

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505382	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Regency Wenatchee Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1326 Red Apple Rd Wenatchee, WA 98801	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure grievances (resident and/or resident representative concerns that can be voiced or written) conveyed to staff underwent prompt resolution and appropriately updated residents on the grievance progress/conclusion for 1 of 2 residents (Resident 46) reviewed for grievances. This failure placed residents at risk for unresolved concerns and unmet care needs.</p> <p>Findings included .</p> <p>Review of the facility policy titled, Grievances Procedure, revised August 2023, showed the facility would ensure each residents' right to .voice grievances (such as those about treatment, care, management of funds, lost clothing, or violation of rights) . and that facility staff were responsible for making prompt efforts to resolve a grievance and to keep the resident appropriately apprised (updated on information) of progress towards the residents grievance resolution. The policy showed the facility would .have a process in place for identification, investigation and follow-up of resident/resident representative grievances in a timely manner, and that residents had a right to obtain a written decision regarding their grievance. Additionally, the policy showed the facility would ensure that grievance decisions included the date the grievance was received, a summary of the resident's grievance, the steps taken to investigate the grievance, and the finding or conclusions of the grievance and the date the written decision was issued.</p> <p>&lt;Resident 46&gt;</p> <p>Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including pneumonia (an infection in the lungs, that can cause a build-up of fluid, making it difficult to breathe), insomnia (difficulty falling and/or staying asleep), sepsis with septic shock (a potentially life-threatening condition that comes when the body's response to an overwhelming infection causes injury to its own tissues and organs) and delirium (a serious change in metal ability that causes confused thinking and lack of awareness of surroundings and can be caused by infections). The 04/14/2025 comprehensive assessment showed that Resident 46 had a moderately impaired cognition with evidence of delirium but was able to make their needs known.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/28/2025 at 2:09 PM, when asked if they were missing any personal items, Resident 46 stated that right after their admission to the facility, 193 dollars in cash went missing, but the facility staff found 93 dollars of it. Resident 46 stated they had a conversation with Staff A, Administrator, about the missing money after the facility had found the 93 dollars, but they had not received any money back nor an update since Staff A had informed them that an investigation would be conducted into the missing money.</p> <p>During an interview on 04/30/2025 at 9:26 AM, Staff N, Laundry/Housekeeping Supervisor, stated the process when money was found in the laundry room was to fill out a grievance form and then give the money over to the Administrator to continue the grievance process. Staff N stated that a weekend laundry aid contacted Staff A and informed them that they had found 93 dollars in cash, which belonged to Resident 46. Staff A stated the money was found the day after the resident had been admitted to the facility and the weekend laundry aid put the money under the Administrator's locked door. During a follow-up interview on the same day at 10:43 AM, Staff N stated they were unaware of the additional 100 dollar amount of cash that Resident 46 stated was in their clothes and would have investigated further by interviewing the laundry aid/looking into where the money might have gone.</p> <p>Review of the facility's grievance log for April 2025, showed no documentation of grievance regarding missing money.</p> <p>During an interview on 04/30/2025 at 10:01 AM Staff A stated that if a resident was missing cash monies in the facility the grievance process would be started, and the facility would try to get them a locked drawer for the money. When asked about Resident 46's missing money, Staff A stated they intended to go through the grievance process, I probably missed that one, since a grievance form was not filled out and the resident informed Staff A that there was 100 more dollars that was in the resident's pants pocket, in addition to the 93 dollars found in the laundry. Staff A stated they did not have documentation of the steps taken to investigate and/or the resolution/conclusion of Resident 46's grievance.</p> <p>Reference: WAC 388-97-0460(2)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure nursing staff reported, witnessed verbal and physical abuse, to the State Agency, immediately, but no later than two hours after the abuse took place, for 1 of 3 residents (Residents 41), reviewed for abuse/neglect. This failure placed the residents at risk for unidentified abuse/neglect, and the potential continued exposure to abuse and/or neglect.