STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505473	A. BUILDING _____ B. WING _____	C 02/05/2020

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UNIVERSITY PLACE REHABILITATION CENTER	5520 BRIDGEPORT WAY WEST UNIVERSITY PLACE, WA 98467

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F 000	INITIAL COMMENTS	F 000		

This report is the result of an unannounced Complaint Investigation conducted at University Place Care Center on 12/27/19, 12/30/19, 1/6/2020, 1/7/2020 &1/8/2020, 1/23/20, 1/24/20, 1/27/20, 1/28/20 & 1/30/20, 2/4/20, 2/5/20 sample of residents was selected from a census of 110. The sample included review of 20 current residents and six discharged residents.

An Immediate Jeopardy was identified on 01/23/20 at 5:05 PM related to pain management F697, and the facility was notified at this time. This failure resulted in Resident #7 experiencing significant pain that was left untreated for two days. The Immediate Jeopardy removal plan indicated immediacy will be removed after implementing an immediate staff training related to assessing pain, notifying the physician to obtain orders and streamlining the admission process.

An Immediate Jeopardy was identified on 02/04/20 at 5:38 PM related to neglect F600, and the facility was notified at this time. This failure resulted in Resident #18 not receiving treatments and monitoring significant skin conditions, and indwelling devices. The facility alleged Immediate Jeopardy removal will be cone through house wide resident assessments to identify all residents with skin conditions, and indwelling devices to ensure all had orders and were receiving treatment according to the plan of care.

An Immediate Jeopardy was identified on 02/05/20 at 4:04 PM related to F726 Competent Staffing and the facility was notified at that time. This failure to ensure all staff had the necessary

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/25/2020

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F 000	Continued From page 1	F 000		

training to provide the prescribed care and treatments placed all residents at risk for substandard care. The facility alleged immediacy would be removed through all staff training related to facility policies and nursing care.

An Immediate Jeopardy was identified on 02/05/20 at 4:04 PM related to F837 related to Governing Body, and the facility was notified at this time. The failure of the governing body to utilize their resources to ensure financial obligations were met and clinical systems were safe, placed residents at risk for interruption of services in the facility and receiving substandard care, both resulting in decreased quality of life for all residents in the facility. The facility alleged immediacy would be removed through payment plan arrangements, streamlining billing through accounting services and implementation of daily clinical oversight. The facility alleged immediacy will be removed by 02/13/20.

Partial Extended Survey was conducted on 01/28/20.

The following were complaints investigated as part of this survey:

3688621	3685844	3681833
3681175	3687540	3683377
3685877	3685969	3681556
3681553	3682528	3683358
3685680	3689328	3689301
3689204	3687923	3689238
3687716	3689486	3688286
3689227	3691296	3680609
3688289	3690982	

The survey was conducted by:
Nataliya Yakimenko, BSN, RN

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F 000	Continued From page 2 Tara Hawks, BSN, RN The survey team is from: Department of Social and Health Services Aging and Long-Term Support Administration Residential Care Services, Region 3, Unit B P.O. Box 98907 Lakewood, WA 98496-8907 Telephone: 253-983-3800 Fax: 253-589-7240	F 000		
F 600 SS=J	. Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure required structures, processes and systems were in place for managing pain, skin conditions, change of condition and indwelling medical devices. These failures resulted in harm related to neglect for	F 600	Individual Residents Resident #18 no longer resides in the facility. Resident # 7 has has subsequent pain assessment completed and states her pain is now adequately managed.	3/3/20

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F 600	Continued From page 3 Residents #'s (7, 18 &21). Combination of these failures created a situation of Immediate Jeopardy. "Neglect," as defined at §483.5, means "the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress." Findings included: RESIDENT#18 Resident #18 was neglected when nursing staff failed to manage surgical wounds and nephrostomy tubes (tube placed through the lower back into the kidney to drain urine), the resident subsequently developed sepsis. Resident #18 is no longer at the facility. Resident #18 admitted to the facility on [redacted]/19 following hospitalization for serious burns. The Resident #18 admitted to the facility with a [redacted] surgical wound, burn site with a skin graft on the right chest wall extending under the arm, and a graft site to the thigh area. On [redacted]/20 Resident #18 was sent to the emergency room for a leaking nephrostomy tube and readmitted back to the facility after the tube was replaced. 1. Record review showed documentation on the Treatment Administration Record (TAR) for a daily wound care to the right torso burns dated 01/08/20. The TAR showed documentation holes indicating the wound care was not complete	F 600	Resident # 21 has had her wounds assessed by United Wound Healing provider to include ongoing treatment plan. Facility MD concurs with ongoing interventions Residents in similar situations Residents with in- dwelling devices, wound impairments, changes in condition and unrelieved pain have the potential to be effected if ongoing assessment and treatment does not occur. Facility has completed assessments on Residents with indwelling devices to ensure treatment plan and ongoing assessment needs have been identified and documented. Facility completed new admission assessments on those Residents who had admitted in the previous 30 days to ensure that there had been no changes in condition, documentation was accurate and treatment plan was in place. Any findings were corrected at that time. Pain assessments were completed on facility Residents to ensure adequate and ongoing pain management. Any findings were corrected at that time. Facility, in conjunction with United Wound Healing, completed a full house skin sweep to ensure that facility was aware of any current skin impairments. Treatments plans were established with any findings. Measures to prevent re occurrence Facility has hired a dedicated admission nurse who has been educated to the admission process related to	

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F 600	Continued From page 4 between 01/07/20 and 01/20/20 for seven days. 2. There were no orders transcribed to the January 2020 Treatment Administration Records (TAR) for the right thigh graft site and no orders for the [redacted] site. There was no documentation showing these areas were assessed at least daily. There was no evidence to support staff clarified or questioned the provider. 3. There was no treatment completed for nephrostomy tubes as evidenced by lack of documentation on the treatment record. The treatment record for January 2020 showed the nephrostomy tubes were not checked daily for thirteen days. Review of nursing progress notes did not find evidence of daily assessment of the medical devices. According to nursing notes on [redacted]/20 the Resident #18 had increased confusion and was sent to the hospital. Hospital records showed the Resident #18 admitted to the emergency room on [redacted]/20 with confusion, and was diagnoses with [redacted] On 02/03/20 at 11:10 AM and on 02/04/20 at 12:39 PM during interview Staff P, VP of Clinical Services said that wound orders were missed at the time of admission and daily nephrostomy tube assessment/monitoring was not done. Staff P, VP of Clinical Services verified that Resident #18 was not followed by a wound team, no measurements and/or wound assessment was done. Additionally, the prior Interim Director of Nursing instructed staff not to document weekly skin assessments as a wound team was supposed to document those.	F 600	assessment, pain management, and implementation of treatments and indwelling device monitoring. Education also includes 2 LNs to verify admission orders. Admission nurse will be working Tuesday through Saturday for ongoing oversight. Facility nurse managers have been trained on the admission process related to assessment, pain management and implementation of treatments and indwelling device monitoring. Education also includes 2 LNs to verify admission orders. Facility has implemented Grand Rounds each morning(M-F) to identify any Resident care needs or potential changes in condition. Licensed nurses have been re-educated to the expectation of completing weekly wound assessments when scheduled, including the documentation of wound characteristics if not followed by United Wound Healing or the local Wound Care Clinic. Facility has established a best practice for weekly wound rounds that include the DON, RCMs, Director of Rehab and other pertinent staff members. Facility Licensed nurses have been re-educated on the Interact stop and watch process, shift to shift reporting, referral of all new wounds to United Wound Healing, ongoing assessment of indwelling devices to include but not limited to: IVs, catheters, urostomy, nephrostomy, colostomy devices, dialysis shunts or ports and wound vacs. Facility has assessed current charge	

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F 600	Continued From page 5 RESIDENT #7 Resident # 7 was neglected and suffered physical and psychological harm when nursing staff failed to complete a through physical assessment, identify and treat severe pain for 48 hours. Resident #7 admitted to the facility on [redacted]/19 after having foot surgery as documented in the hospital records. Resident had discharge instructions to take Oxycodone-Acetaminophen 5/325 mg (narcotic pain medication, for moderate to severe pain) 1-2 tablets every four hours as needed, according to hospital discharge documents. During observations and interview on 12/30/19 at 8:35 AM, Resident #7 explained she came to the facility for rehabilitation after a having surgery to treat a broken foot and she had a broken arm. Resident #7 described experiencing severe pain for two days. Resident #7 said she asked multiple nurses for pain medication but it was not available. The resident said her pain was (10/10). The resident said she tried meditating and using a coloring book to distract her from pain. Nursing note dated 12/21/19 at 12:15 AM documented Resident #7 complained of pain level 10/10 and "demonstrated frustration due to severe pain, but no medication available in the narcotic drawer." Interview with Staff R, RN (Registered Nurse), RCM (Resident Care Manager) on 01/27/20 at 11:26 AM revealed she had no training on how to complete a new admission. Staff R, RN RCM said she did not send the prescription to the pharmacy because she assumed it was medical	F 600	nurse hours and has determined that changing the hours to incorporate coverage over both day shift and evening shift will provide more clinical oversight. Facility has implemented 24 hour manager coverage for a period of 30 days to complete ongoing rounds, support nursing staff and ensure staffing levels are adequate for providing needed care and services. Facility Medical Director has provided education to other providers on the narcotic prescription and ordering process On-going Monitoring HIM director will audit new admission charts the next business day after admission. Any missing items will be provided to the Don and RCMs to ensure completion New admission charts will be reviewed the next business day at the clinical meeting to ensure all indicated assessments have been completed and treatment plans implemented.. Facility will implement ongoing random audits of the admission process, nurse shift to shift process, completion of wound rounds and documentation,completion of treatments per MD orders, caring partner reports and the Grand Rounds process. Post Acute Solutions will provide clinical oversight daily Monday through Friday for the next 4 weeks to ensure compliance of the plan of correction. Oversight need/quantity will be re-evaled at that time. Results of above audits will be presented	

