STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505017	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Care Center	2821 South Walden Street Seattle, WA 98144

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. 42203 Based on interview and record review, the facility failed to ensure residents were provided informed consent for treatments (ensuring an explanation of the risks and benefits was provided) for 3 of 5 (Residents 113, 21, & 17) residents whose medication regimen was reviewed. The failure to provide informed consent placed residents at risk for unwanted adverse side effects, unwanted treatment, and loss of autonomy. Findings included . <Resident 113> According to the 07/18/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 113 had diagnoses including depression and anxiety. The MDS showed Resident 113 received antidepressant and antianxiety medications. Review of the physician's orders showed a 04/26/2024 order for an antidepressant to be administered to Resident 113 at bedtime for insomnia. Record review showed no evidence the risks and benefits of the antidepressant medication were explained to Resident 113. There was no evidence Resident 113 consented to the medication prior to treatment. In an interview on 08/20/2024 at 4:50 PM Staff C (Regional Director of Clinical Operations) stated they did not see an informed consent was provided to Resident 113 prior to treatment. Staff C stated they would expect a consent for a psychotropic medication. 45941 <Resident 17> According to the 06/13/2024 Significant Change MDS, Resident 17 had a diagnosis of depression with suicidal ideation. The MDS showed Resident 17 received antidepressant and antipsychotic medications during the assessment period. Review of Resident 17's record showed no consent was obtained for the antidepressant medication prior to implementing the medications. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/20/2024 at 3:35 PM, Staff C stated they did not see an informed consent was provided to Resident 17 prior to treatment. Staff C stated there should be a consent signed prior to starting an antidepressant medication. <Resident 21> According to the 05/14/2024 Quarterly MDS, Resident 21 had diagnoses including depression, anxiety, and a psychotic disorder. The MDS showed Resident 21 received antipsychotic and antidepressant medications during the assessment period. Review of Resident 21's record showed the consent form for the antipsychotic medications was signed in 2016 and no diagnosis was checked for Resident 21 to know why they were receiving the medication. Another consent form for the antidepressant medication was signed on 02/08/2022 but no diagnosis was checked. In an interview on 08/20/2024 at 3:35 PM, Staff C stated staff should have explained the reason and diagnosis to the resident or their representative prior to starting any psychotropic medications. REFERENCE: WAC 388-97-0260(1)(a)(b)(i)(ii)(iii).

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43642 Based on observation and interview, the facility failed to ensure the facility maintained a homelike environment for 2 of 4 units, and 1 of 1 entry way. The failure to ensure resident rooms were free of wall scrapes, stained doors and walls, damaged flooring, damaged closet doors, missing/damaged ceiling tiles, and dirty privacy curtains, and the failure to ensure the entry way was in good condition, placed residents at risk for a less than homelike environment, frustration, and a diminished sense of self-worth. Findings included . <100 Unit > Observations of the first-floor shower room door on 08/14/2024 at 1:27 PM showed multiple tan colored smears and marks on the outside visible from the hallway. In an interview on 08/21/2024 at 11:27 AM, Staff X (Maintenance Director) looked at the shower room door, stated it looked dirty and should be cleaned up and painted. Observations of the shared bathroom in room [ROOM NUMBER] on 08/15/2024 at 8:52 AM showed dried brown raised debris areas on the wall to the right of the toilet, the wall across from the toilet, and on the floor next to the toilet. The same brown debris areas were still observed four days later, on 08/19/2024 at 7:34 AM. In an interview and observation on 08/21/2024 at 11:27 AM, Staff X confirmed the debris areas were still present, six days after the original observation was made, and stated the areas should have, but were not cleaned by housekeeping staff. Observations on 08/19/2024 at 6:26 AM showed the supply closet doors across from room [ROOM NUMBER] were misaligned and unable to be closed. The doors remained partly open and were visible in the hallway. In an interview and observation on 08/21/2024 at 11:27 AM, Staff X checked the supply room doors and confirmed they were not functioning correctly. Staff X stated their expectation was for staff to report issues found so they can be fixed promptly. Observations on 08/14/2024 at 9:17 AM and on 08/19/2024 at 6:30 AM, five days later, showed the ceiling tiles inside room [ROOM NUMBER] were hanging vertically down, and only being held by the corners of the tile against the frame. In an interview on 08/21/2024 at 11:27 AM, Staff X stated they had just fixed the ceiling tiles and expected any concerns to be fixed promptly for safety and to provide a homelike environment for residents. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 08/19/2024 at 7:34 AM showed a box fan sitting on the floor of room [ROOM NUMBER] that was full of dust debris on the entire front grill. The debris was blowing and moving with the flow of air in the room during observations. In an interview and observation on 08/21/2024 at 11:27 AM, Staff X confirmed the fan in room [ROOM NUMBER] was full of dust debris and stated the fans should be cleaned regularly by the housekeeping staff to prevent build up. Staff X stated it was important and was their expectation that staff provide residents a clean and homelike environment to promote their quality of life. <200 East Unit> Observation on 08/14/2024 at 9:02 AM showed room [ROOM NUMBER] had a wheelchair parked in the bathroom and dirty bedside commode bucket in the wheelchair. Behind the resident's bed in room [ROOM NUMBER], big deep scratches were observed on the wall. The closet in room [ROOM NUMBER] had multiple wood chunks missing and metal hardware was exposed. Observations on 08/14/2024 at 10:11 AM and on 08/19/2024 at 11:00 AM showed room [ROOM NUMBER] had a broken floor tile next to the resident's bed. Observations on 08/14/2024 at 12:26 PM and on 08/19/2024 at 9:22 AM showed the closets in room [ROOM NUMBER] and room [ROOM NUMBER] were very worn with large chunks of wood was missing. The closet in room [ROOM NUMBER]'s was supported with adhesive tape. Observations on 08/15/2024 at 8:45 AM and on 08/19/2024 at 10:21 AM in room [ROOM NUMBER] showed the wall behind the resident's bed had multiple big deep scratches and the baseboard was broken. Observation on 08/19/2024 at 8:22 AM in room [ROOM NUMBER] showed the privacy curtain was dirty with brown stains on it. In an interview on 08/21/2024 at 11:00 AM, Staff X observed the rooms were not clean, gauges in walls, and broken closets and stated the rooms were not homelike. Staff X stated the facility was waiting for an order to be approved for the backing behind the beds. <Facility Entrance> Observations on 08/16/2024 at 2:07 PM showed broken and missing cement tiles at the entrance to the facility on the pathway staff, residents, and visitors walked on to enter the facility. In an interview and observation on 08/21/2024 at 11:27 AM, Staff X confirmed the cement tiles at the facility entrance were broken and stated they needed to be replaced to decrease the risk of injury. REFERENCE: WAC 388-97-0880(1)(2). 45941

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 43642 Based on interview and record review, the facility failed to ensure a system by which residents received required written notices at the time of transfer/discharge, or as soon as practicable for 5 (Residents 127, 34, 113, 55, & 96) of 7 residents reviewed for hospitalization s. Failure to provide written notification to the resident and/or the resident's representative of the reasons for the discharge in writing and in a language and manner they understood, placed residents at risk for a discharge that was not in alignment with the resident's stated goals for care and preferences. Findings included . <Resident 127> Review of Resident 127's 06/18/2024 Discharge Minimum Data Set (MDS - an assessment tool) showed the resident was transferred to an acute care hospital on 06/18/2024, with their return anticipated. Record review showed no documentation staff provided written notification to Resident 127 and/or the resident's representative regarding their discharge as required. <Resident 34> Review of Resident 34's 08/14/2024 MDS showed the resident was transferred to an acute care hospital on 08/14/2024, with their return anticipated. Record review showed no documentation staff provided written notification to Resident 34 and/or the resident's representative regarding their discharge as required. <Resident 113> According to the 07/18/24 Quarterly MDS Resident 113 readmitted to the facility from the hospital on 04/26/2024. The MDS showed Resident 113 had medically complex conditions including an infection with a Multi Drug Resistant Organism (MDRO - a germ not effectively treated by many common antibiotics) and muscle weakness. According to a 04/19/2024 progress note Resident 113 was sent to the hospital for further evaluation after a follow up appointment. Record review showed no documentation staff provided written notification to Resident 113 regarding their discharge as required. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/20/2024 at 12:09 PM, Staff E (Social Services Director) stated they did not complete a written notice of transfer when a resident is transferred to the hospital. When asked if there was any documentation the residents and/or representatives were notified of the transfers to the hospital in writing, Staff E stated they were not aware of any documentation. Staff E stated they only complete the notice of transfer when a resident was being discharged from the facility, not transferred to the hospital as required. Staff E confirmed they did not have a written notice of transfer for Resident 127, Resident 34, or Resident 113. 42203 <Resident 55> Review of the 03/05/2024 Discharge Return Anticipated MDS showed Resident 55 discharged to an acute care hospital on 03/05/2024. Review of Resident 55's record on 08/19/2024 showed no documentation staff provided the required written notification to Resident 55 and/or their representative regarding their discharge on 03/05/2024. <Resident 96> Review of the 12/11/2023 Discharge Return Anticipated MDS showed Resident 96 discharged to an acute care hospital on 12/11/2023. Review of Resident 96's record on 08/19/2024 showed no documentation staff provided the required written notification to Resident 96 and/or their representative regarding their discharge on 12/11/2023. In an interview on 08/20/2024 at 12:09 PM, Staff E stated they were not aware of the requirement for written notification to residents/their representatives regarding discharges and they did not provide any written notification to residents/their representatives upon discharges. REFERENCE: WAC 388-97-0120 (2)(a-d). 45941

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43642 Based on interview and record review, the facility failed to provide the resident and/or the resident's representative a written notice of the facility's bed-hold policy, at the time of transfer or within 24 hours, for 4 of 7 sample residents (Resident 127, 34, 55, & 96) reviewed for hospitalization . This failure placed the residents and/or their representatives at risk of not being informed of their right to, or the cost of, holding the resident's bed while hospitalized that was necessary for decision-making. Findings included . <Resident 127 > In an interview on 08/15/2024 at 1:57 PM, Resident 127 stated they were previously sent to the hospital for stomach issues and blood loss. Review of Resident 127's 06/18/2024 Discharge Minimum Data Set (MDS - an assessment tool) showed the resident was transferred to an acute care hospital on 06/18/2024, with their return anticipated. Record review showed no documentation or other indication the facility provided Resident 127 or their resident representative written information regarding the facility's bed-hold policy as required. <Resident 34> Review of Resident 34's 08/14/2024 Discharge MDS showed the resident was transferred to an acute care hospital on 08/14/2024, with their return anticipated. Record review showed no documentation or other indication the facility provided Resident 34 or their resident representative written information regarding the facility's bed-hold policy as required. In an interview on 08/20/2024 at 12:09 PM, Staff E (Social Services Director) stated bed holds were documented in the progress notes and completed by the admissions department. In an interview on 08/21/2024 at 12:01 PM, Staff W (Admissions Coordinator) stated bed holds were completed by the nursing department. In an interview on 08/21/2024 at 12:29 PM, Staff C (Regional Director of Clinical Operations) stated bed holds were documented on the eINTERACT Transfer Form nursing staff completed when transferring a resident to the hospital. Staff C stated the forms were recently updated to include the bed hold information and indicated it was their expectation if staff were unable to address the bed hold prior to transferring a resident to the hospital, the facility should have documented and followed up promptly. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 127 and Resident 34 records showed no eINTERACT Transfer Form was completed by staff when they were sent out to the hospital and no progress note was made by staff to indicate a bed hold was offered as required. 45941 <Resident 55> Review of Resident 55's 03/05/2024 Discharge - Return Anticipated MDS showed Resident 55 discharged to an acute care hospital on 03/05/2024. Review of Resident 55's census documents showed Resident 55 was sent to the hospital on 03/05/2024 and readmitted to the facility on [DATE]. Review of Resident 55's record showed no documentation indicating a bed hold was offered to Resident 55 and/or their representative when Resident 55 was discharged to the hospital on 03/05/2024 as required. In an interview on 08/19/2024 at 11:21 AM, Staff E stated the facility did not have a specific form for bed hold. Staff E stated staff should have documented in Resident 55's record under progress notes and if it was not there, it was not done. Staff E stated staff should have offered bed hold to the resident as required. <Resident 96> Review of Resident 96's 12/11/2023 Discharge Return Anticipated MDS showed Resident 96 discharged to an acute care hospital on 12/11/2023. Review of Resident 96's census documents showed Resident 96 was sent to the hospital on 12/11/2023 and readmitted to the facility on [DATE]. Review of Resident 96's records showed no documentation indicating a bed hold notification was provided to Resident 96 when they discharged on [DATE] as required. In an interview on 08/20/2024 at 12:09 PM, Staff E stated bed hold notification should be documented in Resident 96's record under progress notes but was not. REFERENCE: WAC 388-97-0120(4). .