</p> <p>Findings included .</p> <p>Review of the facility's policy titled, Abuse/Neglect/Misappropriation/Exploitation, revised October 2022, showed that all facility employees were mandated reporters that must immediately report when there was a reasonable cause to believe an incident of abuse occurred. The facility policy stated all alleged violations involving abuse were to be reported immediately, but not later than two hours after the event had taken place.</p> <p>&lt;Resident 41&gt;</p> <p>Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including right below the knee amputation (BKA, removal of a body part) surgical aftercare, anxiety, long term pain, and peripheral vascular disease (PVD, a narrowing or blockage of blood vessels, leading to reduced blood flow, primarily to the legs and feet, with common symptoms including leg pain and non-healing wounds). The 04/26/2025 comprehensive assessment showed Resident 41 had moderate cognitive impairment but was able to make their needs known.</p> <p>Review of Resident 41's incident investigation, dated 04/24/2025 at 9:00 AM, showed that on 04/24/2025 at 3:40 AM Staff H, Nursing Assistant (NA), witnessed Staff I, Registered Nurse (RN), when providing care , grabbed Resident 41's left arm and shoved the resident while cursing at the resident, telling the resident to Stop (Resident 41's), f*****g s**t.</p> <p>During an interview on 04/29/2025 at 10:25 AM, Resident 41 stated they could not remember the exact date of the incident, but the incident happened in the early morning when the nurse and nursing assistants (NA) had come into the room to change the resident brief. Resident 41 stated Staff I got hostile (showing strong dislike and unfriendly) because the resident was not turning to their side fast enough during incontinent care.</p> <p>During an interview on 05/01/2025 at 5:01 PM, Staff H stated they had gone in/out of Resident 41's room early on the morning of 04/24/2025, and upon entering back into the resident room, after grabbing supplies, Staff H witnessed Staff I grabbing Resident's 41 arm, as the resident swung at Staff I, and Staff I proceeded to pushed the residents arm down while cursing at the resident to stop. Staff H stated they did not report the witnessed verbal and physical abuse to any other staff or State Agency until around 7:30 AM to 8:00 AM, when they texted Staff A, Administrator.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/02/2025 at 11:29 AM, Staff B, Director of Nursing Services, stated they were informed of the allegation of verbal and physical abuse towards Resident at 9:00 AM on 04/24/2025 by Staff H. Staff B stated that the report to the State Agency was made after Staff B became aware of the allegations. Staff B stated a report to the State Agency should have been made immediately after being witnessed by Staff H or within two hours. Staff B stated the correct process for reporting abuse allegations was not followed.</p> <p>Reference: WAC 388-97-0640(5)(a)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately implement effective measures in the protection of a resident from further abuse/neglect, nor conduct a thorough investigation into an allegation of abuse for 2 of 3 residents (Residents 41 and 11), reviewed for abuse and neglect. This failure placed the residents at risk for unidentified abuse, unmet care needs, and the potential for continued exposure to abuse and/or neglect.</p> <p>Findings included .</p> <p>Review of the facility's policy titled, Abuse/Neglect/Misappropriation/Exploitation, revised October 2022, showed that it was the facility's policy to protect residents from abuse and .All alleged incidents of abuse, neglect, misappropriation of resident property and injuries of unknown source must be thoroughly investigated . The policy showed the investigator would collect as much data as needed to be able to reach a reasonable conclusion and that data collection could involve .Interview assigned caregiver, caregivers in the immediate area, caregivers from the shift prior to the incident's discovery, visitors, family, roommates and the alleged perpetrator .' Additionally, the policy showed .Protecting the resident from further harm means keeping the resident safe by .immediately suspend the alleged perpetrator .having a trusted person stay with the resident .</p> <p>&lt;Resident 41&gt;</p> <p>Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including right below the knee amputation (BKA, removal of a body part) surgical aftercare, anxiety, long term pain, and peripheral vascular disease (PVD, a narrowing or blockage of blood vessels, leading to reduced blood flow, primarily to the legs and feet, with common symptoms including leg pain and non-healing wounds). The 04/26/2025 comprehensive assessment showed Resident 41 had moderate cognitive impairment but was able to make their needs known.