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F 600	Continued From page 6 records responsibility. Refer to F726 Staffing Competency for additional information. RESIDENT#21 Resident #21's wounds were neglected when nursing failed to complete thorough assessment and obtain wound measurements. Resident #21 admitted to the facility on [redacted]/19 with diagnoses to include, [redacted] and history of [redacted] Record review of Podiatry Consult dated 12/23/19, showed Resident #21 had no open areas on the right foot. Observations and interview with Resident #21 was conducted on 01/28/20 at 1:32 PM. Resident #21 had a right immobilization cast to the right lower extremity. Resident #21 was unable to provide information about wound care. Resident #21 said she was not sure if she admitted with wounds. 1. Review of TAR for January 2020 showed the Resident had a wound to the bottom of the right foot and there was an order for a daily dressing change. The TAR documentation showed the dressing changes were not completed on 01/06/20, 01/09/20, 01/10/20, 01/15/20, and 01/19/20. 2. Review of TAR for January 2020 showed an order to complete head to toe skin checks weekly. On 01/15/20 the skin check was not signed off as complete.	F 600	to the monthly QAPI committee x3 months for identification of needed education and training opportunities. Individual to Ensure Compliance DON/Executive Director	

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F 600	Continued From page 7 3. Review of TAR for January 2020 showed an order to apply medicated cream daily to the groin area, to the [redacted] area twice daily, and ointment to the buttock folds three times a day. On the following days the orders were not carried out on 01/06/20, 01/09/20, 01/15/20, and 01/16/20 and on 01/19/20. Record review Resident showed on 01/25/20 Staff O, RN, RCM (Resident Care Manager) obtained physician orders to treat an open area on the right outer and bottom aspect of the foot. Staff O, RN RCM on 01/28/20 at 1:34 PM was asked about how and when the resident developed wounds to the right foot. Staff O, RN RCM did not know if the resident admitted with wounds or developed them at the facility and said the wounds were not investigated to rule out abuse/neglect. Staff O, RN RCM was unable to provide weekly assessments and measurements for the wounds. Staff O, RN RCM was informed about multiple omissions of wound care on the January 2020 TAR. The facility staff demonstrated serious disregard for consequences by not providing assessment and treatment to prevent actual and potential negative outcomes. Reference WAC 388-97-0640(1)	F 600		
F 610 SS=H	. Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		3/3/20

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F 610	Continued From page 8 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each allegation was thoroughly investigated involving Residents #s (18, 7, 16, 26, 15, 11, 10&21) and failed to prevent ongoing abuse and neglect. Additionally, the facility failed to maintain state incident reporting log. Failure to thoroughly and timely investigate allegations of care concerns resulted in the facility determining the allegations were unsubstantiated, which led to neglect and harm to residents. Findings included: STATE REPORTING LOG In an interview on 01/24/20 at 1:30 PM, the surveyor requested a copy of the facility's state reporting log for the previous three months. Staff P, VP of Clinical Services (VPCS) said the log	F 610	F-610: Investigate/Prevent/Correct Alleged Violation Individual Residents Resident #18 no longer resides in the facility Resident # 7 has had pain assessment completed and verbalizes pain is being managed Resident # 16 no longer resides in the facility Resident # 26 no longer resides in the facility Resident # 15 no longer resides in the facility Resident # 10 has been interviewed about any care concerns and states every thing is fine right now Staff member Z and S are no longer	

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F 610	Continued From page 9 was missing. RESIDENT #18 Review of a facility grievance form dated 01/19/20 showed Resident #18's daughter had spoken to facility staff and reported she had the following concerns; *change in condition that was not being addressed *had received the wrong medications *weight loss *resident had been bullied *not receiving scheduled showers *dressing changes not being done *staff had been argumentative with family *mucus in chest had not been addressed *foaming at mouth - new change Additionally, the family requested that the identified staff who had been argumentative not be assigned to provide care for Resident #18. Review of the grievance summary dated 01/23/20 showed "Abuse and Neglect have been ruled out." Review of Resident #18's January 2020 Treatment Administration Record (TAR) showed a physician's order dated 01/08/20 to complete treatment and dressing changes to the wound on Resident #18's chest and right torso daily. At the time of the review on 1/23/20, the dressing change had only been documented as being completed on six of 16 days, Further review of the January 2020 TAR showed there was no order for the surgical incision on Resident #18's right thigh where he had recent surgery to remove skin for a skin graft, and no order to care for surgical incision where the	F 610	employed by the facility Rsd # 11 has no recall of the stated Rsd to Rsd incident Rsd # 21 has had her wounds assessed by United Wound Healing provider to include ongoing treatment plan. Facility MD concurs with ongoing interventions Residents in similar situations Residents have the potential to be effected if the facility fails to ensure that allegations are thorough investigated and the Facility reporting log is not maintained. Allegations and grievances for the last 14 days have been reviewed by the VP of clinical services services to ensure that the facility has thoroughly and timely investigated allegations of care concerns. Any concerns were addressed at that time. The state reporting log has been updated and remains current. Measures to prevent reoccurrence The facility had hired an interim Director of Nursing who is familiar with state reporting log and the need to thoroughly investigate all allegations of care concerns. The facility has updated the grievance policy and provided education to the management staff on grievance resolution, abuse and neglect prohibition. The administrator will serve as the grievance officer. Grievances and Incidents reports will be reviewed by the management team at the daily team meeting to ensure all	

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F 610	Continued From page 10 resident's [redacted] had recently been [redacted] There was no documented evidence the surgical incisions were being monitored for healing and/or signs of infection. Staff P, VPCS, reviewed the chart and was not able to locate documentation of wound care or wound monitoring for the identified surgical sites Review of Resident #18's record showed a physician's order for daily showers. Review of the shower documentation with Staff P, VPCS, on 01/28/20, showed documentation of five showers over the last 30 days. Staff P, VPCS, stated she did not know why staff had not documented giving or offering showers daily. Review of Resident #18 weight record showed he had one weight documented in his chart, on 01/20/20, the day after his family alleged he had lost weight. Resident #18's family reported care concerns including weight loss, lack of showers, and lack of dressing changes, argumentative staff, and being bullied. In an interview on 01/28/20, at 12:23 PM, Staff BB, Interim Director of Nursing, IDNS, stated the concerns reported by Resident #18's family should have been entered on the state reporting log and should have been investigated as an allegation of neglect. Resident #18's record showed that staff had not taken his weight, and therefore were not monitoring him for weight loss, dressing changes and wound monitoring were not being completed by nursing staff, showers were not documented, and there was no documentation that the allegation of the wrong medication had been addressed. The summary indicated abuse and	F 610	grievances and care concerns are investigated thoroughly and completed within 5 days. The administrator or designee will meet with Resident Counsel to provide education on the Grievance and investigation process On-going Monitoring The VP of clinical services or VP of Operations will review the grievances and Incident reports weekly for 30 days and then monthly ongoing to ensure care concerns are investigated thoroughly and resolved timely. Results of these reviews will be presented to the monthly QAPI committee x3 months for identification of needed education and training opportunities. Individual to Ensure Compliance DON/Executive Director	

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F 610	Continued From page 11	F 610		

neglect had been ruled out, but the record clearly showed the reported concerns were correct. The facility failed to identify the reported concerns as alleged neglect and failed to identify neglect had occurred.

Refer to F 600 for additional information related to neglect for Resident #18.

RESIDENT #7
Review of the facility incident investigation dated 12/21/19 showed Resident #7 did not receive Percocet (narcotic pain medication) for 48 hours after being admitted to the facility with acute pain following foot surgery, although there was an order and a prescription issued by the hospital.

The incident investigation documented that on 12/21/19 in the afternoon, Resident #7 reported to the nurse she did not receive pain medications since the arrival to the facility ([redacted]/19). The resident said "How could I not be in pain? I have a broken leg; and, a broken arm...I've asked everyone for pain medication; and, no-one will help me."

The incident investigation summary did not substantiate neglect although staff demonstrated serious disregard for consequences and allowed the resident to suffer in pain.

Refer to F600 and F697 for additional information related to Resident #7

DIVERSION
Review of the facility investigation dated 01/20/20 there had been an allegation of staff diverting narcotics.

