provide interventions for the reported refusals and document them in the record. RESIDENT #42 According to the 11/07/2019 Quarterly MDS Resident #42 demonstrated no refusals and per the 01/28/2020 Annual MDS, Resident #42 was assessed to demonstrate the behavior of refusals on one to three days of the assessment period and experienced a significant weight loss. Record review showed there were no weights obtained for Resident #42 for almost three months from 06/27/2019 to 09/19/2019. Meal intake records showed the resident refused 18 of 90 meals /replacements offered in (NAME)2020, 10 of 69 meals / replacements offered in July 2020, 22 of 88 meals/ replacements offered in September 2020. Record review showed no weights were obtained for Resident #42 for two months from 10/15/2019 to 12/10/2019. There was no documentation in the record the facility identified why the weights were not obtained. According to November 2019 meal intake records, the resident refused meals / replacements for 33 of 79 meals offered and refused 27 of 76 meals / replacements offered in December 2019. There were no weights obtained for over six weeks from 1[DATE]19 to 02/11/2020. There was no documentation in the record the facility identified the reasons behind why the weights were not obtained. In an interview on 03/02/2020 at 11:13 AM, Staff B, DON, indicated the weights were not obtained because the resident frequently refused. When asked what staff should do in the event of refusals, Staff B stated that staff should attempt to determine the reason behind the refusals and identifying and promote individualized, non-pharmacological approaches to care that meet the resident's needs. In an interview on 03/02/2020 at 11:13 AM, when asked the expectation if a resident refused weights for more than three weeks, Staff B and C, Resident Care Manager (RCM), interviewed together on 03/02/2020 at 11:18 AM, stated, Reapproach, have different staff try, show her pictures of dogs. Facility staff was asked to provide any information to support staff attempted or promoting individualized, non-pharmacological approaches as it related to the resident's refusals of weights and meals/meal replacements. No information was provided. REFERENCE: WAC 38-97-0960 (1). .
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure three (#s 42, 25 & 52) of five residents reviewed for unnecessary medications were free from unnecessary drugs related to the failure to adequately monitor, ensure adequate indications for use, or prevent excessive duration of medication use. These failures placed residents at risk to receive unnecessary medications and/or adverse side effects. Findings included . RESIDENT #42 Record review showed Physician order [REDACTED].insert 1 suppository rectally as needed for constipation if no result from MOM (Milk of Magnesia), administer per MD order on next shift, during waking hours only. A MOM order directed staff to give 20 mls by mouth as needed for constipation if resident does not have a bowel movement (BM) of three days . According to January 2020 Medication Administration Records (MARs), staff administered a [MEDICATION NAME] suppository on evening shift on 01/02/2020 and dayshift on 01/28/2020. However, the MAR showed the resident did not receive MOM prior to the [MEDICATION NAME]. Additionally, according to bowel records, the resident had a medium BM on dayshift on 01/01/2020 and a small BM on dayshift on 01/02/2020, thus did not require either the MOM or the [MEDICATION NAME]. Similar findings were identified as staff documented the resident had BMs on 01/26, 27 and 28/2020. In an interview on the morning of 03/02/2020, Staff B, Director of Nursing, reviewed the MAR and confirmed, in the absence of any other assessments, the [MEDICATION NAME] was administered without adequate indications for its use. RESIDENT #25 According to the 01/03/2020 Quarterly MDS (Minimum Data Set, an assessment tool), the resident experienced trouble falling or staying asleep. A review of an order Summary dated 12/23/2017, showed instructions for [MEDICATION NAME] 3 mg by mouth at bedtime related to primary [MEDICAL CONDITION]. In an interview on 02/28/2020 at 12:53 PM, the resident said,I have some trouble sleeping, most of the time it's because I'm not wearing my [MEDICAL CONDITION]. A review of February 2020 MAR showed an orders dated 10/14/2019, [MEDICATION NAME] tablet give 3 mg by mouth at bedtime supplement. A review of the Psychotherapy Progress Notes dated 02/04, 02/06 and 02/13/2020, showed the resident experienced sleep difficulties. In an interview on 02/28/2020 at 8:52 AM. Staff D LPN-RCM (Licensed Practical Nurse-Resident Care Manager said, I was unaware the resident was experiencing difficulty sleeping. I know she takes a something ([MEDICATION NAME]) at bedtime, but to my understanding it's a supplement. On 02/28/2020 at 11:07 AM, Staff B said, During the last inspection, we were told [MEDICATION NAME] was a supplement . do we have to monitor supplements. Staff C said, I don't think we have any sleep monitors for her. She isn't on any sleep medications .just [MEDICATION NAME]. RESIDENT #52 Review of Resident #52's MAR revealed two orders for Aspirin: Aspirin EC ([MEDICATION NAME] Coated) Tablet Delayed Release 81 MG by mouth one time a day for [MEDICATION NAME] at 09:00 AM starting 02/04/2020; Aspirin Tablet 81 MG by mouth in the morning for [MEDICATION NAME] 06:00-10:00 AM starting 10/19/2019. The MAR shows that in total, Resident #52 received a duplicative order for twenty days between 02/04/2020 and 0[DATE]20. Resident #52 did not receive the duplicative dose on 02/10/2020, as the EC Aspirin was held for an outpatient procedure. Resident #52 did receive the other Aspirin dose on 02/10/2020. In an interview on 02/27/2020 12:58 PM, when asked whether she could think of a reason for giving both [MEDICATION NAME] Coated and regular Aspirin, Staff C, RCM, replied are you talking about (Resident #52)? . I'm the one who identified and fixed it. REFERENCE: WAC 388-97-1060(3)(k)(i). .