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46479 Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR) Level II comprehensive evaluations were obtained for 3 (Residents 134, 85, & 113) of 7 sampled residents reviewed for PASRR evaluations. This failure placed residents at risk for not receiving necessary mental health care and services. Findings included . <Facility Policy> Review of the undated PASRR Completion facility policy showed the designated staff would make sure the PASRR was completed on all potential residents. This policy showed if the referral indicated the resident had a serious mental illness or intellectual disability, the PASRR would be completed prior to admission. <Resident 134> According to the 07/07/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 134 had no cognitive impairment and had diagnoses of anxiety disorder and a chronic mental illness that caused extreme mood swings. This MDS showed Resident 134 was not considered by the state level II PASRR process to have a Serious Mental Illness (SMI). Review of Resident 134's 07/16/2024 Level I PASRR showed the resident had diagnoses of a mood disorder and anxiety. This PASRR showed staff indicated a referral for a Level II PASRR was needed due to the resident showing indicators of a SMI. Review of Resident 134's record showed no documentation a referral for a Level II PASRR was sent. In an interview on 08/20/2024 at 12:09 PM, Staff E (Social Services Director) reviewed Resident 134's record and confirmed the resident should be referred for a Level II evaluation but was not. Staff E confirmed staff should have followed up on the referral for the Level II but staff did not. 50511 <Resident 85> According to the 07/04/2024 Quarterly MDS, Resident 85 admitted to the facility on [DATE]. The MDS showed Resident 85 had diagnoses of anxiety, depression, psychoactive substance abuse, and bipolar disorder. Review of the 03/07/2023 Level I PASRR showed Resident 85 had serious mental illness (SMI) indicators for mood and anxiety disorders. A level two evaluation referral was indicated on the PASSR form due to SMI. Review of Resident 85's medical records did not show a Level II PASRR with recommendations for the resident's behaviors was completed. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/15/2024 at 1:26 PM, Staff E stated the Level II PASRR follow-up should have been completed but was not able to find a PASSR II evaluation for Resident 85. Staff E stated that a PASSR II was important to determine the level of care needed for the resident and would help with interventions to help care for the resident. 42203 <Resident 113> According to the 07/18/2024 Quarterly MDS, Resident 113 had medically complex conditions including anxiety, depression, and opioid dependence. The MDS showed Resident 113 took antipsychotic and antidepressant medications. Review of the 03/13/2024 Level I PASRR showed Resident 113 exhibited serious functional limitations in the past six months prior to completion of the form related to a serious mental illness. The form showed Resident 113 required a Level II PASRR evaluation for SMI. Record review showed no Level II PASRR evaluation in place for Resident 113. In an interview on 08/20/2024 at 3:51 PM Staff E stated Level II services were not in place for Resident 113 but their expectation was Level II services should have been followed up on to reflect the Level I PASRR but weren't. REFERENCE: WAC 388-97-1915(2)(4).

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities 43642 Based on interview and record review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASRR - a process to determine if a potential nursing home resident had mental health/intellectual disability needs which required further assessment/treatment) assessment accurately reflected residents' mental health conditions for 3 of 5 (Resident 34, 113, & 17) residents reviewed for PASRR. This failure placed residents at risk for inappropriate nursing home placement and/or not receiving timely and necessary services to meet their mental health needs. Findings included . <Facility Policy> According to the facility's undated PASRR policy, all residents would have a Level I PASRR screening completed prior to admission. <Resident 34> According to a 07/30/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 34 had multiple medically complex diagnoses including depression and Post Traumatic Stress Disorder (PTSD - a mental health condition caused by an extremely stressful or terrifying event) and required the use of antidepressant and antianxiety medications during the assessment period. Review of a 07/23/2024 Level 1 PASRR showed Resident 34 had no Serious Mental Illness (SMI) indicators. Staff did not identify Resident 34 had depression or PTSD, and required the use of medications. In an interview on 08/20/2024 at 12:09 PM, Staff E (Social Services Director) stated they check a resident's records upon admission to the facility to assure the PASRR Level 1 was accurate from the hospital. Staff E stated it was important for a PASRR Level 1 to be accurate in order to determine the level of care a resident required. Staff E reviewed Resident 34's PASRR Level 1 and stated it was inaccurate and needed to be updated. 42203 <Resident 113> According to the 07/18/2024 Quarterly MDS, Resident 113 had medically complex conditions including anxiety, depression, and opioid dependence. The MDS showed Resident 113 took antipsychotic, and antidepressant medications. Review of the physician's orders showed Resident 113 currently took two antidepressant medications and an antipsychotic medication from 03/28/2024 until discontinued on 07/25/2024. The indication for the antipsychotic medication was for auditory hallucinations. Review of the comprehensive Care Plan (CP) showed Resident 113 had a Target Behavior due to Psychosis CP. This CP included a goal for staff to assist Resident 113 with daily episodes of psychosis. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 03/13/2024 Level I PASRR indicated Resident 113 had a mood disorder and an anxiety disorder. This Level I PASRR did not show Resident 113 had a psychosis diagnosis, or otherwise address Resident 113's auditory hallucinations. The form showed Resident 113 exhibited serious functional limitations in the past six months prior to completion of the form related to a serious mental illness. In an interview on 08/21/2024 at 11:11 AM Staff E stated the Level I PASRR did not but should reflect Resident 113's psychosis diagnosis and treatment. 45941 <Resident 17> According to the 06/13/2024 Significant Change MDS, Resident 17 had moderately impaired cognition (impaired memory and problem solving) and diagnoses of schizophrenia (a disorder affecting a person's ability to think and behave clearly) and depression. The MDS showed Resident 17 regularly used antipsychotic, and antidepressant medications during the assessment period. The MDS showed Resident 17 had Level II PASRR services related to a Severe Mental Illness (SMI). Review of the 07/11/2024 psychiatric progress notes showed Resident 17 had diagnoses of schizophrenia and depression and received antipsychotic and antidepressant medications. The psychiatrist recommended staff continue administering antipsychotic and antidepressant medications as ordered and continue monitoring behaviors. Review of the 09/08/2023 Level 1 PASRR showed Resident 17 was identified with SMI indicators for schizophrenia and depression, and a Level II PASRR evaluation was not required. This PASRR showed Resident 17's primary language was English. Staff documented on Resident 17's PASRR Level I, a request for invalidation (denial of Level II services) on 09/08/2023. Record review showed no documentation the facility obtained Resident 17's invalidation report. In an interview on 08/20/2024 at 12:09 PM, Staff E stated Resident 17's Level I PASRR was updated on 09/08/2023 and a Level II PASRR was not indicated. Staff E reviewed Resident 17's Level I PASRR and stated the form was inaccurate for language and should be referred for a Level II evaluation. REFERENCE: WAC 388-97-1915 (1). 51149

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review, the facility failed to ensure Care Plans (CP) were accurate, regularly reviewed and revised to reflect current resident status and needs as required for 7 (Residents 48, 113, 10, 150, 55, 99, & 85) of 27 residents reviewed for CP's. This failure left residents at risk for unmet care needs and a diminished quality of life. Findings included . <Resident 48> According to the 07/12/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 48 had disorganized thinking and diagnoses including non-traumatic brain dysfunction and a condition that cause urine to accumulate in the kidneys. The MDS showed Resident 48 was occasionally incontinent of bladder. Review of the comprehensive CP showed the facility developed two CPs addressing bladder continence for Resident 48. The first was a 01/09/2023 Resident is Continent of bladder . CP. The second was a 02/09/2024 Resident is incontinent of bladder . CP. In an interview on 08/21/2024 at 9:40 AM, Staff S (Unit Manager) stated CPs should be updated to reflect the resident's current condition and care needs. <Resident 113> According to the 07/18/2024 Quarterly MDS Resident 113 had medically complex conditions including anxiety and depression. The MDS showed Resident 113 received an antipsychotic medication during the assessment's look back period. Review of the physician's orders showed Resident 113 did not currently receive an antipsychotic medication. Resident 113's antipsychotic medication was discontinued on 07/25/2024. Record review showed a 05/05/2024 at risk for side effects due to antipsychotic drug use . CP still active. This CP included interventions for staff to assess/monitor behaviors and adverse side effects including involuntary movements, and report concerns to the physician or nurse practitioner. In an interview on 08/21/2024 at 9:40 AM, Staff S stated CPs should be accurate and updated to reflect all changes in the resident's condition. 43642 <Resident 10> (continued on next page)

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	505017	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Care Center	2821 South Walden Street Seattle, WA 98144