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F 610	Continued From page 12 RESIDENT #16 The investigation did identify Staff AA, Licensed Practical Nurse, LPN, was involved in missing narcotic medications,including 92 missing oxycodone tablets belonging to Resident #16. Review of Resident #16's MDS (Minimum Data Set - an assessment tool) dated [redacted]/20, showed Resident #16 had discharged to the hospital with anticipated return. The investigation identified that Resident #16 was missing four cards of narcotic medications. All four cards of medications were missing from the drug cart. All four corresponding pages in the narcotic count book had documentation that staff transferred the medications to a different page in the book. However, upon review of the book, there were no other pages to account for the medication being used or ever being accounted for since the time of transfer. Further review of the facility investigation into the diverted narcotics showed a conclusion of unsubstantiated, "misappropriation did not occur as the identified residents no longer reside in the facility." The facility did identify that Resident #16 was missing medications, and Staff AA, LPN, had singed them out of the narcotic book without a witness, therefore misappropriation did occur. The facility failed to identify misappropriation of resident property (medication), as form of abuse. Further review of narcotic book on 01/24/20 showed additional inconsistencies, not previously identified by the facility investigation involving	F 610		

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F 610	Continued From page 13 Resident #26. RESIDENT #26 In an interview on 01/24/20, at 4:50 PM, Staff S, Registered Nurse, RN, reviewed the narcotic log book with the surveyor. Staff S, RN, reviewed page 21 of the book and confirmed the page indicated the medication cart should have 21.75 milliliters of Morphine (a narcotic pain reliever). Staff S, RN, opened the medication cart and stated the medication was not in the cart. Staff S, RN, stated that although he had signed the narcotic book, indicating that all medications listed in the book were accounted for, he had not actually seen the morphine, and could not remember ever seeing the morphine. Refer to F755 for additional investigative finding related to mismanagement of the narcotics involving multiple other residents. The facility failed to complete thorough review of all secured medications to determine the severity of the diversion. RESIDENT #15 Review of the facility incident investigation dated 01/21/20 indicated Resident #15 was missing $90 cash that had been in his pocket. The investigation included a statement from Resident #15, who stated he woke up to see a young male in his room going through his clothes, and then checked him to see if he had been incontinent. The investigation did not include statements from the resident's roommate related to seeing a male in the room matching the description provided	F 610		

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F 610	Continued From page 14	F 610		

and did not include staff statements related to seeing a male who matched the description in the facility. Additionally, there was no evidence to show the facility reviewed the assigned staffing schedule to identify if there was a staff who matched the description assigned to provide care for Resident #15.

Review of Resident #15's records showed an assessment dated [redacted]/20 which identified the resident was newly admitted to the facility, and having depression related to being placed in a skilled nursing facility.

Further review of Resident #15's record showed he was not placed on alert monitoring for potential psycho-social harm related the missing money or for increased depression following the incident.

In an interview on 1/27/20, at 3:00 PM, Staff D, Operations, was informed of the concerns identified when reviewing the investigations and confirmed the investigation was not thorough.

RESIDENT #11
Review of the facility state reporting log showed an entry dated 01/21/20 that indicated there had been a resident to resident altercations in which Resident #11 was the victim.

Review of facility incident investigation dated 01/21/20 which indicated Resident #11 was physically struck with a walker by another resident. Further review of the investigation showed no documentation that facility staff had notified law enforcement of a physical altercation. There was no evidence that Resident #11 was asked if she wanted law enforcement notified.

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In an interview on 01/27/20, at 3:00 PM, Staff D, Operations, was notified the investigation did not include contacting or offering to contact law enforcement. Staff D, Operations, was not able to provide any further details.

RESIDENT #10
Review of the facility's state reporting log showed an entry dated 01/20/20 indicating there had been an allegation against staff related to the treatment of Resident #10.

Review of the identified investigation showed that Resident #10 alleged Staff Z, CNA, had thrown a towel at him while providing care. The investigation included a statement from Staff Z, CNA, which described the incident and stated that Staff S, RN, had entered the room. The investigation did not include a statement from Staff S, RN, who was the only witness to the interactions between Resident #10 and Staff Z, CNA.

The allegations was unsubstantiated as the investigation only included descriptions of the interactions between Resident #10 and Staff Z, CNA, from the two involved, and did not include a statement from the only other person who entered Resident #10's room during the identified timeframe.

In an interview on 01/27/20, at 3:00 PM, Staff D, Operations, was given the information related to the lack of witness statements included in the investigation. Staff D, Operations, was not able to provide any additional information.

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F 610	Continued From page 16 RESIDENT#21 Resident #21's wounds were neglected when the facility failed to complete thorough and consistent assessments and obtain wound measurements from 12/24/20 through 1/28/20. Resident #21 admitted to the facility on [redacted]/19 with diagnoses to include, [redacted] and history of [redacted] Observations and interview with Resident #21 was conducted on 01/28/20 at 1:32 PM. Resident had a right immobilization cast to the right lower extremity. Resident was unable to provide information about wound care. Resident#21 said she was not sure if she admitted with wounds. Record review of Podiatry Consult dated 12/23/19, showed Resident #21 had no open areas on the right foot. 1. Review of TAR for January 2020 showed Resident #21 had a wound to the bottom of the foot and was scheduled for a daily dressing change. The documentation on the TAR showed the dressing changes were not completed on 01/6/20, 01/9/20, 01/10/20, 01/15/20, and 01/19/20. 2. Review of the January 2020 TAR showed an order to complete head to toe skin check weekly. On 01/15/20 the skin check was not signed off as complete. 3. Review of the January 2020 TAR showed an order to apply medicated cream daily to the groin area, to the [redacted] area twice daily, and apply ointment to the buttock folds three times a day. On the following days the orders were not carried	F 610		

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F 610	Continued From page 17 out as evidenced by multiple holes in documentation on 01/6/20, 01/9/20, 01/15/20, and 01/16/20 and on 01/19/20. On 01/25/20 physician orders were obtained to treat the open areas on the right outer and bottom aspect of the foot. Staff O, RN Resident Care Manager (RCM) on 1/28/20 at 1:34 PM was asked about how Resident #21 developed wounds. Staff O, RN RCM did not know if Resident #21 admitted with these wounds or developed them at the facility. There was no investigation completed to rule out abuse/neglect. Staff O, RN RCM was unable to provide measurements for the wounds. Staff O, RN RCM was informed about multiple omissions of wound care on the January 2020 TAR. Reference WAC 388-97-0640(1)	F 610		
F 658 SS=D	. Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to administer medications in accordance with professional standards. This affected 2 of 2 Residents (#'s 5 &6) reviewed for medication errors. This failure placed residents at risk for potential harm.	F 658	F-658: Services Provided Meet Professional Standards Individual Residents Resident #5 No Longer Resides in the facility.	3/3/20

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F 658	Continued From page 18 Findings included: According to facility incident report, on 12/21/19 Resident #5 was administered Resident #6's medications. Resident #6 was given Resident #5's medications. Both residents were evaluated, there was no negative outcome. The same incident report showed that nurses did not identify the residents using two identifiers. The residents' photos were not entered in the electronic record system used to give medications. During an interview on 1/07/2020 at 3:01 PM, Staff A, the Director of Nursing said the nurses should have used the five rights (right patient, right drug, right dose, right route and right time) prior to administering the medications to both residents. Reference WAC 388-97-620(2)(b)(ii) .	F 658	Resident #6 No longer resides in the facility. Residents in similar situations Residents have the potential to be administered the wrong medications if photos are not available. An audit was completed of facility Residents to ensure current picture were available in the EMR. Any findings were corrected at that time. Admissions team has been designated to obtain Rsd photos upon admission Medication errors identified in the last 14 days have been analyzed and trended for any potential patterns and education opportunists. Measures to prevent re occurrence The DON or designee will provide education to licensed nurses on Medication administration policy and best practice to include the 5 rights. The Administrator or designee will provide education to facility staff on the expectation to obtain timely photos of new admissions On-going Monitoring HIM director will check on the presence of Rsd photos during her new admission audit completed the next business day. Results of these audits will be presented to the monthly QAPI committee x3 months for identification of needed education and training opportunities. Individual to Ensure Compliance DON/Executive Director	

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F 697 SS=J	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to adequately manage pain for 1of 3 Residents (#7). The facility failed to assess and recognize acute pain and immediately implement interventions. The lack of action demonstrated serious disregard for consequences and resulted in physical and psychological suffering. This failure resulted in an Immediate Jeopardy. Findings included: RESIDENT #7 Resident #7 was hospitalized [redacted]/19 through [redacted]/19 for displaced fracture of the ankle bone and closed fracture of left forearm bone. Resident had ankle surgery on [redacted]/19, according to the hospital records. Resident #7 admitted to the facility on [redacted]/19. Observation and interview with Resident #7 was completed on 12/30/19 at 08:35 AM. The resident reported she was in severe pain with spasms due to a broken foot for two days and asked multiple nurses for pain medication but it was not available. The resident said her pain was (10/10), but she could probably tolerate 5/10 pain level without medications. The resident said she tried meditating and using a coloring book to distract	F 697	F-697: Pain Management Individual Residents Resident #7 has had a new pain assessment completed and is experiencing adequate pain relief. Residents in similar situations An audit of new admissions for the last 14 days was completed to ensure that ordered pain Rx had been obtained from the pharmacy. There was no findings. Pain assessments for facility Residents has been completed and any negative findings have been discussed with providers for different treatment options. Measures to prevent re occurrence The DON or designee will provide re-education to licensed nurses on the admission process for obtaining narcotic prescriptions and order completion from the pharmacy. The facility has hired an admissions nurse who has been educated on the narcotic prescription and ordering process. The DON or designee provided re-educated to licensed nurses at the time of discovery regarding the responsibility to	3/3/20