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 interview and record review, the facility failed to ensure two (#42 & 25) of five residents reviewed for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505400	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENUMCLAW HEALTH & REHAB CENTER	2323 JENSEN STREET ENUMCLAW, WA 98022

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 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 14) unnecessary medications, were free from unnecessary [MEDICAL CONDITION] drugs related to the failure to: adequately monitor, ensure adequate indications for use, or implement non drug interventions prior to the use of as needed (PRN) [MEDICAL CONDITION] medication use. These failures placed residents at risk to receive unnecessary medications and/or adverse side effects. Findings included . RESIDENT #42 According to the 05/20/2019, 08/10/2019 and 11/07/2019 Quarterly Minimum Data Set (MDS - an assessment tool) and the 01/28/2020 Annual MDSs, Resident #42 had [DIAGNOSES REDACTED]. According to the resident's 01/31/2019 Antipsychotic Medication use (related to) [DIAGNOSES REDACTED]. A 01/31/2019 CP showed the resident was assessed with [REDACTED]. In an interview on 03/02/2019 at 1:20 PM, when asked to describe what paranoia, delusions, or hallucinations the resident demonstrated, Staff B, Director of Nursing (DON), indicated the resident didn't demonstrate paranoia. At this time, Staff E, Social Services Director, when asked the same question, initially indicated he was unsure, but later stated the resident demonstrated delusions as evidenced by the resident's refusals of showers because she stated she had showered at her daughter's house. The resident's daughter did not live locally. Facility staff was asked to provide any information to support Resident #42 demonstrated paranoia or hallucinations. No information was provided. Record review showed [MEDICAL CONDITION] Drug and Behavior Quarterly Reviews (PDBQR) dated 02/19/2019 and 08/21/2019. Facility staff was asked to provide information to support the PDBQRs were completed quarterly as directed in the CP. In an interview on 03/03/2019 at 8:16 AM, Staff B reviewed the resident's record and confirmed facility staff did not review the resident quarterly at the Mood and Behavior Meeting as directed. Review of PDBQR forms dated 08/21/2019, showed the resident received [MEDICATION NAME] (an antipsychotic medication) 0.5 mg (milligrams) in the afternoon and 0.25 mgs in the morning for dementia in other disease classified elsewhere with behavioral disturbances. Staff documented This medication aims to reduce agitation, aggression and refusal of care. Staff documented the Target Behaviors (TB) since last review included, Refusal of care (showers, clothing change), physical aggression towards staff during care and indicated, Will reattempt GDR (Gradual Dose Reduction) to 0.25 (mg) BID (twice a day). According to September 2019 MAR, the resident's [MEDICATION NAME] was increased from 0.25 mg twice a day, to 0.25 mg in the morning and 0.5 mg in the evening on 09/06/2019. Record review showed Resident #42 was hosptalized on [DATE] for a change in condition and returned to the facility on [DATE]. According to the 09/23/2019 note, Resident had a UA (urinalysis)/ C & S (culture and sensitivity) done in the ER (emergency room) that the MD did not want to treat at that time due to being asymptomatic. In the hospital resident had pyuria (pus in urine) and leukocytosis (white blood cells in the urine) .Resident had a one time temperature of 99.9 . According to this note, an additional UA was ordered. Lab results dated 09/23/2019 showed, UA result received with 3+ Leukocyte & 3+ bacteria . According to psychiatry notes dated 09/24/2019, the resident was, still refusing showers and the [MEDICATION NAME] was increased to .5 mg twice a day. According to the September 2019 MAR, the resident was started on an antibiotic to treat a UTI on 09/25/2019. Record review showed no indication facility staff considered the resident's behavior was related to an identified infection, or considered a reevaluation of the dose increase upon resolution of the infection. Review of TB records for September 2019 showed staff were monitoring the following behaviors: Refusal of care, pacing, wandering, verbal aggression, physical aggression, verbal aggression and hallucinations/delusions, and crying/tearfulness. In an interview on 03/02/2019 at 1:20 PM, Staff B indicated that the TB identified that required the use of the antipsychotic medication was [MEDICAL CONDITION] (hallucinations/delusions) and that refusals in and of themselves did not require the use of an antipsychotic medication. Staff B confirmed that the