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to a 06/21/2024 Admission MDS, Resident 10 had multiple medically complex diagnoses including kidney disease and malnutrition. This MDS showed staff assessed Resident 10 was dependent on staff to roll from side to side in bed and to require supervision with eating. Observations on 08/16/2024 at 8:02 AM showed Resident 10 leaning over to reach their meal tray which was set off to the side of their bed. Resident 10 struggled to pick up some food to get the food to reach their mouth. In an interview at this time, Resident 10 stated they sometimes had trouble eating. Review of a revised 08/05/2024 nutrition CP showed an intervention for Assistance Needed (set-up, supervised/touch, partial/moderate, substantial/maximal, dependent.) The CP intervention was not updated to direct staff what level of assistance Resident 10 required. In an interview on 08/21/2024 at 9:40 AM, Staff S stated Resident 10's CP need to be updated and revised to reflect the actual assistance the resident required. <Resident 150> According to an 08/01/2024 Admission MDS, Resident 150 had multiple medically complex diagnoses including malnutrition and required the use of a feeding tube (a tube that delivers a nutritional formula from outside of the body directly into the digestive system). In an interview on 08/16/2024 at 12:22 PM, Staff Y (Certified Nursing Assistant) stated they had access to a residents' Kardex (directions to staff regarding how to provide care), and reviewed that to find out what care a resident required. Review of Resident 150's Kardex on 08/16/2024 showed directions to staff for TF [Tube Feeding] as ordered. There were no directions to staff regarding any TF precautions or safety measures during administration of the TF. In an interview on 08/21/2024 at 9:40 AM, Staff S stated Resident 150's CP (including the Kardex) should be but was not updated to include directions to staff to keep the head of the bed elevated during TF administration due to the risk of aspiration (when food or liquid enters the airway instead of the esophagus, a clinical concern for residents receiving TF). 45941 < Resident 55> According to the 06/21/2024 Quarterly MDS, Resident 55 had significant weight loss in the last six months and was not on prescribed weight loss regimen. The MDS showed Resident 55 required maximal assistance from staff with oral hygiene, eating, and toileting needs. Review of Resident 55's record showed Resident 55's weight on 01/04/2024 was 260 pounds and on 05/28/2024 was down to 221 pounds, representing a weight loss of 39 pounds in four months. Review of Resident 55's CP showed no documentation related to weight loss or any interventions for staff to follow. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/20/2024 at 2:17 PM, Staff H (Dietitian) stated they were aware of Resident 55's significant weight loss. Staff H stated Resident 55's CP should be updated accordingly. <Resident 99> According to the 07/01/2024 Quarterly MDS, Resident 99 readmitted to the facility on [DATE] and had no memory impairment. Review of Resident 99's August 2024 Medication Administration Record (MAR) showed Resident 99 received an antibiotic medication for bladder infection. Review of Resident 99's CPs showed no instructions for staff to follow related to the antibiotic medication use for Resident 99's bladder infection. In an interview on 08/21/2024 at 9:40 AM, Staff S stated CPs should be updated with any changes in resident's condition with new goals and interventions. <Resident 85> According to the 07/04/2024 Quarterly MDS, Resident 85 had clear speech, intact memory, and diagnoses including hypertension, history of pressure ulcers, chronic pain, and muscle weakness. The MDS showed Resident 85 was dependent on staff for lower body dressing and putting on and taking off footwear. Observations on 08/15/2024 at 11:29 AM and 08/19/2024 at 11:01 AM showed Resident 85 had edema (swelling caused by too much fluid retained in the body's tissues) on both lower legs and feet. Observation and interview on 08/19/2024 at 11:10 AM showed Resident 85 did not have compression hose on swollen ankles and legs. Resident 85 stated the facility never provided compression hose. The nurses talked about it, but they never followed through on it. Review of physician's order dated 05/10/2024 showed compression stockings should be applied to both lower legs every morning and at bedtime for edema. Review of 07/07/2024 Nutrition/Hydration CP showed Resident 85 had an edema diagnosis listed on CP. There were no instructions provided in the CP addressing compression hose for edema for Resident 85. Review of Kardex on 08/15/2024 showed there were no instructions for applying compression hose to Resident 85's legs for edema. In an interview on 08/19/2024 at 11:27 AM, Staff F (Unit Manager - Licensed Practical Nurse) stated there was a physician's order for applying compression hose for Resident 85 and it was very important treatment for a resident with edema and fluid retention. Staff F was unable to locate instructions on Resident 85's CP regarding applying compression hose to Resident 85's legs. REFERENCE: WAC 388-97-1020(5)(b). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	50511

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 42203 Based on observation, interview, and record review the facility failed to ensure Physician's Orders (POs) were followed for 1 (Residents 1) of 27 sample residents reviewed, nurses signed only for tasks completed for 2 (Residents 10 & 85) of 27 sample residents, POs were clarified for 2 (Residents 10 & 107) of 27 sample residents reviewed, ensure medications were given within parameters for 1 (Resident 34) of 27 sample residents, and ensure tube feeding supplies were labeled as required for 1 of 3 residents (resident 150) reviewed for tube feeding. These failures left residents at risk for unmet care needs, unnecessary treatment, inaccurate records, and other negative health outcomes. <Resident 1> According to the 06/20/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 1 had diagnoses including a history of stroke, loss of speech, one sided paralysis, difficulty swallowing, and the presence of a feeding tube (tubing to deliver artificial nutrition to the stomach). Review of the August 2024 Medication Administration Record (MAR) showed an 08/07/2024 PO to flush Resident 1's feeding tube with 160 Cubic Centimeters (CC) of water every 4 hours for 16 hours, for a total of 640 CC daily. This MAR showed on 08/07/2024 staff documented they flushed Resident 1's feeding tube with 360 CC of water, with 700 CC on 08/09/2024, 440 CC on 08/11/2024 and 08/12/2024, 180 CC on 08/13/2024 and 08/14/2024, 540 CC on 08/15/2024, 800 CC on 08/16/2024, and 280 CC on 08/17/2024. Observation on 08/15/2024 at 8:19 AM, on 08/16/2024 at 8:03 AM, 9:18 AM, and 1:35 PM, and on 08/19/2024 at 5:17 AM at 10:52 AM showed Resident 1's tube feeding pump was set to flush at 160 CC every four hours as ordered. In an interview on 08/21/2024 at 12:29 PM Staff C (Regional Director of Clinical Operations) stated it was important to for facility nursing staff to follow orders. 43642 <Signing For Tasks Not Completed> <Resident 10> Observations on 08/15/2024 at 8:58 AM showed Resident 10 with a pain medication patch on the top of their right ankle. This patch had a handwritten date of, 8/14. On 08/16/2024 at 8:42 AM, this same patch remained on Resident 10's right ankle. Review of August 2024 MAR showed orders for a pain medication patch to be applied to Resident 10 two times a day and gave an area for staff to document the patch was put on at 8:00 AM and removed each night at 8:00 PM. This MAR showed staff documented the patch was applied on 08/14/2024 and removed on 08/14/2024 but was still observed on Resident 10 two days later. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and observation on 08/16/2024 at 9:01 AM, Staff Z (Licensed Practical Nurse) confirmed the pain medication patch was from two days prior, removed the patch, and stated, we should not have missed removing the patch. <Resident 85> According to the 07/04/2024 Quarterly MDS, Resident 85 had clear speech, intact memory, and had diagnoses including hypertension, history of pressure ulcers, chronic pain, and muscle weakness. The MDS showed Resident 85 was dependent on staff for lower body dressing and putting on and taking off footwear. Review of a 05/10/2024 physician's order showed compression wraps/stockings were to be applied to both Resident 85's lower legs every morning and removed at bedtime for edema (swelling from fluid retention). Review of the August 2024 Treatment Administration Record (TAR) showed a 05/10/2024 order instructing staff to apply compression stocking to Resident 85's lower legs every morning and remove them at bedtime for edema. The TAR showed staff documented the compression stockings were applied in the AM and removed at bedtime from 08/01/2024 through 08/20/2024. Observations on 08/15/2024 and 08/19/2024 showed Resident 85 had edema on both lower legs and feet and no compression hose on legs. Observation and interview on 8/19/2024 at 11:10 AM showed Resident 85 was not wearing the compression stockings on their swollen ankles and legs as ordered by the physician. Resident 85 stated the facility never provided compression stockings to them, the nurses talked about it, but never followed through. In an interview on 08/19/2024 at 11:10 AM Staff T (Certified Nursing Assistant), stated they knew the resident needed compression stockings, the resident had compression stockings put on daily, and that Resident 85 did not refuse care. In an interview on 08/19/2024 at 11:19 AM, Staff P (Registered Nurse), stated they were aware of the resident's swollen feet. Staff P confirmed Resident 85 did not have compression stockings on their legs and stated compression stockings would help to bring down the swelling. Staff P stated they would go find compression hose for the resident as Staff T was not able to find compression hose in the resident's room. In an interview on 08/19/2024 at 11:27 AM, Staff F (Unit Manager - Licensed Practical Nurse) stated there was an order directing staff to apply the compression stockings for Resident 85. Staff F stated staff should have completed the task, as it was very important treatment for Resident 85 due to edema and fluid retention. <Clarification of Orders> <Resident 10> (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a 06/21/2024 Admission MDS, Resident 10 had multiple medically complex diagnoses including low back pain. Review of Resident 10's PO showed a 06/17/2024 order for a pain medication patch to be applied to the affected area twice daily for pain. This order did not identify where Resident 10's affected areas were located in order to assure correct placement and did not indicate if staff should apply a new patch twice a day or put on one patch and then remove it in the evening. In an interview on 08/16/2024 at 9:01 AM, Staff Z stated Resident 10 tells the staff where to apply the pain medication patch. In an interview on 08/21/2024 at 12:29 PM, Staff C (Regional Director of Clinical Operations) stated the PO should direct staff where to apply the pain medication patch and needed to be clarified. <Resident 107> According to the 07/19/2024 Quarterly MDS, Resident 107 had intact memory. The MDS showed Resident 107 had a diagnosis of kidney failure and required dialysis (a lifelong outpatient procedure that filters waste from the blood). Review of Resident 107's 03/08/2024 dialysis Care Plan (CP) showed the resident received their dialysis treatments every Monday, Wednesday, and Friday. The CP showed the resident was picked up from the facility at 5:30 AM and the treatment lasted until 11:00 AM. Review of Resident 107's Self-Medication Assessment showed the resident was not a candidate for the self-medication program. Review of Resident 107's August 2024 MAR showed the resident had 11 POs for medications that were due at 8:00 AM. This MAR showed on Mondays, Wednesdays, and Fridays staff documented the resident was absent from the facility or other/see nurse's notes. There were no POs instructing staff to hold or send Resident 107's medications with them when they left for dialysis. Review of Resident 107's nurse progress notes showed on 08/19/2024, 08/16/2024, 08/12/2024, 08/09/2024, 08/07/2024, 08/05/2024, and 08/02/2024 the resident was at dialysis for their morning medications. In an interview on 08/21/2024 at 12:29 PM, Staff C confirmed there were no POs to hold Resident 107's medications on dialysis days. Staff C stated it was their expectation staff clarified the orders, but staff did not. <Medications Given Outside of Parameters> <Resident 34> Review of a 07/30/2024 Admission MDS showed Resident 34 had multiple medically complex diagnoses including fractures, had frequent pain, and required the use of narcotic pain medications during the assessment period. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 34's August 2024 MAR showed a 07/24/2024 PO for staff to administer a half tablet of a narcotic pain medication for a pain scale of 5-7 on a one-to-10 pain scale. A second 07/24/2024 PO showed staff were to administer one tablet of the narcotic pain medication for a pain scale of 8-10 on a one-to-10 pain scale. On 08/10/2024 Resident 34 received only a half tablet of the narcotic pain medication for a pain documented of nine out of 10, rather than the full tablet as directed in the orders. In an interview on 08/21/2024 at 12:29 PM, Staff C stated it was their expectation staff follow the POs as directed and administer pain medications as instructed in the parameters. <Unlabeled Tube Feeding Bag> <Resident 150> Observations on 08/19/2024 at 5:17 AM showed a bag of a nutritional supplement hanging on a pole and being administered to Resident 150 via a feeding tube. There was no label identifying the residents name, the rate of administration, or the date and time of when the supplement was started. In an interview on 08/19/2024 at 6:56 AM, Staff Z stated the nutritional supplement bag should have, but was not labeled by staff with the required information when the administration started for Resident 150. REFERENCE: WAC 388-97-1620(2)(b)(i)(ii), (6)(b)(i). 46479 50511