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F 697	Continued From page 20 her from the pain. Hospital document titled "After Visit Summary", showed Resident #7 discharged to the facility on [redacted]/19 with instructions to take Oxycodone-Acetaminophen (strong narcotic medication for moderate to severe pain) 1-2 tablets every four hours as needed. The same document showed the resident received this medication while hospitalized. Review of hospital discharge records on 01/24/19 at 2:31 PM showed a prescription dated 12/19/19 for oxycodone-acetaminophen 5/325 mg with instruction to take 1-2 tablets every four hours as needed for pain. Review of the facility admit orders and medication administration record (MAR) showed the hospital discharge orders for Oxycodone were not transcribed until [redacted]/19, two days after the resident admitted. Further record review did not find evidence that licensed nursing staff assessed Resident #7 for subjective and objective signs of pain every shift for the first 48 hours. Additionally, the nurses failed to assess and document the resident's tolerable pain level in order to determine effective interventions. The comprehensive pain assessment was not complete until 12/27/19, eight days later. Interview and record review with Staff Q, LPN RCM on 01/24/20 at 1230 PM, showed the pain care plan was not initiated until 12/21/20. Staff Q, LPN RCM said that interim care plan should be initiated on the day of admit for acute pain. Nursing note dated 12/21/19 at 12:15 AM documented Resident #7 complained of pain	F 697	notify provider if ordered medications are not available. Caring partners will interview Rsds regarding pain management during routine caring partner rounds. Facility staff have been educated on observing for and reporting Rsd pain to licensed nurses. HIM director or Admissions nurse will review new admission packets to ensure narcotic scripts are available upon Rsd admission. If prescriptions are not available, DC planners will be notified to obtain prescriptions. Facility medical director has educated other facility providers on the narcotic prescription and ordering process. Facility has initiated daily (M-F) Grand rounds to identify and care needs or potential changes in condition. As part of the general orientation process, access will be obtained for licensed nurses to grant access to the Omni Cell emergency medication supply. On-going Monitoring DON or designee will complete random ongoing audits of the admission process as it relates to narcotic management. HIM director will complete new admission audits the next day (M-F) after admission to ensure pain assessment has been completed. Findings will be corrected at that time. Caring Partner concerns regarding pain management will be shared with the clinical team at the morning stand up meeting. Results of these audits will be presented	

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F 697	Continued From page 21 level 10/10 and "demonstrated frustration due to severe pain, but no medication available in the narcotic drawer." Review of facility incident investigation dated 12/21/19 showed Resident #7 did not receive Percocet (narcotic pain medication) for 48 hours after being admitted to the facility, although there was an order and a prescription issued by the hospital. The incident investigation documented that on 12/21/19 in the afternoon, Resident #7 reported to the nurse she did not receive pain medications since the arrival to the facility ([redacted]/19). The resident said "How could I not be in pain? I have a broken leg; and, a broken arm...I've asked everyone for pain medication; and, no one will help me." Further review of the incident investigation showed on 12/21/19 during the night shift a nurse witnessed Resident #7 moaning and groaning in pain. The resident tried repositioning her casted leg but it was ineffective. The nurse described the resident was tearful and said her pain level was 10/10. On 01/27/20 at 11:26 AM, Staff R, Registered Nurse reported she completed admit paperwork for Resident #7 on [redacted]/20. Staff R, RN stated she did not receive training on admit process and she did not know that it was her responsibility to fax the prescriptions to the pharmacy. Additionally, Staff R, RN reported narcotics are available in facility emergency supply which can be given to any resident with a physician's order but she did not have an access code.	F 697	to the monthly QAPI committee x3 months for identification of needed education and training opportunities. Individual to Ensure Compliance DON	

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F 697	Continued From page 22 Interviews conducted on 01/27/20 between 10:38 AM and 12:00 PM with four licensed nurses who were assigned to provide direct patient care. Three out of four nurses, Staff T, LPN, Staff S, RN and Staff EE, LPN reported they did not have access to omnicell (emergency supply of medication, including narcotics). On 12/30/19 at 8:28 AM, Staff A, Director of Nursing said the nurses should have contacted the physician and obtained a narcotic authorization code sooner. Refer to F 600 for additional information related to neglect involving Resident #7 and F610 for failure to conduct a thorough investigation of neglect. Reference WAC 388-97-1060 .	F 697		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 725		3/3/20

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F 725	Continued From page 23 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure sufficient number of nursing staff to provide care and services according with professional standards. This failure affected Resident #'s (15, 23, 24, 25) when residents did not receive scheduled insulin timely. These failures placed residents at risk for unmet care needs and negative outcomes. Findings included: COLLATERAL CONTACT INTERVIEWS On 01/21/20 at 4:00 PM in an interview a Collateral Contact (CC) #1 reported that facility leadership assigned up to 26 residents to one nurse. CC #1 stated that was unsafe assignment and nurses' concerns of unsafe staffing levels were ignored by facility leadership. On 01/08/20 at 4:19 PM an anonymous Collateral Contact reported that nursing staff had up to 30 residents assigned to one nurse. The contact	F 725	F-725: Sufficient Nursing Staff Individual Residents Resident #24 has been assessed and no negative outcomes were observed from his delay in insulin. Resident # 23 no longer resides in the facility. Resident # 15 no longer resides in the facility Resident # 25 no longer resides in the facility Residents in similar situations Facility Residents are at risk for unmet care needs if the facility fails to provide sufficient staff to provide care and services in accordance with professional standards. Measures to prevent re occurrence The facility has hired a new staffing	

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F 725	Continued From page 24 informed the state agency that the resident acuity was high and the staffing levels were unsafe. The reporter was concerned about resident neglect. On 01/13/20 at 10:02 AM CC #3 reported to the state agency that facility was short-staffed and there was delay in call light response. On 01/21/20 at 7:30 AM CC #4 reported to the state agency that facility was understaffed and resident was not taken care of timely which resulted in a urinary tract infection. On 1/23/20 at 6:29 AM anonymous CC reported the facility was short staffed and staff was burned out. STAFF INTERVIEW On 01/27/20 at 10:38 AM Staff CC, RN reported she was not done administering 8:00 AM medications. On 01/27/20 at 11:43 AM Staff DD, RN reported she was not done administering 8:00 AM medications. On 01/27/20 at 11:50 AM Staff S, RN reported staffing is "scary unsafe" here. Staff S, RN said in the last two weeks there were multiple night shifts when there was only two nurses on duty because the third nurse was a no show. Staff S, RN was unable to recall exact dates. Staff S, RN said the staffing schedule is inaccurate and shows more nurses on paper then in reality because no one updated the schedule. On 01/24/20 2:45 PM Staff Q, LPN, RCM reported there is no standardized shift to shift	F 725	coordinator who has been educated on staffing level needs for census and acuity as well as updating staffing assignments ongoing. A nurse manager will be assigned to cover each week-end for assistance with any staffing concerns. Facility has implemented 24 hour manager coverage for 30 days to ensure staffing levels are safe for current census and acuity. A facility manager of the day will be assigned each holiday and week-end day to assist with staffing concerns should they arise. The facility has consolidated Resident rooms to provide safer staffing abilities. On-going Monitoring Facility Administrator, DON, staffing coordinator and HR director will conduct daily staffing meetings (M-F) to ensure ongoing sufficient staffing. Facility Administrator or Don will review staffing assignments for the week-end prior to end of business on Friday. Results of staffing patterns will be presented to the monthly QAPI committee x3 months for identification of needed education and training opportunities. Individual to Ensure Compliance DON	

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report due to staffing shortage. Staff Q, LPN, RCM reported there was nursing burnout. Staffing schedule is not accurate because it is not updated.

In an interview on 01/27/20, at 3:15 PM, Staff X, Licensed Practical Nurse, LPN, and Staff Y, Certified Nursing Assistant, CNA, reviewed the current evening shift staffing levels and reported:

The 100 hall had two nursing assistants, and should have four, to provide care for 36 residents.
The 200 hall had one nursing assistant and should have two to provide care for 19-20 residents.
The 300 hall had one nursing assistant and should have two to provide care for 16-17 residents.
The 400 hall had three nursing assistants and should have four to provide care for 38-39 residents.
Staff X, LPN, state there was four licensed nurses working on the floor to provide care for entire facility.

DELAY IN CARE (MEDICATION ADMINISTRATION)

On 01/27/20 according to facility census there were 110 residents in the facility. Interviews between 10:30 AM and 12:00 PM were completed with four direct care nurses on duty, Staff T, CC, DD, and EE. Nursing staff reported the staffing ratio of 1:27 was unsafe. Four of four nurses reported they were still passing 0800 am medications after 11:00 AM including insulin, a high risk medication.

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F 725	Continued From page 26 Review of 4 out of 5 residents on various units identified they did not receive scheduled insulin timely, and one resident did not have a scheduled blood sugar level checked for four hours in order to receive oral hypoglycemic agents. RESIDENT #24 Resident #24 admitted to the facility on [redacted]/19 with diagnoses to include a [redacted] and [redacted] according to the hospital discharge summary. Record review showed Resident # 24 had orders for Insulin Lispro 4 units once a day at 7:00 AM. On 01/27/20 at 11:57 AM interview with Staff T, Licensed Practical Nurse (LPN) revealed Resident #24 did not receive 7:00 AM insulin dose as off 11:57 AM, or over four hours late. Staff T, LPN reported she was behind on administering morning medications because she had 27 residents. Staff reported this ratio was not safe because she was behind on the medication pass. RESIDENT #23 Resident #23 admitted to the facility on [redacted]/20 with diagnoses to include [redacted] and [redacted] Record review showed Resident #24 had an order to receive 40 units of Humulin 70/30 Insulin at 8:00 AM. On 01/27/20 at 11:57 AM interview with Staff T, Licensed Practical Nurse (LPN) revealed Resident #23 did not receive 8:00 AM Insulin dose as of 11:57 AM, or over three hours late. RESIDENT #25	F 725		