September 2019 TB records showed the resident demonstrated no [MEDICAL CONDITION] (hallucinations /delusion). Staff B also indicated that any changes in [MEDICAL CONDITION] medications during active infections should be evaluated to determine if any change in presenting behaviors were related to infection. RESIDENT #25 According to the 01/03/2020 Quarterly MDS, Resident #25 was assessed with [REDACTED]. A review of a fax 06/18/2019, instructed staff to increase the [MEDICATION NAME] to 20 mg daily. In an interview on 03/03/2020 at 10:15 AM, Staff B reported the resident was started on [MEDICATION NAME] in May of 2019, and the dose was increased in (NAME)2019. When asked to provide documentation to support the dose increase, Staff B said, .the behavior monitor flow sheets will show why the resident's medications was increased. A review of behavior records showed staff identified that, crying/tearfulness were target behaviors that required the use of antidepressant medication. According to the TB monitoring records for June, July, August, September, October, November, and December 2019 and January 2020, Resident #25 did not demonstrate crying/tearfulness. On 03/03/2020 at 2:12 PM, Staff's B and C acknowledge the TB records were blank and there was no documentation to support the resident demonstrated behaviors that required the initial increase in (NAME)2019 or continued need of use. REFERENCE WAC 388-97-1060(3)(k)(i). .
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 labeled and/or removed in accordance with currently accepted professional standards in one of four medication carts reviewed. This placed residents at risk to receive expired medications and biologicals. Findings included . 100 UNIT MEDICATION CART Observation of the 100 unit medication cart on 02/25/2020 at 1:15 PM showed multiple packets of [MEDICATION NAME] and [MEDICATION NAME] with no identifying information including resident name or prescriber. According to Staff N, Licensed Practical Nurse (LPN), the medications belonged to Resident #43. A bottle of artificial tears for Resident #29 was open but undated. Observation of the 100 Unit treatment cart on 02/25/2020 at 1:25 PM showed a topical [MEDICATION NAME] powder open on 11/22/19 with no identifying information, including resident name or prescriber. A tube of [MED] ointment which was open, but the open date sticker was blank. At this time, Staff V, Registered Nurse (RN), confirmed that if there is an open date sticker, staff should document the date the medication/treatment is opened. Record review showed Resident #27 had an order for [REDACTED]. In an interview on 03/03/2020 at 1:45 PM, Staff B, Director of Nursing, indicated that this was probably from a previous order and that medications should be removed from the cart when a resident's treatment is completed. A [MEDICATION NAME] cream for Resident #34 was noted as open but the date opened sticker was blank. In an interview on 02/25/20 at 1:31 PM Staff N stated, She's not on that anymore--that's from August. In an interview on 03/03/2020 at 1:45 PM, Staff B stated that order was discontinued six months prior, on 08/27/2019, and should have been removed from the cart. [MEDICATION NAME] cream was noted for Resident #42, with no open date. According to Staff N, on 02/25/2020 at 1:45 PM, She hasn't been on that for a while. In an interview on 03/03/2020 at 1:45 PM, Staff B stated that order was discontinued on 01/23/2020, and should have been removed from the cart. Resident #24 was identified with an antifungal medication with an open date of 11/20/19. According to documents provided by Staff B on 03/03/2020, this medication was discontinued on 12/19/2019. A powdered antifungal medication was identified for Resident #10 with an open date of 11/19/19. According to Staff N on 02/25/2020 at 1:31 PM, She's not using that anymore. Hall 500 MEDICATION CART 3 On 02/25/2020 at 8:30 AM, [MED] ([MEDICATION NAME]) bottle opened 02/22/2020 stored in medication cart. Instruction label on the bottle reflected, Keep refrigerated after opening. Staff R, RN, stated this need to be refrigerated. HALL 200 MEDICATION CART 2 On 02/25/2020 at 08:45 AM, Two bottles [MED] ([MEDICATION NAME]) with open date [DATE]20 were stored in medication cart 2. The label on each bottle Instructed staff to Keep refrigerated after opening. Unopened bottle of Latanoprost eye drop for Resident#62. Stored in the cart with instruction label REFRIGERATE UNTIL OPEN. Staff V RN, confirmed that these medication stored in the cart were supposed to be refrigerated as per the instructions. On 03/02/20 at 11:08 AM, Staff B, acknowledged that medications should be stored as per manufacturer recommendations. REFERENCE: WAC 388-97-1300(2), -2340. .