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on observation, interview, and record review the facility failed to provide assistance with Activities of Daily Living (ADL), related to cleanliness and grooming for 7 (Residents 21,55, 99, 134, 10, 150, & 71) of 10 sample residents reviewed for ADLs. Facility failure to provide residents who were dependent on staff for assistance with oral care, showers, getting out of bed, dressing, shaving, and nail care, placed the residents at risk for poor hygiene, greasy hair, long facial hair, embarrassment and diminished quality of life. Findings included . <Facility Policy> According to the facility's revised March 2018 ADLs policy, residents would be provided with the care, treatment, and services needed to ensure they maintain or improve their ability to carry out their own ADLs. Residents unable to carry out their own ADLs, would be provided the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. <Resident 21> According to the 05/14/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 21 had impaired memory. The MDS showed Resident 21 required one person assistance with personal hygiene and had no rejection of care during the assessment period. The MDS showed Resident 21 was occasionally incontinent of bowel and bladder. Observations on 08/15/2024 at 11:29 AM and 08/16/2024 at 12:42 PM showed Resident 21 with long, broken fingernails, greasy hair, and a strong urine odor. According to the 07/06/2023 ADLs Care Plan (CP), Resident 21 required assistance from staff with personal hygiene, including bathing and dressing, due to physical weakness. The CP instructed staff to provide showers to the resident twice a week and provide nail care on shower days. Review of Resident 21's record on 08/16/2024 showed Resident 21 received three showers in the prior 30 days. In an interview on 08/19/2024 at 11:02 AM, Staff I (Registered Nurse) stated Resident 21 needed assistance from staff with personal hygiene including showers, nail care, and dressing. Staff I confirmed Resident 21 had long fingernails that needed trimming. Staff I stated there was a urine odor in Resident 21's room because the resident urinated in their bed at nighttime. <Resident 55> According to the 06/21/2024 Quarterly MDS, Resident 55 readmitted to the facility on [DATE] with left side weakness and required maximal assistance from staff with oral care, personal hygiene, toileting needs, and bed mobility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 08/14/2024 at 1:52 PM, and 08/15/2024 at 10:37 AM, Resident 55 was lying in bed in a hospital gown with long, broken fingernails, and greasy hair. Resident 55 stated they did not get a shower because they could not walk to the shower room. In an interview on 08/16/2024 at 12:36 PM, Staff L (Certified Nursing Assistant - CNA) stated the facility did not have an assigned shower aide. Each CNA had to provide showers to their residents. Staff L stated they provided bed baths to most of their residents. Staff L stated they provided showers only to the residents who could walk to the shower rooms. In an observation and interview on 08/19/2024 at 10:24 AM Resident 55 was lying in bed wearing a hospital gown. Resident 55 had greasy hair, long fingernails, and their teeth were not clean. Resident 55 stated they did not get help to brush their teeth that morning. According to the 09/30/2022 ADL CP, Resident 55 required two-person total assistance to maintain personal hygiene every shift and assistance with showers/bed bath twice weekly, and toileting as needed. According to the 10/13/2022 Oral/Dental health CP, Resident 55 had broken and missing teeth. Staff were instructed to assist with brushing Resident 55's teeth with a soft toothbrush two to three times daily. In an interview on 08/19/2024 at 10:39 AM, Staff J (CNA) stated they did not provide the morning care to Resident 55. Staff J stated they were new to the facility and learning the routine. <Resident 99> According to the 07/01/2024 Quarterly MDS, Resident 99 readmitted to the facility on [DATE] and required two-person total assistance from staff with oral care, personal hygiene, toilet hygiene, and showers. In an observations and interview on 08/15/2024 at 9:25 AM and 08/16/2024 at 12:32 PM, Resident 99 was lying in bed in a hospital gown. Resident 99 had long broken fingernails and greasy hair. Resident 99 stated they did not receive a shower for a long time because they could not walk to the shower room. Resident 99 stated staff never washed their hair since their admission. Resident 99 stated they needed assistance from staff to trim their nails. According to the 11/11/2023 ADL CP, Resident 99 required one-to-two-person assist with showers twice weekly, and one person assist with dressing and maintaining good personal hygiene every shift and as needed daily. In an interview on 08/16/2024 at 12:36 PM, Staff L (CNA) stated the facility did not have an assigned shower aide. Each CNA had to provide showers to their residents. Staff L stated they provided bed baths to most of their residents. Staff L stated they provided showers only to the residents who could walk to the shower rooms. Staff L stated staff were responsible to trim resident's nails on shower days. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/21/2024 at 9:40 AM, Staff S (Unit Manager) stated staff should follow up with resident's needs and all scheduled ADLs including oral care and dressing residents in the morning, showers and nail care. Staff S stated if residents refused care, it should be documented. 46479 <Resident 134> According to the 07/07/2024 Admission MDS, Resident 134 had no cognitive impairment, was understood, and could understand others in conversation. This MDS showed choosing between a bed bath and a shower was very important to Resident 134 and that Resident 134 was dependent on staff for assistance with showers/baths. In an interview on 08/14/2024 at 10:37 AM, Resident 134 stated they received only one shower since their admission to the facility the month prior. Resident 134 stated the rest of their bathing was bed baths which I hate. Review of the 07/01/2024 Decreased ADL Function CP showed Resident 134 preferred to have a shower with assistance from staff. Review on 08/21/2024 of Resident 134's bathing records showed for the 30 days prior showed the resident received bathing twice. Resident 134 received a shower on 07/27/2024 and a bed bath on 07/31/2024. No other showers or bathing assistance were documented as provided to the resident. In an interview on 08/21/2024 at 9:40 AM, Staff S stated staff should provide all necessary ADL care including oral care, dressing residents, showers and nail care, and document any refusals. 43642 <Resident 10> According to a 06/21/2024 Admission MDS, Resident 10 had clear speech, was understood, and usually able to understand others. This MDS showed staff assessed Resident 10 to require substantial assistance for upper body dressing, personal hygiene, was dependent on staff for lower body dressing, and had no rejection of care. Observations on 08/15/2024 at 8:58 AM, showed Resident 10 lying in bed wearing a hospital gown, with multiple long white curly chin hairs. In an interview at this time, Resident 10 stated, I have asked, but I have not gotten anyone to shave my chin hairs. Resident 10 stated they had clothes and liked to get dressed every day. In an interview on 08/16/2024 at 8:02 AM, Resident 10 stated they liked to get up out of bed to eat their meals and stated of staff, they are always so busy. Observations at this time showed Resident 10 wearing a gown and lying in bed with their chin hairs unshaven. In an interview on 08/16/2024 at 9:01 AM, Staff Z (Licensed Practical Nurse) confirmed Resident 10 had long unshaven chin hairs and stated staff should have but did not provide shaving care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 08/16/2024 at 12:07 PM showed Resident 10 still lying in bed wearing a hospital gown. In an interview at this time, Resident 10 stated they preferred to get up before lunch and stated it would be easier to eat sitting upright in a chair. In an interview on 08/16/2024 at 12:17 PM, Staff Y (CNA) stated they usually dressed Resident 10 if they transferred them to a chair. Staff Y stated Resident 10 sometimes got up but stated they did not offer to assist the resident to get up yet that shift. Observations on 08/19/2024 at 9:22 AM showed Resident 10 asleep in their bed with the room dark and no television on. Resident 10 wore a hospital gown at that time. In an interview on 08/19/2024 at 10:39 AM, Resident 10 stated they were unsure if they were going to get out of bed today, and stated, I don't know, they [staff] came in and changed me, but did not offer to get me up. Resident 10 was in a clean hospital gown. When asked if Resident 10 preferred to be up in the wheelchair at times, the resident stated, yes, I think they are just busy cleaning everyone up. Review of a 06/15/2024 ADL CP showed Resident 10 required assistance with dressing and personal hygiene. This CP gave directions to staff to assist with maintaining good personal hygiene every shift and as needed and to encourage resident to pick out own clothes daily. A 06/26/2024 altered respiratory CP showed directions to staff to encourage Resident 10 to be up out of bed daily and participate in activity and exercise. In an interview on 08/21/2024 at 9:40 AM, Staff S reviewed Resident 10's records and stated the resident was dependent on staff and needed assistance with ADLs. Staff S stated they did not see anything in Resident 10's records to indicate they were unable to get up out of bed. <Resident 150> According to a 08/01/2024 Admission MDS, Resident 150 had multiple medically complex diagnoses including a stroke and hemiplegia (paralysis or weakness of one side of the body). This MDS showed staff assessed Resident 150 with an impairment on one side of the upper body and required substantial assistance for upper body dressing and personal hygiene, and was dependent on staff for lower body dressing. The MDS showed Resident 150 had no rejection of care. Observation on 08/14/2024 at 2:04 PM showed Resident 150 lying in bed wearing a hospital gown with multiple long chin hairs. Similar observations were made on 08/15/2024 at 9:11 AM. In an interview on 08/16/2024 at 9:01 AM, Staff Z confirmed Resident 150 had unshaven chin hairs and stated staff should have but did not provide shaving care. On 08/16/2024 at 12:08 PM, observation showed Resident 150 wearing a hospital