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F 725	Continued From page 27 Resident #20 admitted on [redacted]/20 with diagnoses to include [redacted] and [redacted] Record review showed Resident #23 had 4 units of Insulin Glargine scheduled at 8:00 AM. On 01/27/20 at 10:38 AM interview with Staff EE, Licensed Practical Nurse (LPN) revealed Resident #23 did not receive 8:00 AM Insulin dose as of 10:30 AM, or two and a half hours late. RESIDENT #15 Resident #15 admitted to the facility on [redacted]/20 with diagnoses to include [redacted] and [redacted] Record review showed Resident #15 had scheduled oral hypoglycemic agents prior to meals to control blood sugars. The resident had a physician order to check blood sugars daily at 7:00 AM and instructions to hold medications if a meal was missed. On 01/27/20 at 12:00 PM interview with Staff EE, Licensed Practical Nurse (LPN) revealed Resident #15 did not have his blood sugars checked as of 12:00 PM or four hours late. Staff EE, LPN said she is behind because staff called in sick. Staff BB, RN, Interim Director of Nursing (IDNS) was interviewed on 01/27/20 at 12:03 PM, Review of facility census with Staff BB, RN IDNS showed there were 110 residents in the facility. The staff member confirmed there were only four direct care nurses on duty for 110 residents, creating a ratio of 1 nurse to 27 residents. Staff BB RN, IDNS was asked if she was aware that	F 725		

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F 725	Continued From page 28 morning insulin (high risk medications) was not given as of 11:30 AM for four residents. Staff replied she did not know that nurses were late with administering medications. Staff BB said normally there should be six nurses on duty. On 01/28/20 at 12:16 PM Staff P, VP of Clinical Services was interviewed about direct care nurses ratio when the census is 110. Staff PP, VP of Clinical Services explained that there should be six nurses and she was working on staffing. Reference WAC 388-97-1080 (1)	F 725		
F 726 SS=L	. Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not	F 726		3/3/20

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F 726	Continued From page 29 limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to have a system in place to verify and ensure that nursing staff had appropriate competencies, and skills to provide services to residents with acute medical conditions. This failure placed all nursing staff at actual risk of providing unsafe, substandard quality care and all residents at risk for harm. The lack of systematic approach to ensure competent nursing staff created a situation of Immediate Jeopardy. Findings included: RESIDENT #7 Resident #7 admitted to the facility on [redacted]/19 after ankle surgery. Resident #7 remained without pain medication for 48 hours. Staff R, RN admitted Resident #7 on [redacted]/19 according to the admit record. Staff R, RN did not have training on the admit process which lead to an omission error which contributed to resident harm. In an interview with Staff R, RN on 01/27/20 at 11:26 AM reported she did not know how to complete and admit and had no training on the	F 726	F-726: Competent Nursing Staff Individual Residents Resident # 7 has had pain assessment completed and states pain is now adequately managed Residents in similar situations Facility Residents are at risk if facility fails to have a system to verify and ensure that nursing staff have appropriate competencies and skills to provide services to those with acute medical conditions Measures to prevent re -occurrence Facility will restructure their licensed nurse competency program to include competencies upon hire, annually and on an ongoing bases as needs arise. The facility has hired a staff development coordinator who will, in conjunction with the HR director, ensure competencies are completed as needed. Facility has hired a dedicated admission nurse who has been educated	

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F 726	Continued From page 30 admission process. Staff R, RN said she did not fax the prescription for a narcotic medication to the pharmacy on 12/19/19 because she assumed it was medical records responsibility, subsequently the resident remained in severe pain for 48 hours. Staff R, RN also reported that she did not have access to facility emergency medication supply including narcotics. Refer to F697 for details related to Resident #7 experiencing severe pain following surgical procedure and acute pain for 48 hours. RESIDENT#18 Resident #18 admitted to the facility on [redacted]/19 following hospitalization for serious burns. The Resident #18 admitted to the facility with a [redacted] surgical wound, burn site with a skin graft on the right chest wall extending under the arm, and a graft site to the thigh area. The resident also had a nephrostomy (a tube inserted in the back into the kidneys to drain the urine.) Record review showed there were no orders transcribed to the January 2020 Treatment Administration Records (TAR) for the right thigh graft site and no orders for the [redacted] site. There was no documentation showing these areas were assessed at least daily. Further record review showed there was no treatment completed for nephrostomy tubes as evidenced by lack of documentation on the TAR. The treatment record for January 2020 showed the nephrostomy tubes were not checked daily for thirteen days. Review of nursing progress notes did not find evidence of daily assessment of the medical devices.	F 726	to the admission process related to assessment, pain management, and implementation of treatments and indwelling device monitoring. Education also includes 2 LNs to verify admission orders. Admission nurse will be working Tuesday through Saturday for ongoing oversight. Facility nurse managers have been trained on the admission process related to assessment, pain management and implementation of treatments and indwelling device monitoring. Education also includes 2 LNs to verify admission orders. All nurse carts have keys to access the central supply room, medication room and medication refrigerator. Omnie cell access has been requested for all facility licensed nurses. Facility nurses have been educated on the location of the policies and procedures as well as on call nurse manager schedule for assistance if needed. Facility nurses have been educated on narcotic medication ordering process and care of in dwelling devices. On-going Monitoring HIM director will audit new admission charts the next business day after admission. Any missing items will be provided to the Don and RCMs to ensure completion New admission charts will be reviewed the next business day at the clinical meeting to ensure all indicated assessments have been completed and treatment plans	

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F 726	Continued From page 31 According to nursing notes on [redacted]/20 the Resident #18 had increased confusion and was sent to the hospital. Hospital records showed the Resident #18 admitted to the emergency room on [redacted]/20 with confusion, and was diagnoses with [redacted] On 02/03/20 at 11:10 AM and on 02/04/20 at 12:39 PM during interview Staff P, VP of Clinical Services said that wound orders were missed at the time of admission and daily nephrostomy tube assessment/monitoring was not done. RESIDENT #7 Resident #7 admitted to the facility on [redacted]/19 after having foot surgery as documented in the hospital records. Resident #7 had discharge instructions to take Oxycodone-Acetaminophen 5/325 mg (narcotic pain medication, for moderate to severe pain) 1-2 tablets every four hours as needed, according to hospital discharge documents. Resident #7 was neglected and suffered physical and psychological harm when nursing staff failed to complete a through physical assessment, identify and treat severe pain for 48 hours. At the time of admit the prescription for narcotic medications was not faxed to the pharmacy and facility nursing staff failed to follow through on obtaining narcotic medication for the resident. During observations and interview on 12/30/19 at 8:35 AM, Resident #7 explained she came to the facility for rehabilitation after a having surgery to treat a broken foot and a broken arm. Resident #7 described experiencing severe pain for two days. Resident #7 said she asked multiple nurses	F 726	implemented. Facility will implement ongoing random audits of the admission process, narcotic availability and new hire skills and competencies. Post Acute Solutions will provide clinical oversight daily Monday through Friday for the next 4 weeks to ensure compliance of the plan of correction. Oversight need/quantity will be re-evaled at that time. Results of these audits patterns will be presented to the monthly QAPI committee x3 months for identification of needed education and training opportunities. Individual to Ensure Compliance DON/Administrator Date of Compliance 3-3-20 F-755 Pharmacy Srvcs/Procedures/Pharmacist/Records Individual Residents Resident #1 No longer resides in the facility Resident #2 narcotic ledger is currently accurate Resident #3 no longer resides in the facility Resident # 4 narcotic ledger is currently accurate Resident # 11 narcotic ledger is currently accurate	

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F 726	Continued From page 32 for pain medication but it was not available. The resident said her pain was (10/10). Staff R, RN (Registered Nurse), RCM (Resident Care Manager) on 01/27/20 at 11:26 AM said she admitted Resident #7 on [redacted]/19. During the interview it was identified Staff RN, RCM had no training on how to complete a new admission. Staff R, RN RCM said she did not send the prescription for pain medication to the pharmacy because she assumed it was medical records responsibility. Staff R, RN RCM reported she had no access to Omni cell (emergency supply of medications including narcotics.) Interviews with other licensed nurses conducted on 01/27/20 revealed the facility did not have adequate orientation process and/or training was adequate in order to deliver safe care. The interviews identified there was lack of education and competencies related to completing admissions, access to the emergency narcotic supply, and knowledge about accessing the facility policy and procedures. Staff T, LPN on 01/27/20 at 11:40 AM reported she did not have access to Omni cell (emergency medication supply) and had no keys to the medication room. Staff T, LPN reported that during orientation there was no training on Omni cell access. Staff T, LPN reported she was not aware where facility policy and procedures were located. Staff T, LPN reported on any given day she was responsible to take care of 22 to 27 residents. Staff DD, LPN was interviewed on 01/27/20 11:43 AM about location of facility policy and	F 726	Resident # 15 no longer resides in the facility Resident # 16 narcotic ledger is currently accurate Resident # 18 narcotic ledger is currently accurate Resident # 26 medication was found to be destroyed on different page of the narcotic ledger Residents in similar situations Failure to ensure the disposition of controlled medications was completed in sufficient detail places residents at risk for medication errors, misappropriation of medication and inadequate pain control. Pain assessments for facility residents have been completed to ensure they are receiving adequate pain management. Any concerns have been addressed with assigned providers. Measures to prevent re occurrence Licensed nurses received re-education on the narcotic reconciliation process including only 2 Registered nurses will destroy an and all narcotics. The facility Medical Director has contacted other facility providers to educate on the narcotic prescription and ordering process. Facility nurse managers will destroy narcotics routinely on a weekly basis to prevent potential opportunities for errors or diversion. The facility has hired a licensed nurse whose job duty will be specifically to ensure ongoing safe Admission practices for narcotic prescriptions and ordering. Any narcotics that were no longer being	