F 0791 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or obtain dental services for each resident.** Based on observation, interview and record review, the facility failed to ensure prompt dental services were provided for two (#s 14 & 34) of five residents reviewed for dental services. This failure placed the residents at risk for unmet dental needs, weight loss, and a diminished quality of life. Findings included . RESIDENT #14 According to the 09/28/2019 and 12/19/2019 Quarterly Minimum Data Sets (MDS - an assessment tool) Resident #14 required extensive one person assistance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505400	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENUMCLAW HEALTH & REHAB CENTER	2323 JENSEN STREET ENUMCLAW, WA 98022

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 0791 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 15) with personal hygiene and had no natural teeth. According to the resident's Kardex (instructions to nursing staff for care), the resident had Full Upper and Full Lower dentures. A Risk for Oral dental impairment related to full dentures CP (Care Plan) (target date 04/08/2020) listed a goal of will be free of .pain .in the oral cavity with interventions including, Coordinate arrangements for dental care . and Keep dentures in good repair, monitor / document/ report PRN (as needed) any {signs or symptoms of oral/dental problems needing attention, staff to provide / assist with oral care (twice a day) and PRN. Observations on 02/26/2020 at 8:25 AM showed Resident #14 lying in bed, the resident was noted with uncombed hair and teeth that was heavily crusted with white and pink bits. The resident stated she was wearing only upper dentures and the lower dentures, hurt. During an observation on 02/27/2020 at 1:28 PM, Staff B confirmed Resident #14 was not wearing lower dentures. At this time, when asked where the lower dentures were, Staff B stated, I don't know. In a subsequent interview on the morning of 03/02/2020, Staff B reported the lower dentures were found in the desk drawer of the Resident Care Manager (RCM), who had found them in the Medication room. In an interview on 03/03/2020 at 2:05 PM, Staff W, Certified Nursing Assistant (CNA), stated she had worked at the facility for over two years and worked with Resident #14. When asked about the use of lower dentures for Resident #14, Staff W stated, The last time I tried to put them (lower dentures) in she threw them at me . Staff W stated this occurred, maybe a year ago .she doesn't wear the bottoms she wears the tops, I don't think the bottoms fit. Observation on 03/03/2020 at 2:10 PM showed Staff B inquire with Resident #14 why she didn't wear her dentures. Resident #14 stated, It hurts. In an interview on 03/03/2020 at 2:16 PM when asked what aides were suppose to do if they become aware a resident wasn't wearing dentures, Staff B replied, Report it to the nurse and Social Services. Staff B explained she expected staff, in the event a resident stopped wearing dentures, to figure out the reason why they aren't wearing the denture. Staff B stated it was important to determine this for, chewing, eating, pain, dignity . Staff B was asked to provide documentation to support facility staff acted on the knowledge the resident wasn't wearing the lower denture because it was poorly fitting. No information was provided. Despite awareness of the resident not wearing dentures, staff failed to identify /determine reason for not wearing the dentures, assess the impact on the resident's health status, and pursue appropriate interventions. RESIDENT #34 Resident #34's medical record showed the resident received Medicaid reimbursement. According to the 01/15/2020 Annual MDS, Resident # 34 was cognitively intact, able to make needs known, and required one person assistance with personal hygiene. In an interview on 02/25/2020 at 10:30 AM, Resident #34 said she saw a dentist in the facility in (NAME)2019, and was referred for tooth extraction and recommendation for new dentures, but it had not happened. Observation revealed the resident had one tooth in her mouth. Review of Resident #34's Smile Seattle Dentures consult reflected, Referral for X-rays, evaluation and extraction. Recommendation for new dentures upper and lower. Review of Care Plan dated 01/17/2019 reflected Risk of Oral dental impairment related to advanced age. Intervention: CNA to notify licensed Nurse any bleeding, swelling of gums and pain daily with oral care. In an interview on 0[DATE] at 10:50 AM, Staff D, RCM, was asked what the facility's role in resident dental care was. Staff D replied nurses were responsible for making dental referrals and appointments. Staff D acknowledged Residents #34 required dental care services that were not, but should have been, provided. REFERENCE: WAC 388-97-1060(3) (j)(vii). .