gown, lying in bed, with staff at their bedside assisting the resident with eating. Observation on 08/19/2024 at 9:20 AM showed Resident 150 lying awake in bed wearing a hospital gown, with no television or other stimulus, in a dark room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/16/2024 at 12:14 PM, Staff J (CNA) stated they were unsure if Resident 150 got up during the day as this was their first time working with the resident. In an interview on 08/16/2024 at 12:22 PM, Staff Y (CNA) stated Resident 150 did not get up and stated, I have not seen her up. Staff Y stated they were unsure why Resident 150 did not get up during the day. Review of a 07/26/2024 ADL CP showed Resident 150 required assistance with dressing and personal hygiene. This CP gave directions to staff to assist with maintaining good personal hygiene every shift and as needed and to encourage resident to pick out their own clothes daily. In an interview on 08/21/2024 at 9:40 AM, Staff S reviewed Resident 150's records and stated the resident was dependent on staff and needed assistance with ADLs. Staff S stated they did not see anything in Resident 150's records to indicate they were unable to get up out of bed. <Resident 71> According to a 07/01/2024 Admission MDS, Resident 71 had clear speech, was understood, and usually able to understand others. This MDS showed staff assessed Resident 71 to require moderate assistance to roll side to side in bed and from lying to sitting, and required substantial assistance from staff for sitting to standing and chair transfers. Resident 71 had no rejection of care during the assessment period. In an interview on 08/15/2024 at 12:35 PM, Resident 71 stated they were not helped to get out of their bed since the previous week. Resident 71 stated staff did not offer assistance to get out of bed yet that day, I would like to get out of bed every day. Observation at this time showed Resident 71 lying in bed. Observation on 08/16/2024 at 7:54 AM showed Resident 71 lying in bed with staff at their bedside assisting them with breakfast. Resident 71 was not seated in a chair for their meal. Similar observations of Resident 71 lying in bed were noted on 08/20/2024 at 8:34 AM. Review of a 06/25/2024 risk for falls CP showed Resident 71 required one-person assistance for transfers. In an interview on 08/21/2024 at 9:40 AM, Staff S stated it was their expectation staff assist residents to get up, get dressed, and provide personal hygiene daily and as needed. Staff S stated it was important to get resident's up and dressed to give them a routine, keep them motivated, improve circulation, and stated, lying in bed could be depressing for them. REFERENCE: WAC 388-97-1060(2)(c). 51149

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review the facility failed to ensure residents were provided with a program of individualized activities for 2 of 5 (Residents 95 & 150) residents reviewed for activities. These failures left residents at risk for boredom and a diminished quality of life. Findings included . <Facility Policy> According to the facility's revised June 2018 Activity Programs policy, the purpose of the activity program was to support residents' wellbeing with independent and group activities. The policy showed activity programs were designed for maximum individual participation. <Resident 95> According to the 06/06/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 95 was assessed with a slightly impaired mood and diagnoses including anxiety and depression. The MDS showed all activity preferences were very important to Resident 95. The MDS showed Resident 95 was dependent on staff to get out of bed. Record review showed a 09/19/2023 Activities Care Plan (CP) developed for Resident 95. This CP included goals for Resident 95 to engage in independent activities of their choice and attend a group activity weekly. Review of the progress notes showed two progress notes completed by Activities from Resident 95's admission on 09/18/2023 through 08/14/2024: a 03/18/2024 quarterly activity note showing Resident 95's preferred name, and describing Resident 95's enjoyment of [NAME] novels, watching news and sports on the television, listening to rock music, and doing word searches and crossword puzzles; a 06/05/2024 note listing the same interests. Review of the activities charting from 08/01/2024 through 08/20/2024 showed Resident 95 was provided leisure checks on 08/01/2024, 08/06/2024, 08/07/2024, and 08/09/2024 which were coded as independent. The documentation showed Resident 95 actively participated with the library cart program on 08/01/2024. There were no other documented activities during this time frame until 08/19/2024. There was no documentation of Resident 95 refusing group activity participation or independent activities from 08/01/2024 until 08/19/2024. There was no documentation Resident 95 was offered to participate in group activities weekly, as care planned. In an interview on 08/15/2024 at 11:13 AM Resident 95 stated staff never brought them things to do. Resident 95's television was on. Resident 95 stated staff picked the channel for them. The remote control for Resident 95's television was not available. There was no activity calendar in room, or any other activity materials observed to be available for Resident 95. Observation on 08/19/2024 at 10:55 AM showed Resident 95 in bed with their television on, and no remote control available to the resident. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	43642 <Resident 150> According to a 08/01/2024 Admission MDS, Resident 150 had multiple medically complex diagnoses including a stroke and paralysis or weakness of one side of the body, had an impairment to the upper arm on one side, and required substantial assistance to roll from side to side in bed. This MDS showed, according to family, it was very important to Resident 150 to do their favorite activities, go outside to get fresh air, and participate in religious services. Observations on 08/14/2024 at 2:04 PM, 08/15/2024 at 9:11 AM and 2:00 PM, and on 08/19/2024 at 9:20 AM showed Resident 150 lying in bed in a hospital gown, with no television on, and not participating in activities. Resident 150 only had a daily pamphlet at their bedside. Observations on 08/19/2024 at 8:48 AM showed Staff BB (Life Enrichment Assistant) on the first floor with an activity cart going door to door. Staff BB was passing out the daily pamphlet. In an interview at this time, Staff BB stated they were on vacation, out of the country, and just returned to work. When asked where activity attendance documentation could be found, Staff BB stated they documented activities in the resident's electronic records. Review of a 07/29/2024 psychosocial well-being Care Area Assessment (CAA) showed staff should provide Resident 150 social interactions that were meaningful/purposeful to reduce isolation, promote friendships to aid in sharing emotions, alleviate stress, and grieving the sense of loss. A 08/06/2024 activities CAA showed Resident 150 liked to read craft magazines, crocheted in the past, listened to music, and wanted to be on the Communion list on Sundays. Review of revised 08/05/2024 life enrichment CP showed staff identified goals for Resident 150 to attend at least one to three life enrichment activities per month and engage in independent leisure pursuit of choice. This CP gave directions to staff invite Resident 150 to activities daily and to provide activity cart materials for independent leisure pursuit of choice craft material, crochet, quilting items, books, magazines, and wordsearch puzzles. Review of Resident 150's 30-day look back activity documentation on 08/18/2024 showed no activities were documented for the previous 30 days. In an interview on 08/20/2024 at 4:11 PM, Staff AA (Activity Director) stated activities were important to help take people's minds off problems, gives residents meaning for life, and to give them something to look forward to. Staff AA stated it was their expectation activities began when a resident admitted to the facility. Staff AA indicated they had lots of supplies including, books, magazines, tablets, and radios, and encouraged group activities to residents. Staff AA stated they document in a resident's electronic records when activities were provided. When asked about Resident 150's activities, Staff AA stated they had a hard time understanding the resident when they spoke with them, so they reached out to the family regarding activities the resident enjoyed. Staff AA stated they brought Resident 150 a daily pamphlet but stated the resident did not go to group activities. REFERENCE: WAC 388-97- 0940(1).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50511 Based on observation, interview, and record review, the facility failed to ensure residents received care and treatment in accordance with professional standards of practice to attain or maintain their highest practicable level of well-being for 2 of 5 residents (Resident 60 & 85) reviewed. The facility failed to ensure Resident 60 was provided pain management, services for loose stools, or follow the Care Plan (CP) for 1 of 1 residents for edema (swelling caused by too much fluid trapped in the body tissue). These failures placed the residents at increased risk of worsening conditions, discomfort, and a decreased quality of life. Findings included . <Pain Management> <Facility Policy> Review of the facility's undated Wound Care policy showed the policy included guidelines for preparation of wound care, reviewing the resident's CP to determine any special needs of the resident including administering pain medication prior to wound care. Review of the facility's Skin Breakdown-Clinical Protocol policy revised April 2018 showed the nurse should describe, document, and assess the wound for pain. <Resident 60> Review of the Significant Change Minimum Data Set (MDS - a required assessment tool) dated 07/16/2024, showed Resident 60 was admitted to the facility on [DATE] with multiple chronic conditions including chronic kidney disease, diabetes, dementia (loss of memory) and a venous (pertaining to the vein) skin ulcer (open wound) on their left lower leg. The MDS showed Resident 60 had clear speech and was usually understood in expressing ideas and wants. Review of the MDS pain assessment completed 06/26/2024, showed Resident 60 had moderate pain during the prior five days and their pain almost constantly interfered with day-to-day activities. The assessment showed staff should listen to the resident's vocal complaints and observe facial expressions to assess for pain. Review of an 08/13/2024 outside wound team note showed the provider recommended Resident 60 receive pain medication 30 minutes prior to wound treatment and to administer as needed pain medications. Review of the August 2024 Treatment Administration Record (TAR) showed a treatment order for wound care dated 07/23/2024. The order showed wound care should be provided to the left lateral (side) ankle twice a day and as needed. Review of the 06/19/2024 Medication Administration Record (MAR) showed Resident 60 had a physician's order (PO) for pain medication every four hours as needed for general discomfort and showed staff did not administer any pain medications to Resident 60 from 08/01/2024 to 08/20/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/14/2024 at 9:47 AM, Resident 60 stated My feet are starting to hurt and that isn't good. In an interview on 08/15/2024 at 11:10 AM, Resident 60 stated they had pain in their left heel. In an observation and interview on 08/16/2024 at 10:43 AM, Resident 60 complained of pain in their heel when Staff M (Licensed Practical Nurse - LPN) provided treatment to the