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F 726	Continued From page 33 procedures. Staff DD, LPN was not able to verbalize where she would find policies. Staff DD, LPN reported she was assigned anywhere from 24-27 residents. Staff EE, LPN on 01/27/20 at 11:49 AM reported she did not have access to Omni cell and did not have keys to the medication room. Staff EE, LPN was asked if during orientation she received training on where to find facility policy and procedures and reported she was not informed. Staff EE, LPN said she is assigned to care for up to 24-27 residents. Staff S, RN was interviewed on 01/27/20 at 11:50 AM and stated he worked at the facility at least three months. Staff S, RN stated he did not receive adequate orientation. Staff S, RN did not know where policy and procedures were located and said he did not have access to Omni cell. On 01/27/20 at 11:26 AM Staff R, RN RCM (Resident Care Manager) reported she did not have orientation on the RCM position or how to complete new resident admit. Staff R, RN RCM reported she did not want to put her license on the line because staffing was unsafe and she terminated her employment for that reason. In an interview on 02/05/20, at 2:10 PM, Staff N, RN, stated she the admission process takes four to five hours to complete in order to do it thoroughly. Staff N, RN, stated she works the floor and does not have time to complete admissions. In an interview on 02/05/20 at 2:10 PM, Staff O, RCM, stated the previous Director of Nursing,	F 726	administered have been destroyed by 2 Registered Nurses who have been educated to the narcotic destroying process Narcotic ledgers have been re-aligned per narcotic class to prevent potential errors. On-going Monitoring DON or designee will complete ongoing random audits of the narcotic reconciliation process to ensure compliance with facility policy. Results of these audits will be presented to the monthly QAPI committee x3 months for identification of needed education and training opportunities. Individual to Ensure Compliance DON	

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DNS, directed the staff who were doing the admissions to just "do what you can do, then pass it to the floor nurse" to complete. Staff O, RCM, was asked if the floor nurses have time to complete the admissions process in addition to passing medications, completing treatments, and responding to resident needs, Staff O, RCM, stated the floor nurses do not have enough time to complete an admission, but the charge nurse and the RCM also did not have enough time to complete admissions during their shift.

In an interview on 02/05/20, at 3:30 PM, Staff O, Resident Care Manager, RCM, stated the facility has not had a specific staff member assigned to admitting new residents. When asked how they determine who is going to admit an incoming resident, Staff O, RCM, stated it depends on who did it last, and that the staff take turns, and rotate who will do the admission process. Staff O, RCM, stated the admission process was rotated between Resident Care Managers, Charge Nurses, and MDS (Minimum Data Set, an assessment tool) nurses. Staff O, RCM, stated there was no training or orientation of what tasks needed to completed, or how to complete them, related to the admission process. Staff O, RCM, stated there was not a checklist, or other type of tool, for staff to use to ensure all of the steps of the admission process were complete.

In an interview on 02/05/20, at 3:30 PM, Staff O, RCM, was asked how staff know what needs to be done to complete an admission when there is not a training or check off list. Staff O, RCM, the "biggest thing" to do is get the physician's orders and send them to the pharmacy to obtain the medications. Staff O, RCM, stated the staff who work in the medical records department will

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review the orders and confirm them. Staff O, RCM, stated the nurse will then meet with the resident and call the doctor to make any needed adjustments or clarification of the orders. Staff O, RCM, stated once the medications are ordered, the admissions nurse should complete a head to toe assessment, obtain consent forms, get pictures and the remaining required documents.

In an interview on 02/05/20, at 3:17 PM, Staff F, Medical Director, MD, stated there has been issues with staff obtaining orders from the hospital transferring residents to the facility. Staff F, MD, gave the example of staff will receive orders for medications, but there will not be orders for dressing changes or wound care. Staff F, MD, stated the facility staff cannot provide care without treatment orders. Staff F, MD, stated the facility does have staff completing admissions that do not have the skills to complete the admission process adequately.

Review of employee records of clinical competencies on 02/5/20 at 3:18 PM for Staff O, RN, RCM, Staff U, LPN, Staff FF, RN showed there was no evaluation of skills related to admission process, nephrostomy tubes and process for obtaining controlled substances including narcotic medications.

In an interview on 2/5/20 at 3:53 PM Staff P, VP of Clinical Services explained she was working on multiple Process Improvements but was "unable to tackle this problem yet."

Reference WAC 388-97-1080(1)

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UNIVERSITY PLACE REHABILITATION CENTER	5520 BRIDGEPORT WAY WEST UNIVERSITY PLACE, WA 98467

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F 726	Continued From page 36	F 726		
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 755	F-755 Pharmacy	3/3/20

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F 755	Continued From page 37 review, the facility failed to ensure the disposition of controlled drugs was completed in sufficient detail to enable accurate reconciliation. This affected 9 out of 10 residents (#'s 1, 2, 3, 4, 11, 15, 16, 18, and 26). This failure placed residents at potential risk for medication errors, misappropriation of medications, and inadequate pain control. Findings included: NARCOTIC LEDGER DISCREPANCIES RESIDENT #1 Record review on 12/27/19 showed discrepancies were documented on page 42 of the narcotic ledger. On 12/12/19 narcotic ledger documentation showed two Oxycodone 5 mg (narcotic) tablets were removed but the medication administration record (MAR) did not have documentation indicating the medication was administered to Resident #1 On 12/16/19 narcotic ledger showed two Oxycodone 5 mg tablets were removed. The MAR did not show the medicine was administered to Resident #1. Review of December 2019 MAR documentation showed Oxycodone 10 mg was administered on 12/15/19 and 12/16/19, however, the narcotic ledger did not document the removal of the medications. RESIDENT #2 Record review on 12/27/19 showed discrepancies were documented on page 44 of the narcotic	F 755	Srvcs/Procedures/Pharmacist/Records Individual Residents Resident #1 No longer resides in the facility Resident #2 narcotic ledger is currently accurate Resident #3 no longer resides in the facility Resident # 4 narcotic ledger is currently accurate Resident # 11 narcotic ledger is currently accurate Resident # 15 no longer resides in the facility Resident # 16 narcotic ledger is currently accurate Resident # 18 narcotic ledger is currently accurate Resident # 26 no longer resides in the facility Residents in similar situations Failure to ensure the disposition of controlled medications was completed in sufficient detail places residents at risk for medication errors, misappropriation of medication and inadequate pain control. Pain assessments for facility residents have been completed to ensure they are receiving adequate pain management. Any concerns have been addressed with assigned providers. Measures to prevent re occurrence Licensed nurses received re-education on the narcotic reconciliation process including only 2 Registered nurses will destroy any and all narcotics.	

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F 755	Continued From page 38 ledger. On 12/12/19 two Oxycodone tablets were removed at 7:00 AM, however, the resident was hospitalized on 12/11/19. The narcotic medication was removed when the resident was not at the facility. The card containing narcotics was destroyed. RESIDENT # 3 Page 46 of the narcotic ledger showed an active order for Oxycodone 10 mg. The narcotic card was destroyed on 12/12/19. RESIDENT #4 Record review on 01/07/2020 showed discrepancies on page 47 of the narcotic ledger. Oxycodone 5 mg tablet was removed on 01/05/20 and 01/06/20. There was no documentation on the MAR showing the narcotics were administered to Resident #4. RESIDENT #11 On 01/24/20 at 4:10 PM record review of 100 hall narcotic log on page 6 documented 18 tablets of Oxycodone were transferred to page 18. There was no documentation explaining which book it was transferred to and there was no date or a signature. Page 7 of the same narcotic ledger documented that 14 tablets of Oxycodone 5 mg were transferred to page 20. There was no date, signature and no reference to a book number. Page 8 showed 30 tablets of Oxycodone 5 mg were transferred to page #20. There was no signature, date and book reference.	F 755	The facility Medical Director has contacted other facility providers to educate on the narcotic prescription and ordering process. Facility nurse managers will destroy narcotics routinely on a weekly basis to prevent potential opportunities for errors or diversion. The facility has hired a licensed nurse whose job duty will be specifically to ensure ongoing safe Admission practices for narcotic prescriptions and ordering. Any narcotics that were no longer being administered have been destroyed by 2 Registered Nurses who have been educated to the narcotic destroying process Narcotic ledgers have been re-aligned per narcotic class to prevent potential errors. On-going Monitoring DON or designee will complete ongoing random audits of the narcotic reconciliation process to ensure compliance with facility policy. Results of these audits will be presented to the monthly QAPI committee x3 months for identification of needed education and training opportunities. Individual to Ensure Compliance DON Date of Compliance 3-3-20 F-760 Residents are Free of Significant Med Errors	