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 (FA) which identified the resources needed to provide the necessary care and services the residents required. This failure placed all residents at risk of unidentified and/or unmet care needs. Findings included . A review of the Facility Assessment (FA - an assessment that addresses the resident population needs and its resources), dated October 29, 2018-October 28, 2019, showed the last review date of 10/28/2019. The facility assessment (FA) was incomplete and lacked the components of being a thorough assessment. In an interview on 03/04/20 at 7:59 AM Staff A, Administrator, stated the purpose of a facility assessment is, to identify the needs of the resident and develop a plan for meeting their needs . to make sure we have the training and equipment and staff to meet their needs. Review of the FA showed only MDS (Minimum Data Set, an assessment tool) information for residents, including [DIAGNOSES REDACTED]. The FA included no information regarding any plan for meeting the resident's needs, or what equipment staff would require to meet those needs. When asked how she would assess if facility had the equipment to meet resident needs, Staff A replied, I review the grievance log we would assess to see if they have what they need. Staff A indicated the facility would become aware of equipment needs if residents put forth grievances that equipment wasn't available. According to the Staffing, Training, Services, & Personnel section of the FA, the assessed overall staffing needs were identified as, In Progress with no objective information listed for the following Activities of Daily Living (ADLs): daily care, bed mobility, transfer, walk in room, toilet use, bathing, hygiene/grooming, Occupational Therapy. According to the FA, We do not currently have a QAPI (Quality Assuance & Performanec Improvement) plan for any of these specific items. When asked how the FA showed the amount of equipment and staff required to care for residents, Staff A replied at 8:10 AM on 03/04/20, There is no number besides the MDS data. Staff A confirmed facility identified issues with staffing stating, We have a PIP (Process Improvement Plan) for that (staffing). We have PIP (Process Improvement Plan) for staffing. The assessment lacked a thorough review of the care and services needs of all of the resident population, including the amount of staff and the competencies needed to meet the needs of the residents and the types of required training and education. Under the Acuity section of the FA, it addressed resident use of Occupational and Physical Therapy had a very high frequency of days relative to benchmarks, but failed to assess the number of staff required to meet the needs of the residents. According to the FA, We are currently in the process of hiring more staff. We have sponsored ads out and offer shift bonuses for additional shifts picked up. We are also using agency for a short time to cover shifts. Need for additional PRN (as needed) staff for occupational therapy to cover for vacations and weekends. However, further review showed no indication of the number of each type of staff was required to care for the residents. The total FA census was 73 and reflected oxygen treatments were required on 33 of the admission/stays. In an interview on 03/04/20 at 7:59 AM, when asked how many oxygen concentrators were required to care for the resident population, Staff A replied, It would depend. I don't know, you need some spares.' When asked if the assessment should reflect how much oxygen equipment is required, Staff A replied, I don't know, we base it on if there is a wait time or a complaint that you don't have it. The FA lacked trends from incident logs, grievances and resident records to determine if staff were meeting the needs of the residents and how it compared to the previous year. When asked how the FA would determine if there were adequate number of wheelchairs or Hoyer lifts, Staff A replied, It would depend on wait times. When asked the specific number of Hoyer lifts required for the current residents, Staff A stated, It would be based on resident population. Staff A, after reviewing the FA, was unable to state the number of Hoyer lifts required for resident care. When asked if the FA should reflect the number of licensed nurses and restorative nursing staff required to care for the residents, Staff A replied, Yes. Upon review of the FA, Staff A confirmed there were no objective, measurable numbers to reflect any needs of the residents. When asked how many restorative staff were required to provide services to the residents, Staff A replied, It depends on the number of restorative programs. Staff A was unable to find any information to show how many restorative staff were needed to meet the needs of the residents stating, It (the FA) used to have numbers for how many (staff were needed) it doesn't have that anymore. In an interview on 03/04/20 at 8:18 AM when asked how many restorative aides do you need to meet the needs of the residents, Staff B, Director of Nursing, stated Two. Staff B proceeded to explain current staffing needs based on current census and acuity was three nurses on dayshift and three nurses on evening shift .typically six aides on dayshift. Staff B explained that staffing, depends on census . REFERENCE WAC: No Associated Tag. .