wound. Staff M stated the floor nurse already gave Resident 60 two pain pills just before wound care treatment to decrease pain. In an interview on 08/21/2024 at 9:51 AM, Staff F (Unit Manager - LPN) stated they were working with the family to determine if hospice services were appropriate for Resident 60, which would include pain management. Staff Stated they only heard Resident 60 complain of pain during wound care. Staff F stated they expected the staff to provide repositioning, distraction techniques, and pain medications before wound care or for general pain. <Bowel Monitoring> <Facility Policy> According to the facility's undated Bowel Clinical Protocol the nurse should assess and document a quantitative (how much/how often) and qualitative (color/shape/odor) description of diarrhea (loose watery stools) when present. The policy showed the assessment should include how many episodes, at what time, amount, onset, all current medications, and a review of vital signs and signs of dehydration. On 08/14/2024 at 9:39 AM, Resident 60 stated I have frequent diarrhea a lot in my room, you would not believe the number of pads I go through in a day. The staff clean my legs as bowel movement was running down my legs today. On 08/15/2024 at 11:17 AM Resident 60 stated they had a lot of diarrhea lately. Observation on 08/16/2024 at 10:40 AM showed Resident 60's room had a strong smell of bowel incontinence. At that time, Resident 60 was observed asking Staff C (Regional Director of Clinical Services) why do I keep pooping everywhere? I can never make it to the bathroom. Review of the Significant Change MDS, dated [DATE], showed Resident 60 was dependent on care staff for toileting hygiene and was always incontinent. Review of the 07/13/2024 change of condition CP showed the resident was at risk for constipation for fecal impaction related to decreased mobility and a history of constipation. The CP did not identify Resident 60 could be at risk for diarrhea due to multiple chronic conditions or treatments for fecal impaction. Review of the 05/24/2024 Baseline CP showed a Bladder and Bowel assessment should be completed on admit, quarterly, and as indicated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the August 2024 care record showed bowel movement monitoring should be completed every shift. Record review of the care staff task documentation for August 2024 showed diarrhea was noted by care staff on 16 occasions. Review of Resident 60's progress notes from 07/30/2024 to 08/18/2024 showed staff did not document the resident's episodes of diarrhea or notify the provider of the frequent diarrhea. In an interview on 08/21/2024 at 9:57 AM, Staff F stated when care staff observed diarrhea, they should have informed the nurse. Staff F stated there was a failure in the facility's diarrhea management system. Staff F stated, We could miss a lot of things, a patient could have C-DIFF (Clostridioides difficile a bacterial infection that causes severe diarrhea) or different things, our nursing staff must evaluate. Staff F stated they relied on care staff to inform the nurses right away, but this did not occur. Staff F stated their expectation was for the information to be passed from the care staff to the nurses so serious health issues could be addressed. <Edema> <Resident 85> According to the 07/04/2024 Quarterly MDS, Resident 85 had clear speech, intact memory, and had diagnoses including hypertension, history of pressure ulcers, chronic pain, and muscle weakness. The MDS showed Resident 85 was dependent on staff for lower body dressing and putting on and taking off footwear. Review of a 05/10/2024 physician's order showed compression wraps/stockings were to be applied to both Resident 85's lower legs every morning and removed at bedtime for edema. Review of Resident 85's 07/07/2024 quarterly revised CP showed the resident had an edema diagnosis listed on their CP. There were no instructions provided, to staff, in the CP addressing compression hose for edema for Resident 85. Review of the Kardex (task sheet for care staff) on 08/15/2024, showed no instructions for staff directing them to applying the compression stockings to Resident 85's legs for edema. Review of the August 2024 TAR showed a 05/10/2024 order instructing staff to apply compression stocking to Resident 85's lower legs every morning and remove at bedtime for edema. The TAR showed staff documented the compression stockings were applied in the AM and removed at bedtime from 08/01/2024 through 08/20/2024. Observations on 08/15/2024 and 08/19/2024 showed Resident 85 had edema on both lower legs and feet and no compression hose on either leg. Observation and interview on 8/19/2024 at 11:10 AM showed Resident 85 was not wearing the compression stockings on their swollen ankles and legs as ordered by the physician. Resident 85 stated the facility never provided compression stockings to them; the nurses talked about it, but they never followed through on it. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/19/2024 at 11:10 AM Staff T (Certified Nursing Assistant), stated they knew the resident needed compression stockings, the resident had compression stockings put on daily and that Resident 85 did not refuse care. In an interview on 08/19/2024 at 11: 19 AM, Staff P (Registered Nurse), stated they were aware of the resident's swollen feet. Staff P confirmed Resident 85 was not wearing the compression stockings on their legs and stated compression stockings would help to bring down the swelling. Staff P stated they would go find compression hose for the resident as Staff T was not able to find compression hose in the resident's room. In an interview on 08/19/2024 at 11:27 AM, Staff F stated there was an order directing staff to apply the compression stockings for Resident 85 and it was a very important treatment for a resident with edema and fluid retention. Staff F was unable to locate instructions on Resident 85's CP regarding applying compression stockings to Resident 85's legs. REFERENCE: WAC 388-97-1060(3)(4)(viii).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 45941 Based on observation, interview, and record review, the facility failed to ensure 1 (Resident 55) of 5 residents reviewed for Pressure Ulcers (PU's) received the necessary treatment and services, consistent with professional standards of practice, to promote healing, and prevent new ulcers from developing. Failure of the facility to consistently complete weekly skin assessments, assess skin integrity to identify PUs timely, ensure air mattress settings were appropriate according to resident's weight, repositioning in bed, update the Care Plan (CP) with Resident 55's refusals, and to follow the CP, placed Resident 55 at risk to develop a new PU, and diminished quality of life Findings included . <Facility Policy> According to the facility's revised April 2018 Pressure Ulcer/Skin Breakdown protocol, the facility would assess residents upon admission and thereafter, to identify if the residents had existing PU's or other skin conditions and would document the risk factors for developing PUs in resident's record. The protocol showed the provider would assess and order wound treatments, including pressure reduction surfaces and would guide the appropriate CP for wound healing and to prevent new PU development. <Resident 55> According to the 06/20/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 55 admitted to the facility with weakness to the left side of their body. The MDS showed Resident 55 developed PUs in the facility and was at risk for developing more PUs. The MDS showed Resident 55 required maximal assistance for bed mobility, rolling from back to left and right side in bed, toileting, and showering. Resident 55 had no behavior of rejection of care during the assessment period. The 02/13/2024 PU CP showed Resident 55 had a PU on their right upper back and was at risk for PU development related to decreased bed mobility. Nursing interventions included instructions for staff to administer treatments as ordered, encourage and assist to turn and reposition to side lying to relieve pressure to wound, encourage to be up out of bed daily, heel/elbow protectors, offloading with pillows, and weekly skin checks, and to notify the provider for any changes in skin status. Review of Resident 55's July and August 2024 weekly skin checks record showed the facility completed the skin check task on 07/19/2024 for the month of July. The documentation showed no skin checks were completed in August 2024. The facility failed to complete the weekly skin check assessments as ordered and documented in Resident 55's record. Observations on 08/14/2024 at 1:50 PM and on 08/15/2024 at 9:02 AM showed Resident 55 was lying on their back in bed and had no heel/elbow protectors on. Resident 55's right lower leg had a dressing and their back had a wound vacuum applied as ordered. Resident 55 had an air mattress in bed with the settings set to 270 pounds. Resident 55's current weight was 221 pounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/16/2024 at 9:32 AM of the wound care nurse providing care to Resident 55's right lower leg chronic wound with no signs of infection. During the treatment of the right lower leg wound, Resident 55 complained of pain in their right foot. The observation showed Resident 55 had a new, small dark purple spot on the right small toe surrounded with redness. In an interview on 08/16/2024 at 9:48 AM, Staff M (Wound Care Nurse) stated Resident did not like heel floaters in bed and they offered heel boots to relieve pressure off the heels. Observation on 08/19/2024 at 10:24 AM and 12:02 PM showed Resident 55 was lying in bed on their back and the air mattress was set up on 540 pounds weight. In an interview on 08/19/2024 at 10:26 AM, Staff J (Certified Nursing Assistant) stated they did not know anything about the air mattress setting and they did not change the setting. In an interview on 08/19/2024 at 10:30 AM, Resident 55 stated they always stayed in bed because they had wounds on their back and buttock areas. Resident 55 stated they were lying on their back in bed all the time because lying on their side hurt their leg. Resident 55 stated they did not want to use a pillow under their heels because that was painful for their legs. Review of the 08/20/2024 contracted wound care provider's progress note showed that all of Resident 55's wounds had deteriorated. In an interview on 08/20/2024 at 11:45 AM, Staff C (Regional Director of Clinical Operations) stated staff should follow the physician orders, CPs, and facility policies but they did not. REFERENCE: WAC 388-97-1060(3)(b).