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F 755	Continued From page 39 On page 9 it was documented that 30 tablets of Oxycodone was transferred to page 21. It was not specify which book and there was no signature or date. RESIDENT #15 On page 31 of the narcotic ledger showed initial count was 8 tablets of Oxycodone 5 mg tablets. Two tablets were removed on 11/22/19. The remaining count of 6 tablets was crossed off and a zero was written below. Page 37 of the narcotic ledger showed 19 tablets of Alprazolam 0.5 mg was wasted. There was only one signature. RESIDENT #16 Page 48 of the narcotic ledger dated 01/20/20 showed 30 Oxycodone was destroyed by one nurse. RESIDENT #18 Page 58 of the narcotic ledger showed 29 tablets of Alprazolam 0.25 mg was wasted by one nurse. RESIDENT #26 In an interview on 01/24/20, at 4:50 PM, Staff S, RN, reviewed the narcotic log book with the surveyor. Staff S, RN, reviewed page 21 of the book and confirmed the page indicated the medication cart should have 21.75 milliliters of Morphine (a narcotic pain reliever). Staff S, RN, opened the medication cart and stated the medication was not in the cart. Staff S, RN, stated that although he had signed the narcotic book, indicating that all medications listed in the book were accounted for, he had not actually seen the morphine, and could not remember ever seeing the morphine.	F 755	Individual Residents Rsd # 24 has been assessed and no negative outcome was observed from insulin being administered late Resident # 23 no longer resides in the facility Resident #25 no longer resides in the facility Resident # 15 no longer resides in the facility Residents in similar situations Residents are at risk for harm if medications are not administered timely. Measures to prevent re occurrence The facility has hired a new staffing coordinator who has been educated on staffing level needs for census and acuity as well as updating staffing assignments ongoing. A nurse manager will be assigned to cover each week-end for assistance with any staffing concerns. Facility has implemented 24 hour manager coverage for 30 days to ensure staffing levels are safe for current census and acuity. A facility manager of the day will be assigned each holiday and week-end day to assist with staffing concerns should they arise. The facility has consolidated Resident rooms to provide safer staffing abilities. Facility licensed nurses have been re-educated to ask for assistance form assigned nurse managers if unable to provide medications timely. Meditation errors occurring in the last 14	

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F 755	Continued From page 40 During an interview and record review on 12/27/19 at 10:05 AM and on 1/07/2020 at 08:58 AM, Staff A, Director of Nursing (DNS) explained the facility policy was to document administration of controlled substances on both the narcotic ledger and on the MAR. The DNS also stated that nursing received training on narcotic management on 11/19/19. Staff A, DNS reported she was conducting weekly narcotic audits. The above findings show that facility narcotic auditing system was inadequate as narcotic ledgers continued showing improper documentation and inaccuracies and lack of accountability for narcotic management. On 1/24/20 at 5:01 PM Staff O, LPN Nurse Manager said stated when transferring from book two book requires two nurses verification and both nurses to sign the transfer and that page number and book number should be documented. Reference WAC 388-97-1300(1)(b)(ii)	F 755	days have been trended for root cause to implement any changes that may be needed to ensure timely administration of medications On-going Monitoring DON or designee will complete ongoing tracking and trending of medication errors to ensure ongoing best practice as it relates to medication administration. Results of these trends will be presented to the monthly QAPI committee x3 months for identification of needed education and training opportunities. Individual to Ensure Compliance DON	
F 760 SS=E	. Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure four of five residents (Residents #s 15, 23, 24, 25) were free	F 760	F-760 Residents are Free of Significant Med Errors	3/4/20

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F 760	Continued From page 41 of significant medication errors involving high risk medications. This failure placed residents at potential risk of harm. Findings included: RESIDENT #24 Resident #24 admitted to the facility on [redacted]/19 with diagnoses to include a [redacted] and [redacted] according to the hospital discharge summary. Record review showed Resident # 24 had orders for Insulin Lispro 4 units once a day at 7:00 AM. On 01/27/20 at 11:57 AM interview with Staff T, Licensed Practical Nurse (LPN) revealed Resident #24 did not receive 7:00 AM insulin dose as off 11:57 AM. Staff T, LPN reported she was behind on administering morning medications because she had 27 residents. Staff reported this ration was not safe because she was behind on medication pass. RESIDENT #23 Resident #23 admitted to the facility on [redacted]/20 with diagnoses to include [redacted] and [redacted] Record review showed Resident #24 had an order to receive 40 units of Humulin 70/30 Insulin at 8:00 AM. On 01/27/20 at 11:57 AM interview with Staff T, Licensed Practical Nurse (LPN) revealed Resident #23 did not receive 8:00 AM Insulin dose as of 11:57 AM. RESIDENT #25 Resident #20 admitted on [redacted]/20 with	F 760	Individual Residents Resident # 24 has been assessed and no negative outcome was observed from insulin being administered late Resident # 23 no longer resides in the facility Resident #25 no longer resides in the facility Resident # 15 no longer resides in the facility Residents in similar situations Residents are at risk for harm if medications are not administered timely. Measures to prevent re occurrence The facility has hired a new staffing coordinator who has been educated on staffing level needs for census and acuity as well as updating staffing assignments ongoing. A nurse manager will be assigned to cover each week-end for assistance with any staffing concerns. Facility has implemented 24 hour manager coverage for 30 days to ensure staffing levels are safe for current census and acuity. A facility manager of the day will be assigned each holiday and week-end day to assist with staffing concerns should they arise. The facility has consolidated Resident rooms to provide safer staffing abilities. Facility licensed nurses have been re-educated to ask for assistance or notify assigned nurse managers if unable to administer medications timely. Medication errors occurring in the last 14	

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F 760	Continued From page 42 diagnoses to include [redacted] and [redacted] Record review showed Resident #23 had 4 units of Insulin Glargine scheduled at 8:00 AM. On 01/27/20 at 10:38 AM interview with Staff EE, Licensed Practical Nurse (LPN) revealed Resident #23 did not receive 8:00 AM Insulin dose as of 10:30 AM. RESIDENT #15 Resident #15 admitted to the facility on [redacted]/20 with diagnoses to include [redacted] and [redacted] Record review showed Resident #15 was scheduled oral hypoglycemic agents prior to meals to control blood sugars. The resident had a physician order to check blood sugars daily at 7:00 AM and instructions to hold medications if a meal was missed. On 01/27/20 at 12:00 PM interview with Staff EE, Licensed Practical Nurse (LPN) revealed Resident #15 did not have his blood sugars checked as of 12:00 PM or four hours late. Staff BB, RN, Interim Director of Nursing (IDNS) was interviewed on 01/27/20 at 12:03 PM, Review of facility census with Staff BB, RN, and IDNS showed there were 110 residents in the facility. The staff member confirmed there were four direct care nurses on duty creating a ratio of 1 nurse to 27 nurse's residents. Staff RN, IDNS was asked if she was aware that insulin (high risk medications) were not given past 11:30 AM. Staff replied she did not know that nurses were running over three hours late with administering	F 760	days have been trended for root cause to implement any changes that may be needed to ensure timely administration of medications On-going Monitoring DON or designee will complete ongoing tracking and trending of medication errors to ensure ongoing best practice as it relates to medication administration. Results of these trends will be presented to the monthly QAPI committee x3 months for identification of needed education and training opportunities. Individual to Ensure Compliance DON	

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F 760	Continued From page 43 medications including insulin. Refer to F725 for Sufficient Nursing Staff. Reference WAC 388-97-1060(3)(k)(iii) .	F 760		
F 837 SS=K	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: Based on the interview and record review, the facility failed to have a functioning governing body to oversee the management and operation of the facility. The governing body failed to act timely to protect the well-being of residents from potential negative outcomes of financial hardship and ensure bills were paid timely. Additonally, the	F 837	F-837 Governing body Refer to deficiencies F755, F697, F658, F760 and F610 for individual resident plan ¿ Residents in similar situations Residents have the potential to be affected by this practice. The	3/3/20

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F 837	Continued From page 44 governing body failed to ensure safe and effective clinical systems as evidenced by repeat harm level citations leading up to Immediate Jeopardies over a nine month period. These failure resulted in substandard care related to resident neglect. Findings included: Review of the facility Administrative Management policy dated 2011, showed that the governing board shall be responsible for the management and operation of the facility. The governing board is responsible for but is not limited to, conversion and use of the facility's funds. In an interview on 01/06/2020 at 11:30 AM, Staff E, VIP of Operations was asked about governing body members and respective dates of employment. The newly formed governing body consists of the following individuals: -Staff E, VIP of operations who started on 11/1/19. -Staff D, Operations started on 1/01/2020 -Staff K, Operations started on 1/01/2020 -Staff L, Financial Consultant- employed since 2019. -Staff J, Facility Owner since 2017 On 09/23/19 the facility was issued a citatiaon when the Administration failed to effectively, efficiently, and in accordance with acceptable standards of practice manage its resources to ensure continued services. Failure of the facility placed residents at risk of service disruptions. The facility alleged back in compliance date of 12/02/19. On October 4, 2019, the State of Washington	F 837	Administrator met with resident council to provide opportunity for discussion related to governing body, financial management and services. Individual concerns were generated as needed and resolved through the facility grievance process. A letter was sent to service providers to review new payment and invoicing process and point of contact. ¿ Measures to prevent re occurrence Education was provided to Licensed Nurses by VP of Clinical Services as referenced in specific citations stated above. Clinical oversight was implemented through Post Solutions. Policies and procedures were established and reviewed and monitoring systems implemented through daily oversight and supervision. An Accounts Payable process was implemented by the management company to establish one point of invoicing and billing practice. Service providers were educated through written notice on new process to streamline invoices and prevent delay in future payments. On-going monitoring The facility management company will monitor accounts payable weekly x12 weeks to ensure timely payments are made to critical vendors to ensure resident services and safety are achieved. Weekly meetings with the facility owner will occur x12 weeks to ensure communication regarding payment status and services. Clinical services will be monitored daily (M-F) x4 weeks and	

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F 837	Continued From page 45 imposed a directed plan of corrections that "The licensee must hire a qualified financial advisor/accountant at its own expense, to assist the facility in the development of an effective system in an ongoing effort to sustain financial stability of operations for the provision of care to all residents. The licensee and financial advisor/accountant must meet with the department to review the facility's financial assessment and plan to re-gain substantial compliance." The facility was found delinquent in payments with the following entities/vendors/contractors: DEPARTMENT OF REVENUE Records from the Department of Revenue (DOR), on 12/06/19, showed the facility was issued two tax warrants for nonpayment. The company entered into a payment agreement with DOR in September 2019. The agreement was that the company pay its current monthly combined excise tax returns on time and remit $5,000 per month towards back taxes. The company defaulted upon the agreement immediately on the first due date of 09/25/19. The payment for September 2019 taxes was declined by the bank for insufficient funds. No payment has been remitted for the October 2019 taxes that was due November 25, 2019. A review of records provided by the DOR showed that on 09/25/19 a warrant for unpaid taxes was filed in the County Superior Court. On 10/02/19 an additional warrant was filed for unpaid taxes. On 01/06/2020 at 11:30 AM, Staff E, VIP of Operations and Staff D, Operations/Consultant knew the arranged payment plan with the DOR,	F 837	then weekly x 8 weeks to ensure clinical systems are implemented and completed in compliance with regulations. Quarterly system audits will occur x4 quarters to ensure ongoing compliance with facility policies and procedures. Individuals to ensure compliance Post Acute Solutions	

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F 837	Continued From page 46	F 837		

but they did not know the checks bounced and that facility has been issued tax warrants.