</p> <p>Review of the alleged abuse investigation, dated 04/24/2025 at 9:00 AM, showed that Staff H, Nursing Assistant (NA), reported to the Administrator and Director of Nursing Services (DNS), that they had witnessed Staff I, Registered Nurse (RN), physically and verbally abuse Resident 41 when administering medications and providing care to the resident. Staff H stated that Resident 41 had requested a suppository medication (a type of drug, inserted through the rectum) to help them have a bowel movement. Staff H stated that Staff I's inserted the suppository medication incorrectly, and Resident 41 yelled at Staff I you're hurting me. Staff H stated that both Staff H and Staff I left the resident's room to gather supplies and upon Staff H's reentry to Resident 41's room they overheard the resident telling Staff I you're hurting me you b***h, and witnessed Resident 41 swinging her left arm at Staff I and Staff I grabbing the resident's left arm and proceeded to shove while cursing at the resident, telling the resident to Stop (Resident 41) f****g s**t. The investigation showed Resident 41 stated that when the suppository was inserted incorrect the resident threw their arm up at Staff I to get the staff members attention and Staff I grabbed the resident's arm and pushed them, The nurse is rude and was rough with me. Resident 41 requested their emergency contact to be informed about the incident. Additionally, no interview with Resident 41's representative (RR) was documented.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of the 04/24/2025 alleged abuse investigation showed Staff H conveyed the witnessed abuse to the Director of Nursing Services (DNS) on 04/24/2025 at 9:00 AM and then Staff I, who had already completed their night shift, was suspended pending the investigation and safety of Resident 41 was ensured. The investigation showed that Staff H feared the nurse and so did not report the witnessed event until after their shift had ended.</p> <p>During an interview on 04/29/2025 at 10:25 AM, Resident 41 was unable to remember specifics about the incident at certain times, was not interested in talking more about the incident and did not remember the suppository medication that was administered by Staff I. Resident 41 then stated that during the incident Staff I was really mean and aggressive when providing cares, because the resident was not turning to their side fast enough and they did not feel safe with Staff I.</p> <p>During a follow-up interview on 04/30/2025 at 2:36 PM Resident 41 was forgetful/confused on specifics related to the incident but then stated feeling uncomfortable and helpless with the way Staff I provided care to them.</p> <p>During an interview on 05/01/2025 at 5:01 PM, Staff H stated that after witnessing the incident of abuse in Resident 41's room. Staff H stated they did not report the witnessed abuse to any other staff until around 7:30 AM to 8:00 AM, when they notified the Administrator. Staff H stated they did not report to the State Agency hotline number. Staff H stated they did not protect the resident from further harm and was afraid of the nurse, so after the incident went back to their regular duties. When asked if Staff I had gone back into Resident 41's room, Staff H stated that it was possible.</p> <p>During an interview on 05/02/2025 at 7:13 AM, Staff A, Administrator, stated that interviews with other staff, Resident 41's roommate and other residents were completed during the investigation and did not correlate with Staff H's witnessed statements of verbal/physical abuse by Staff I on Resident 41. Staff A stated that none of the interviews conducted corroborated (to support with evidence or make something more certain) with the allegations brought forth by Staff H. Staff A stated the investigation had been completed and education was performed on Staff I regarding the incorrect insertion of the suppository medications.</p> <p>During an interview on 05/02/2025 at 9:20 AM, Resident 41's Representative (RR), stated they had known the resident for 14 years now and were notified by the Administrator about the incident. The RR stated they came to talk with Resident 41 after they got off work. The RR stated Resident 41 stated that Staff I was hurting them, pushing them and the resident felt helpless in the situation. RR stated, (Resident 41) did feel abused and did not feel safe with Staff I and did not want that nurse working with them anymore. (Resident 41) was frightened.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/02/2025 at 11:29 AM, Staff B, DNS, stated they had interviewed Resident 41, other residents, staff and the RR. When inquiring about the RR, Staff B stated that Resident 41 did not have family, and the resident had requested to talk with their RR after the incident/allegation of abuse took place. Staff B stated the RR came in to talk with Resident 41 on the 24th or 25th of April 2025 but was unsure of the exact date/time. Staff B stated that per Resident 41, Staff I was rude, rough and fast when providing care, but felt safe with the staff member. Staff B stated the resident's recollection of the events was not good and that it would change. Staff B stated that staff/resident interviews conducted could not corroborate the allegations brought forth by Staff H and the investigation was completed. When informed of RR interview, Staff B stated they were unaware of information conveyed to the RR by Resident 41 and thought Staff A had interviewed the RR and that the RR did not have any concerns. Staff B stated the correct process was not followed and the investigation was not thorough. Staff B stated the investigation would have to be reopened and follow-up with the RR.