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42203 Based on observation, interview, and record review facility failed to maintain and environment that was free from accident hazards. The failure to: ensure appropriate supervision and storage of smoking materials for 1 of 2 sample residents (Resident 113) and 5 supplemental (Residents 135, 117, 54, 43, & 22) residents who smoked; failed to secure chemicals in 2 of 4 clean utility rooms; and failed to secure sharps in 1 of 4 clean utility rooms, placed residents at risk for smoking related injuries, accident hazards, and diminished safety. Findings included . <Smoking> <Facility Policy> Review of the facility's Smoking Policy revised June 2023 showed residents would be evaluated on admission to determine if they were a smoker or non-smoker. The evaluation would determine the resident's ability to smoke safely with or without supervision. This policy showed both independent smokers and residents assessed to require smoking supervision would not be permitted to keep cigarettes or other smoking materials in their possession. All smoking materials were to be locked with the activities department and after-hours nursing departments. <Resident 135> Review of the 07/11/2024 Admission Minimum Data Set (MDS - an assessment tool) showed Resident 135 did not have cognitive impairment, was understood, and could understand others in conversation. This MDS showed Resident 135 did not use tobacco products. Observation on 08/14/2024 at 10:19 AM showed Resident 135 lying in bed. A pack of cigarettes was observed at the foot of the bed. Observation on 08/16/2024 at 12:58 PM of the designated smoke break showed Resident 135 arrive to the smoke break. Resident 135 had their own cigarettes and lighter with them that they brought to the smoke break. Staff D (Smoking Aide) offered Resident 135 a smoking apron, Resident 135 refused the smoking apron stating they were not a baby and did not need a bib. At that time, Staff D stated Resident 135 always gave them a hard time stating one time, the resident threw the smoking apron over the fence. At the end of the smoke break, Resident 135 took their cigarettes and lighter with them, they were not collected by Staff D. Review of Resident 135's 08/05/2024 Smoking and Safety evaluation showed the resident used tobacco products, had balance problems while sitting or standing, and was an independent smoker. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 135's 08/05/2024 Risk vs. Benefit document showed the area of concern was for Resident 135 smoking off the facility property. This form showed the resident was aware they were responsible for any injuries sustained while smoking off property. This form showed the care plan needs section was left blank, and the form was not signed or dated by the resident. Review of the 08/09/2024 Center Smoking Policy Acknowledgement showed per the facility's smoking policy, tobacco products and fire materials were not allowed in resident rooms. Residents were to store tobacco products and fire materials at the nurse's station. This document was signed by Resident 135. <Resident 117> Review of the 05/14/2024 Admission MDS showed Resident 117 did not have cognitive impairment, was understood, and could understand others in conversation. Observation on 08/15/2024 at 8:58 AM showed Resident 117 in their room, sitting in their wheelchair. Resident 117 had a pack of cigarettes in their lap. Review of Resident 117's 08/16/2024 Smoking and Safety evaluation showed the resident used tobacco products. This assessment showed Resident 117 had balance problems while sitting or standing, limited or no range of motion in arms or hands, dropped ashes on themselves, and the resident followed the facility's policy on location and time of smoking. <Resident 54> Review of Resident 54's 07/17/2024 Quarterly MDS showed the resident did not have impaired cognition, was understood, and able to understand others in conversation. Observation on 08/14/2024 at 2:37 PM showed Resident 54 sitting in their wheelchair in their room. A pack of cigarettes was observed on Resident 54's lap. Resident 54 stated they smoked once per day and kept their cigarettes with them. Resident 54 stated staff kept the lighters. Review of Resident 54's 08/16/2024 Smoking and Safety evaluation (completed two days after Resident 54 was observed with cigarettes) showed the resident used tobacco products, had limited or no range of motion in arms or hands, dropped ashes on themselves, and the resident followed the facility's policy on location and time of smoking. Review of Resident 54's 08/16/2024 Risk vs. Benefits document showed the resident had associated risks for smoking on the facility's property. The document showed the facility would provide a smoking aide to assist the resident with smoking needs and if the resident was found smoking in their room, the facility would issue a 30-day discharge notice to Resident 54. This document was not signed or dated by the resident. Review of Resident 54's 08/14/2024 Risk vs. Benefits document identified risks if the resident smoked off the facility property. This document showed the resident was aware they could burn themselves and would take responsibility for damage to clothes or wheelchair. The document showed the resident was aware to return smoking items to the nurse or smoking aid. This document was not signed or dated by the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a 04/24/2024 Center Smoking Policy Acknowledgement showed tobacco products and fire materials were not allowed in resident rooms and residents were to keep their smoking materials at a designated location. This form was signed by Resident 54 on 05/05/2024. <Resident 43> Review of Resident 43's 08/06/2024 Admission MDS showed the resident did not have cognitive impairment, was understood, and could understand others in conversation. This MDS showed Resident 43 did not use tobacco products. Review of Resident 43's 08/08/2024 Smoking and Safety evaluation showed Resident 43 follow the facility's policy on location and time of smoking. Review of Resident 43's 07/31/2024 Acknowledgement of Smoking Risks document showed the resident understood and agreed that tobacco products and fire materials were not allowed in resident rooms and those materials were to be stored in a designated area. This agreement was signed by Resident 43. Observation on 08/16/2024 at 12:58 PM showed Resident 43 arrive to the facility smoke break. Resident 43 pulled their own lighter and cigarettes out of their coat pocket. At the end of the smoke break, Resident 43 put their smoking materials back in their coat pocket and left the designated smoking area. <Resident 22> Review of Resident 22's 08/14/2024 Smoking and Safety evaluation, the resident followed the facility's policy on location and time of smoking. Observation on 08/20/2024 at 1:00 PM at the designated smoke break time showed Resident 22 and Resident 54 already in the smoking area, smoking cigarettes, prior to the smoking aid arriving to supervise the smoke break. Resident 22 and Resident 54 had their own smoking supplies on them, and they were not wearing smoking aprons. <Resident 113> According to the 07/18/24 Quarterly MDS Resident 113 had a moderate memory impairment and diagnoses including anxiety, depression, and opioid use. Resident 113's 03/19/2024 Admission MDS showed the resident was not assessed to currently use tobacco. Record review showed an 08/14/2024 Tobacco Use Care Plan (CP). This CP had a goal for Resident 113 to adhere to the facility's smoking policy. Review of the 08/14/2024 Smoking and Safety Assessment showed Resident 113 was assessed to smoke tobacco products. The assessment showed Resident 113 had balance problems and would follow the facility's policy on smoking times and locations. The assessment did not indicate if Resident 113 was safe to smoke independently, or what, if any, supervision or assistance the resident needed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/15/2024 at 1:56 PM showed Resident 113 sleeping in their bed. A cigarette lighter was observed on the floor under Resident 113's over-the-bed table. In an interview on 08/20/2024 at 12:05 PM, Staff A (Administrator) stated all smoking supplies were to be kept with the smoking aid. Staff A stated residents were not to keep their smoking supplies on their person. 46479 43642 <Unsecured Chemicals> Observations on 08/14/2024 at 9:13 AM showed the janitor room on the first floor was unlocked. Inside the unlocked room was multiple bottles of chemicals sitting on top of a cabinet just inside the door. Two bottles of a disinfectant and one bottle of a glass cleaner were labeled, CAUTION, keep out of the reach of children. There was also a bottle of rubbing alcohol, a gallon of floor cleaner, an unlabeled spray bottle with 275 milliliters of a clear liquid, and a bottle of glass cleaner labeled, keep out of reach of children. On 08/14/2024 at 10:16 AM, observations showed a housekeeping staff enter the unlocked janitor room, put something inside, and then exit with the door remaining unlocked. In an interview on 08/14/2024 at 10:19 AM, Staff S (Unit Manager) confirmed the unlocked janitor door and chemicals and stated the door should be locked and secured for safety. Observation on 08/14/2024 at 9:26 AM showed the Second Floor-West clean utility room was unlocked. Within the clean utility room was a storage closet labeled emergency supplies that was also unlocked. On the top shelf of the emergency supply closet a bottle filled to the top with blue liquid had a labeled . Super Blue Mild Acid Bowl Cleaner dated 02/16/2024. The warning label printed on the back of the bottle showed Danger, could cause skin irritation and cause serious eye damage. A sign posted on the wall outside of the second-floor clean utility room that read eye wash station. Observation of the counter and sink area in the clean utility room showed there was no eye wash signs or solutions inside of the clean utility room. <Unsecured Sharps> Observations on 08/14/2024 at 9:50 AM showed the clean utility room on the first floor was unlocked. Inside the unlocked room was bins of supplies. One of the bins was full of shaving razors. In an interview on 08/14/2024 at 10:19 AM, Staff S (Unit Manager) confirmed the unlocked clean utility room door and the razors inside. Staff S stated there was supposed to be a code to unlock the door, but it had not worked since they were hired, almost two months earlier. Observations on 08/15/2024 at 8:16 AM and 08/19/2024 at 5:11 AM showed the clean utility room on the first floor was unlocked. Inside the unlocked room was the same bin full of shaving razors. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/21/2024 at 12:29 PM, Staff C (Regional Director of Clinical Operations) stated chemicals and razors should not be left unsecured as it could be a safety risk. REFERENCE: WAC 388-97-1060(3)(g). 50511

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 45941 Based on observation, interview, and record review the facility failed to ensure 2 of 4 residents (Residents 21 & 71) reviewed for bowel and bladder incontinence, received the care and services necessary to maintain and avoid loss of bowel and bladder functions. This failure placed the residents at risk for continued decline in bowel and bladder function, skin issues, and feelings of frustration and embarrassment. Findings included . <Resident 21> According to the 05/14/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 21 had impaired memory. The MDS showed Resident 21 required one person assistance with personal hygiene and had no rejection of care behavior during the assessment period. The MDS showed Resident 21 was occasionally incontinent of bowel and bladder. Observations on 08/15/2024 at 11:29 AM showed Resident 21 was lying in bed. Resident 21's room had a strong urine odor. Observation on 08/16/2024 at 10:24 AM showed Resident 21 out of their bed with their clothes wet with urine. Resident 21 went to the bathroom, changed their clothes and sat in a chair in their room. Resident 21's room had strong urine odor. In an interview on 08/16/2024 at 10:30 AM Staff U (Certified Nursing Assistant - CNA) stated Resident 21 was able to get to the bathroom in their room independently. Staff U stated Resident 21 used the bathroom during daytime but was incontinent of bladder at night. Review of the 02/17/2022 Bowel and Bladder Care Plan (CP) showed Resident 21 had frequent episodes of bladder incontinence and included directions to staff to complete a bowel and bladder assessment on admission, quarterly, and as indicated. Record review showed a bowel and bladder assessment was started for Resident 21 on 02/27/2024, but never completed. None of the questions in this assessment were answered. In an interview on 08/19/2024 at 11:00 AM, Staff I (Registered Nurse) stated Resident 21 was aware of their bladder needs and could get to the bathroom independently during the day and used briefs at night. Staff I stated Resident 21 did not want to get out of bed to use the bathroom at night. Staff I was unable to provide documentation showing staff assessed Resident 21's bladder needs at night or documentation showing staff offered assistance to the resident to use a bed side commode or the bathroom at night. Staff I stated Resident 21 would be a candidate for bladder training, but the facility did not assess the resident for bladder needs. 