SAFETY NET ASSESSMENT (SNA)
According to DSHS records, on 12/06/19 the facility was notified that the SNA account was 60 days overdue and the account was turned over to the Office Of Financial Recovery (OFR).

Review of state records dated 12/13/19 showed the facility has defaulted on December 2019 SNA payment.

US FOODS
During an interview on 01/03/2020 at 2:41 PM, a representative from US Foods stated that the facility made a payment today, on day 17, a few days beyond their 14-day term. The current balance was $21,321.91. There is no probability of service interruption in the future.

RT HOOD
In an interview on 01/03/2020 at 12:43 PM, RT Hood representative stated that the facility has not made a payment for hood cleaning services provided in May 2019, and owe the company $742.08. The company will seek reimbursement before providing future services and will reach out to the facility in May 2020 when another cleaning is due. If the facility does not pay outstanding balance they will be taken off the schedule.

CASCADE FIRE AND ALARM
On 01/06/2020 at 2:48 PM interview with a representative from Cascade Fire and Alarm (company which evaluates quarterly and/or annually fire suppression system) reported the facility failed to pay a bill in the amount of $12,202.23, which was due for services in April

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F 837	Continued From page 47	F 837		

2019 and January 2020. The representative stated that it would be up to the supervisor's discretion to continue to provision of services with an outstanding balance.

GENERATOR
The facility uses Legacy Generator Services to complete yearly testing. In an interview on 01/08/2020 at 9:30 AM, Staff H was asked about a potential interruption in service for the generator. Staff H reported the generator testing was current at this time. Staff H was not sure if future services would be interrupted because the facility owes them money. Staff H said if he was to call the company to service the generator he does not know if they would come out due to outstanding balance.

MEDICAL DIRECTOR
During an interview on 01/03/2020 at 2:24 PM, Staff F, Medical Director reported she has not been paid for 15 months for services, and the facility owed her $72,000. Staff F, Medical Director said she was not sure what she was going to do about continuing providing services without payment. Staff F said she was likely to continue providing services.

MEDICATION VENDOR
Review of documents provided by Omnicare (pharmaceutical services and medications) representative on 01/03/2020, showed the facility was behind in payments and had failed to make the latest payment towards agreed-upon Promissory Note due 12/15/19. The facility owes $112,732.32. According to the Vendor Balance Summary dated 12/23/19 the facility owes Omnicare $170,205.28. Omnicare also indicated

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UNIVERSITY PLACE REHABILITATION CENTER	5520 BRIDGEPORT WAY WEST UNIVERSITY PLACE, WA 98467

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there was a probability of service interruption in the future as a result of non-payment.

On 01/03/2020 Omnicare sent out a Notice of Termination letters to the facility, explaining that services would terminate on 01/27/20, however, the owner of the facility has been in contact with the pharmacy and is working on overdue payments.

DENTAL SERVICES
During an interview on 01/03/2020 at 1:06 PM, a representative from Smile Seattle Dentures stated that they service 10-15 residents a month, and each resident once a year for annual checkup. According to the representative, the facility was a year behind in payments and in December 2019 a letter was sent to the facility that they needed to pay their outstanding bill, or arrange a payment agreement for service to continue into the new year.

REPEAT DEFFICIENCIES AND HARM TO RESIDENTS

NARCOTIC MANAGEMENT
The facility failed to sustain a plan of corrections for previous citations related to narcotic management, and medications errors, issued on 09/23/19 with alleged back in compliance date of 12/02/10.

The facility was issued another citation on 02/05/20 related to inadequate narcotic management.

Refer to F755 for additional information.

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F 837	Continued From page 49 PAIN MANAGEMENT The facility failed to sustain a plan of corrections for a harm level citation issued on 09/23/19 for inadequate pain management. The facility alleged back in compliance date of 12/02/19. On 01/23/20 an Immediate Jeopardy situation was identified when Resident #7 did not receive pain medicaton for 48 hours for acute surgical pain. Refer to F697 for additional information related to Resident #7. MEDICATION ERRORS The facility failed to sustain a plan of corrections for previous harm level citation for significant medication errors issued on 10/21/19 with alleged back in compliance date of 12/02/19. The facility was found out of compliance again on 02/05/20 related to medication errors. Refer to F658 and F760 for additional information. FACILITY INVESTIGATIONS The facility was cited for failing to thoroughly investigate all reports of alleged abuse, neglect or quality of care concerns. The facility alleged compliance on 03/08/19. The facility was cited again for failing to conduct thorough investigations on 09/13/19 with an alleged compliance date of 12/02/19. On 2/05/20 the survey team identified a pattern of failure related to not investigating all allegations	F 837		

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F 837	Continued From page 50 and identifying neglect and abuse that occurred in January and February of 2020. Refer to F610 for additional information QUALITY OF CARE On 10/21/19 the facility was issued four harm level citations related to inadequate management of post surgical wounds, assessment, preventing pressure injuries, falls, and high risk medications. The facility also received a citaiton related to nursing competencies. The facility alleged back in compliance date of 12/02/19. On 02/04/20 the facility was found in Immediate Jeopardy related to actual harm and neglect of a resident who required post surgical monitoring. On 02/05/20 the facility was found in Immediate Jeopardy related to lack of competent nursing staff. The repeat deficiency demonstrate lack of effective and/or strategic approach to managing finances and clinical services by the governing body. Reference WAC 388-97-1620(2)(c) .	F 837		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must:	F 867		3/3/20

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F 867	Continued From page 51 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to implement effective action plans to correct inefficient processes and/or regulatory deficiencies utilizing systematic and data-driven approach. These failures resulted in repeat deficiencies and placed residents at risk for harm and immediate jeopardy related to resident neglect. Findings included: NARCOTIC MANAGEMENT The facility failed to sustain a plan of corrections for previous citations related to narcotic management, and medications errors, issued on 9/23/19 with alleged back in compliance date of 12/02/19. The facility was issued another citation on 02/05/20 related to inadequate narcotic management. Refer to F755 for additional information. PAIN MANAGEMENT The facility failed to sustain a plan of corrections for a harm level citation issued on 09/23/19 for inadequate pain management when staff failed to assess and treat resident's pain timely and in accordance with professional standards. The facility alleged back in compliance date of 12/02/19.	F 867	F-867 QAPI/QAA Improvement Activities Individual Residents No individual Residents were identified Residents in similar situations Failure of the facility to implement appropriate plans of action for Narcotic management, Pain management, Facility Investigations and Medication errors places the residents at risk for harm. Measures to prevent re-occurrence The Quality Assurance Performance Committee will convene weekly x 2 months to monitor the implementation of the plans of correction for Pain management, Facility Investigations Narcotic management and Medication errors. Facility staff have been re-educated on the policy and best practices for an effective QAPI committee. On-going Monitoring The VP of operations or VP of clinical services will attend the weekly QAPI meetings for 6 weeks to ensure that audits trends and current plans of correction are reviewed and action plans are implemented if necessary.	

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F 867	Continued From page 52 The facility failed to correct pain management system which lead to Resident #7 suffering from pain. The failure to correct the deficiency resulted in Immediate Jeopardy identified on 01/23/20, or less than two months following harm level citation. Refer to F697 for additional information. MEDICATION ERRORS The facility failed to sustain a plan of corrections for previous harm level citation for significant medication errors issued on 10/21/19 with alleged back in compliance date of 12/02/19 The facility was issued another citation on 02/05/2020 for medication errors. Additionally, the facility did not have a system in place to collect and track data for medication errors. Refer to F658 for additional information. In an interview the DNS stated she logged the medication errors on paper. Review of the log did not show that each medication error was tracked and analyzed whether it was related to timing, right route, right dose, delay, omission, right patient, and include data comparing various units and shifts. FACILITY INVESTIGATIONS The facility was cited for failing to thoroughly investigate all reports of alleged abuse, neglect or quality of care concerns. The facility alleged compliance on 03/08/19. The facility was cited again for failing to conduct	F 867	Individual to Ensure Compliance Post Acute Solutions will ensure compliance	

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F 867	Continued From page 53 thorough investigations on 09/13/19 with an alleged compliance date of 12/02/19. On 02/05/20 the survey team identified a pattern of failure related to lack of thorough investigations of all allegations that occurred in January and February of 2020 resulting in ongoing neglect and susequent harm to residents with immediate jeopardy. Refer to F610 for detailed information. Reference WAC 388-97-1760(1)(2) .	F 867		