</p> <p>During an interview on 05/05/2025 at 5:11 PM, Staff C, Regional Clinical Director (RCD), stated that Staff H should have protected Resident 41 after witnessing the alleged abuse by Staff I. Staff C stated the protection of the resident from further harm was not implemented, Staff I still had access to Resident 41 after the witnessed abuse and the correct process was not followed.</p> <p>&lt;Resident 11&gt;</p> <p>Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including dementia and degenerative joint disease (a type of arthritis characterized by the breakdown of [NAME] in the joints causing pain, stiffness and decreased movement) in both knees. Resident 11 ' s most recent comprehensive assessment dated [DATE] showed they had moderately impaired cognition and required minimum to moderate assistance of one to two caregivers for activities of daily living (ADL ' s) and could not ambulate.</p> <p>During an observation and interview with Resident 11 on 05/02/2025 at 11:13 AM, showed them sitting in their wheelchair in their room looking out the window. Resident 11 stated they had never had a fall in their room or bathroom and could walk independently without any assistance.</p> <p>Review of the facility reporting logbook showed Resident 11 had nine falls in the facility within the past five months. November 2024 through March 2025.</p> <p>Review of the facility incident reports for Resident 11 showed they had two observed falls on 11/14/2024 and 12/23/2024 and seven unobserved falls on 11/04/2024, 12/26/2024, 01/13/2025, 02/19/2025, 03/01/2025, 03/13/2025 and 03/31/2025. None of the unobserved falls had witness statements attached showing a thorough investigation was completed into the possible causes of the falls or that abuse, and neglect had thoroughly been ruled out as a cause of the falls.</p> <p>Review of Resident 11 ' s care plan initiated on 03/03/2021 and last revised on 04/07/2025, showed the resident was at risk for falls related to pain, weakness, deconditioning, degenerative joint disease in both knees, vertigo (dizziness), history of falls, cognitive impairment, profound hearing loss, epilepsy (a seizure disorder), impulsiveness, impaired vision, poor decision making, and overestimating abilities.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of the care plan showed the problem of being at a high risk for falls and goals to be free of falls were updated on 01/13/2025, 03/18/2025 and 04/07/2025. Additional interventions to decrease the risk for falls were only initiated for the two of the nine falls dated 01/13/2025 and 02/19/2025.</p> <p>During an interview with Staff B, DON and Staff C, RCD, on 05/07/2025 at 12:48 PM, they both acknowledged that thorough investigations into the causes of the falls and to ensure abuse or neglect was not the cause of the falls was not completed. In addition, they both acknowledged that limited interventions were put into place after the falls to prevent future falls and keep Resident 11 as safe as possible.</p> <p>Reference: WAC 388-97-0640 (2)(a)(6)(a)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of practice regarding, A) a residents Central Vascular Access Device (CVAD, also known as a central line, is a thin, soft tube that is inserted into a main vein in the arm, leg, or neck for long-term administration of antibiotics, medication, nutrition, and/or blood draws) dressing change and medication administration after nursing staff noted the central line migration (movement of the tubing from its original position) for 1 of 4 residents (Residents 32) reviewed for central lines, B) nursing staff failing to process, initiate, and follow physician orders with residents wound care for 1 of 4 residents (Resident 41) reviewed for wound care orders. This failed practice placed residents at risk for improper medication delivery, a delay in treatment, and adverse outcomes.</p> <p>Findings included .</p> <p>Review of the facility's guidance titled, Central Vascular Access Device Dressing Change, revised 01/15/2004, showed a Peripherally Inserted Central Catheter (PICC) was a specific type of central line, the dressing on all CVAD's should be dated, so a dressing change schedule could be started for every seven days and .upper arm circumference (a measurement around a residents arm, used as a baseline to detect possible swelling or blood clots) with PICC, and external catheter length measurement must still be completed as part of the initial assessment . The facility's guidance showed that the external catheter measurement was to be obtained upon admission, during dressing changes and that a securement/stabilization device (a small attachment that helps anchor the PICC line in place, to the skin, and prevent migration of the line) should be used and to not removed during a PICC line dressing change. Additionally, the facility's guidance showed that when changing the PICC line dressing, staff should not . disturb (to move or change something from its usual position) catheter . or remove the securement device.