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined that the facility failed to ensure a system by which staff were aware of and implemented interventions to prevent the spread of infection, and that reusable equipment was appropriately cleaned and disinfected placed residents at risk for the spread of disease. Findings included .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505400	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENUMCLAW HEALTH & REHAB CENTER	**2323 JENSEN STREET ENUMCLAW, WA 98022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 16) UNLABELED PERSONAL EQUIPMENT URINALS On 02/25/2020 at 10:29 AM, two urinals were observed resting on paper towels on the cistern over the toilet in the bathroom of room [ROOM NUMBER]. Neither urinal was labeled to enable the occupants of room [ROOM NUMBER] to distinguish which belonged to whom. The urinals were observed as unlabeled a second time on 03/02/2020 at 10:32 AM. On this occasion the urinals were bagged separately but still located on the cistern without labeling to direct residents which was theirs. PERSONAL CARE EQUIPMENT During an observation on 02/27/2020 at 10:22 AM, Staff B, Director of Nursing, confirmed the joint bathroom between rooms [ROOM NUMBERS] contained an unlabeled denture cup, unlabeled gray kidney basin containing Fixodent, a denture brush, a razor and deodorant. When asked to whom these items belonged, Staff B stated, They should be labeled. SMOKING APRONS Observations of smoking on 03/03/2020 at the assigned 1:30 PM smoking time showed Staff Monet passing cigarettes to residents under a covered enclosure. Staff DD stated there are, Usually five residents, there are four smokers, and (Resident) chews. Staff G, Dietary Service Manager, and Staff DD explained the system stating, We put on smocks or aprons on the residents. Observations at this time showed staff removed an apron from a bin on a cart containing multiple aprons and place the apron on Resident #14. After smoking, staff were observed to remove the apron from Resident #14 and place it in the collective bin on the cart. When asked if the gowns were washed, Staff G stated, (Staff J, Staff Development) takes care of sanitizing (the aprons). In an subsequent interview with Staff C, Resident Care Manager, and Staff H, Corporate Nurse Consultant, on 03/03/2020 at 2:15 PM, it was determined the facility did not have a system by which the communal smoking aprons were sanitized between resident use. MEDICATION OBSERVATION On 03/04/2020 at 8:45 AM, Staff R, Registered Nurse, was observed using a multi-use blood pressure cuff to monitor Resident #115's blood pressure. Staff R was observed cleaning the blood pressure cuff with two alcohol pads. In an interview at 9:05 AM, Staff R was asked to explain the protocol for cleaning /disinfecting multi-use equipment. According to Staff R, staff used alcohol or sanitizer to clean equipment. Staff R replied, If the person wasn't on isolation precautions, they could use an alcohol pad to wipe the item down. On 03/04/2020 at 9:09 AM, Staff J was asked to explain the facility's protocol for cleaning multi-use items. According to Staff J, the facility had a policy for cleaning critical and non-critical items. Staff J said, a blood pressure cuff was considered a non-critical item and could be disinfected using disinfectant wipes. REFERENCE: WAC 388-97-1320(1)(a). .
F 0947 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 maintain an in-service training program for Certified Nursing Assistants (CNAs) to ensure each CNA received at least 12 hours of training per year. Two of five CNAs (Staff I and U) employed by the facility for over two years had not completed 12 hours of training, in the past full year of employment. The facility did not developed and maintained a system for tracking in-service education for CNAs. Failure to ensure CNAs completed required hours of training placed residents at risk for receiving less than adequate care. Findings include: On 03/02/2020 at 11:20 AM, records documenting in-service training for a sample of five CNAs who had worked in the Health Center for over 2 years were reviewed with Staff J, Staff Development Coordinator. In order to assess the training hours, Staff J needed to tally them as we conducted the review. This process demonstrated that, in the past full year of employment, Staff I, hired on 01/05/2000, had received 7.5 hours and Staff U, hired on 05/26/2016, had received 11.75. Staff J expressed surprise and acknowledged that the annual in-service hours were not adequate, stating I have a hard time getting CNAs to in-services. I give out $150 in raffle prizes at trainings to encourage attendance . REFERENCE: WAC 388-97-1680(2)(a-c) .