</p> <p>Review of Lippincott's nursing procedures manual, 8th edition, Peripherally Inserted Central Catheter Use, dated 2019, showed that a stabilization device should be used to decrease the risk of unintentional movement of the catheter or dislodgement which could lead to complications. Additionally, movement of the catheter should be avoided but if noted during a dressing change that the catheter has migrated more than two centimeters (cm, a unit of measure) a provider should be notified due to the need to confirm if the PICC is still in the correct position.</p> <p>&lt;Resident 32&gt;</p> <p>Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including bone infection and right-hand surgical aftercare. The 04/06/2025 comprehensive assessment showed the resident had a PICC line for antibiotic therapy, was cognitively intact and able to make their needs known.</p> <p>Review of the resident admission assessment dated [DATE] showed the resident was receiving intravenous (IV, the administration of medications or fluids directly into a person's vein) therapy with antibiotics for their bone infection with an IV insertion date of 04/04/2025. The assessment did not show the external catheter length measurement or the upper arm circumference measurement.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 04/29/2025 at 9:10 AM, showed Resident 32 in their room. The resident's PICC line had a change date of 04/23/2025 handwritten on the top of the dressing and a small two inch (in, a unit of measure) long by $\frac{1}{4}$; in wide amount of blood was noted under the PICC line dressing. The external catheter length and time of the last dressing change were not noted on the dressing.</p> <p>During an interview on 05/01/2025 at 12:54 PM, while in Resident 32's room observing the PICC line dressing, Staff O, Registered Nurse (RN), stated they did not know the external catheter length and the blood noted under the dressing was recent since the last dressing change.</p> <p>During a concurrent observation and interview on 05/01/2025 at 1:28 PM, Staff O was in Resident 32's room performing a PICC line dressing change. Staff O stated they remembered the external catheter length was six cm but was unsure if it was documented. Observations showed after removing the old dressing, Staff O picked up and moved the placement of the PICC line from a downward position, where the PICC line access ports were pointing toward the residents elbow, to an upward position, where the PICC line access ports were pointing toward the resident's armpit and then continued to flip/rotate the PICC line two more times (no securement device was in place). Staff O measured the external catheter length and noted that it had been pulled out from six cm to nine cm. Staff O did not measure Resident 32's upper arm circumference.</p> <p>During an interview on 05/01/2025 at 2:07 PM, Staff D, RN/Resident Case Manager (RCM), stated the process for admission/assessments of residents with PICC lines would include documenting the external catheter length. Staff D was unable to find documentation showing Resident 32's external PICC length or upper arm circumference. Staff D stated the external length of the PICC line was needed to assess if migration of the line took place. Staff D stated that when migration of the PICC line was noted, the line would no longer be used for infusion of medications and the provider would be notified.</p> <p>During an interview on 05/01/2025 at 2:19 PM, Staff B, Director of Nursing Services, and Staff C, Regional Clinical Director, stated that when a resident was admitted with a PICC line a group of orders were to bed and included the external catheter length. Staff B stated the process for central lines included assessing the PICC lines external catheter length and the upper arm circumference, so that migration of the catheter line or complications with swelling could be noted/acted upon. Staff B stated they were unable to find Resident 32's external catheter length or upper arm circumference and the correct process was not followed. Staff B and Staff C stated they were informed that Resident 32's PICC line catheter had migrated from six cm to nine cm, so Resident 32's IV medication infusions should be stopped and a notification to the provider would be completed before utilizing the residents PICC line.</p> <p>During a concurrent observation, upon the surveyor and Staff B entering Resident 32's room, and interview on 05/01/2025 at 2:45 PM showed IV medication infusing through the residents PICC line. Staff B stated the IV medication should not be infused through the PICC line since the line had migrated and Staff O did not follow the correct process. Staff B stated they were going to stop the infusion immediately.</p> <p>During an interview on 05/01/2025 at 3:21 PM, Staff B stated that during a CVAD/PICC dressing change the catheter should not be moved from its usual position and Staff O's moving the catheter placement and flipping/rotating catheter during a central line dressing change was not the correct process.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505382	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Regency Wenatchee Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1326 Red Apple Rd Wenatchee, WA 98801	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>&lt;Resident 41&gt;</p> <p>Review of the medical record showed the resident was admitted to the facility on [DATE] and readmitted from the hospital on [DATE] with diagnoses including right below the knee amputation (BKA, removal of a body part) surgical aftercare, anxiety, long term pain, and peripheral vascular disease (PVD, a narrowing or blockage of blood vessels, leading to reduced blood flow, primarily to the legs and feet, with common symptoms including leg pain and non-healing wounds) with a history of PVD angioplasty (a procedure to open the blocked or narrowed arteries in the legs). The 04/26/2025 comprehensive assessment showed Resident 41 had moderate cognitive impairment but was able to make their needs known.</p> <p>Review of the hospital physician's transfer orders dated 04/22/2025, showed Resident 41 right BKA was to have a dressing change every other day/as needed and to apply betadine (a solution that is used to disinfect skin and prevents further infections) over the incision site. The transfer orders stated the left fourth toe was necrotic (a term used to describe the death of living tissue due to a lack of blood supply) and .gauze to keep in between 4th/5th toe .</p> <p>Review of the admission assessment dated [DATE] at 11:36 AM, showed Staff P, RN/RCM, stated that Resident 41's fourth toe on their left foot was necrotic and was to be painted with betadine every other day.</p> <p>Review of Resident 41's provider orders dated 04/25/2025, showed that nursing staff input orders for necrotic 4th digit left toe: monitor daily. Notify MD (facility provider) of any change or if it falls off. every shift. No orders for a dressing change or gauze placement for the resident's necrotic toe were noted.</p> <p>During a concurrent observation and interview on 04/29/2025 at 11:36 AM, Resident 41 was noted lying in bed with their left foot open to the air. The resident's fourth toe on the left foot was necrotic and no dressing was in place. Resident 41 was unsure if a dressing was in place between their toes on their left foot, but did not have their pressure relieving boot in place under their left foot so they could let it air out.</p> <p>During a concurrent observation and interview on 05/01/2025 at 11:52 AM, Resident 41 was noted in their room with Staff Q, RN and Staff R, Medical Provider, performing a dressing change on the resident's right BKA. No dressing or gauze noted in between the resident's left [NAME] necrotic 4th toe. After the resident's right BKA dressing was completed Staff R inquired about the resident left fourth necrotic toe and Staff Q stated that they were not performing a dressing change for the residents necrotic fourth toe and were to be monitoring the toe daily.</p> <p>During an interview on 05/01/2025 at 12:38 PM, Staff Q stated that no dressing had been in place for Resident 41's left foot necrotic toe since the resident's readmission on [DATE]. Staff Q stated they looked at the orders in a resident chart and it was not their process to look at the wound care transfer orders from the hospital.</p> <p>During an interview on 05/01/2025 at 12:51 PM, after reviewing Resident 41's wound care transfer orders, Staff R stated that nursing staff should have been completing a dressing change for the resident's necrotic 4th toe. Staff R stated the necrotic toe's dead tissue should have been separated from the living tissue of the resident's other toes.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Regency Wenatchee Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1326 Red Apple Rd Wenatchee, WA 98801	
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/05/2025 at 3:30 PM, Staff P stated they completed the admission assessment for Resident 41. Staff P stated they had missed the orders to have the gauze in-between the resident necrotic fourth/fifth toe, and they did not read through the whole order.</p> <p>During an interview on 05/05/2025 at 4:34 PM, Staff C, Regional Clinical Director, stated that Resident 41's physician's orders transfer orders from the hospital were not processed or initiated correctly and nursing staff were not following the orders regarding the resident's wound care.</p> <p>Reference: WAC 388-97-1620(2)(b)(ii)</p>		