43642 <Resident 71> (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a 07/01/2024 Admission MDS, Resident 71 had clear speech, was understood, and usually able to understand others. This MDS showed staff assessed Resident 71 to require moderate assistance to roll side to side in bed, required substantial assistance from staff for sitting to standing and chair transfers, and was dependent on staff for toileting hygiene. Resident 71 had no rejection of care during the assessment period. In an interview on 08/15/2024 at 12:35 PM, Resident 71 stated they had a fall with fractures prior to admission to the facility. Resident 71 stated when they first got to the facility, they would ask staff for a bed pan for toileting. Resident 71 stated they got frustrated and stopped asking staff because staff would not bring it to them, and reported they just use briefs now. Review of the 06/25/2024 incontinent of bladder and bowel CP showed directions to staff to assist Resident 71 to the toilet, bedside commode, or bedpan as needed. The CP had interventions including completing a bladder and bowel assessment on admit, quarterly, and as indicted. The revised 07/02/2024 ADL function CP included an intervention to offer and assist Resident 71 to the toilet. Review of a 06/26/2024 Skilled Evaluation Assessment showed staff identified Resident 71 had urinary incontinence, but no further information was found on the form regarding incontinence frequency, if the incontinence was of new onset, or if the resident used briefs, toilet, bedpan, urinal, or a bedside commode for toileting. In an interview on 08/21/2024 at 9:40 AM, when asked what the process was for assessing a resident's incontinence and toileting needs, Staff S (Unit Manager) stated they did not complete an assessment for Resident 71. Staff S was unable to locate a bladder assessment for Resident 71. In an interview on 08/21/2024 at 12:29 PM, Staff C (Regional Director of Clinical Operations) stated their expectation was for bladder assessments to be completed on admission, quarterly, and as needed. Staff C stated the assessment should include the reason a resident was incontinent and what care equipment/supplies they required if they were incontinent. Staff C stated bladder assessments were important to evaluate a resident's function and maintain them at their highest level. REFERENCE: WAC 388-97-1060 (2)(a)(iii). 51149

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43642 Based on observation and interview, the facility failed to ensure medications were stored, labeled, and dated when opened and/or discarded when expired for 4 of 4 medication carts (100 Hall Cart 1, 200 Hall Cart 1, 200 Hall Cart 2, & 300 Hall Cart 1) and 2 of 2 medication rooms (Unit 200 East & Unit 200 West) observed. The failure to ensure unneeded medications and medical supplies were returned to the pharmacy or discarded when expired, medication refrigerators were monitored for appropriate temperatures, and medications were labeled for individual use placed residents at risk for ineffective treatment, expired medications, and contaminated medications Findings included . <Facility Policy> According to the facility's revised November 2020 Storage of Medications Policy, drugs and biologicals must be appropriately stored, including being locked and kept at the correct temperature. This policy showed nursing staff were responsible to ensure medication storage areas were clean. The policy showed discontinued, outdated, and deteriorated medications should be disposed of or returned to the pharmacy. The facility's August 2018 Storage of Medications Policy showed refrigerated medications should be stored between 36 - 46 Fahrenheit (F). <Medication Rooms> <200 East Medication Room> Observation of the 200 East Medication Room on 08/14/2024 at 9:10 AM showed an opened vial of a Tuberculosis skin testing agent that was labeled as opened on 07/08/2024, over 30 days prior. <200 [NAME] Medication Room> Observation of the 200 [NAME] Medication Room on 08/14/2024 at 10:30 AM showed the medication fridge had a temperature log. This log showed staff did not record the temperature from 08/05/2024 until 08/12/2024, for a total of seven days with no temperature recorded/monitored. <Medication Carts> <100 Hall Medication Cart 1> (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the 100 Hall Medication Cart 1 on 08/14/2024 at 11:15 AM showed the cart contained: a loose green pill at the bottom of a drawer; 29 pieces of nicotine gum that expired 02/2024; 141 25 Gauge (G) 1-inch needles that expired 05/01/2024; four 18 G 1.5-inch needles that expired on 07/01/2023; one 23 G 1-inch needle that expired on 02/01/2024; an open, undated tube of a pain/inflammation relieving gel, three containers of opened barrier cream that did not have resident names on them; six assorted opened skin ointments with no resident names; In an interview at that time, Staff CC stated all expired medications and supplies and/or unlabeled treatments should be removed from carts and discarded. <200 Hall Medication Cart 1> Observation of the 200 Hall Medication Cart 1 on 08/20/2024 at 11:00 AM showed: an opened bottle of stool softener with an expiration date of 03/11/2024; an opened, undated inhaler used to prevent/treat difficulty breathing for Resident 50; and a tube of antibacterial ointment that expired 07/2024. <200 Hall Medication Cart 2> Observation of the 200 Hall Medication Cart 2 on 08/14/2024 at 12:15 PM showed: five 18 G 1.5-inch needles that expired on 07/01/2023; 106 25 G 1-inch needles that expired on 05/01/2024; three 23 G 1-inch needles that expired on 02/01/2024. <300 Hall Medication Cart 1> Observation of the 300 Hall Medication Cart 1 on 08/14/2024 at 2:15 PM showed: 13 23 G 1-inch needles that expired on 02/2024; four 18 G 1.5-inch needles that expired on 07/01/2023; four 25 G 1-inch needles that expired on 05/01/2024; and 40 21 G 1-inch needles that expired on 04/02/2024. In an an interview on 08/14/2024 at 1:23 PM Staff B (Assistant Director of Nursing) stated expired medications, treatments, and supplies should be removed from medication rooms and carts. Staff B stated they expected medication refrigerator temperatures to be monitored nightly by staff. REFERENCE: WAC 388-97-1300(1)(b)(ii).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on observation, interview, and record review the facility failed to establish and maintain infection control practices that provide a safe and sanitary environment to help prevent the transmission of communicable diseases. The facility failed to: 1) perform Hand Hygiene (HH) during resident care and during dining service; 2) ensure staff used Personal Protective Equipment (PPE) for residents reviewed for Transmission Based Precautions (TBP); 3) identify and initiate Enhanced Barrier Precautions (EBP) for residents who required EBP precautions; 4) ensure staff disposed of contaminated gloves before entering the hallway. These failures placed residents at risk for the development and transmission of communicable diseases and related complications. Findings included . <Facility Policies> According to a facility's revised 06/08/2022 Infection Prevention and Control Program (IPCP) policy, the IPCP would utilize a system for prevention, identifying, reporting, investigating, and controlling infections, and communicable disease. The policy showed the program would provide infection surveillance to assist in identification of infections and communicable diseases before they can spread. According to a facility policy titled, Hand Hygiene, revised October 2023, the facility would consider HH the primary means to prevent the spread of healthcare-associated infections. HH would be performed before and after each resident's contact, before and after going to each resident's rooms, and after removing gloves. According to a facility policy titled, Isolation - Categories of TBP, revised September 2022, TBP would be initiated when a resident develops signs and symptoms of a transmissible infection and at risk for transmitting the infection to other residents and staff. This policy showed when a resident had an infection or was potentially infectious, the infection would be tracked, and interventions would be implemented to minimize the additional risks to the residents. The policy showed the facility would monitor for proper HH, use of PPE and TBP, and showed gloves would be removed before leaving resident's rooms. <Hand Hygiene> During an observation and interview on 08/15/2024 at 11:15 AM, Staff L (Certified Nursing Assistant - CNA) entered room [ROOM NUMBER] to bring the resident their lunch. Staff L was observed, without gloves, to move the over-the-bed table to the resident, assist the resident to sit up, and set their meal tray. Staff L exited room [ROOM NUMBER] without performing HH, collected the room [ROOM NUMBER] lunch tray from the meal cart and proceeded to room [ROOM NUMBER]. Staff L setup the lunch tray for the resident in room [ROOM NUMBER], bed 1. Staff L then collected room [ROOM NUMBER]'s lunch tray from the meal cart and brought the tray to room [ROOM NUMBER] without putting on gloves or performing HH, then cleared and moved the over-the-bed table over the resident, and setup their meal tray. Staff L then delivered the trays to the residents in room [ROOM NUMBER] without performing HH. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/15/2024 at 12:04 PM, Staff L stated they were supposed to perform HH before and after going to resident's rooms and providing care, but they did not sanitize or wash their hands because they were very busy. In an interview on 08/20/2024 at 12:00 PM Staff R (Infection Control) stated they expected staff to perform HH before entering a room or exiting a room, before and after resident contact, and between passing meals to residents. < Resident 37> Review of the Admission MDS dated [DATE], showed Resident 37 admitted to the facility on [DATE], with diagnoses including obstructive uropathy (a blockage causing Resident 37 trouble urinating). Observation on 08/14/2024 at 2:14 PM showed Resident 37 had a urinary catheter in place with the drainage tube extending from the bladder into a drainage bag. Observation on 08/20/2024 from 1:25 PM to 01:43 PM, showed Resident 37 sitting in a wheelchair while Staff G (CNA) washed their hands. Then Staff G put on gloves and a gown and prepared the supplies needed to assist with catheter care. Staff G then removed their gloves, washed their hands, put on clean gloves, and performed Resident 37's catheter care. Staff G finished catheter care and opened the bathroom door with the back of their hand while wearing the same (now soiled) gloves. Resident 37 entered the bathroom and Staff G assisted them to empty the catheter drainage bag into the toilet. Staff G then touched Resident 37's walker wearing the same soiled gloves. In an interview on 08/20/2024 at 3:57 PM, Staff R stated staff were expected to wash their hands after touching any resident. <Transmission Based Precautions> <room [ROOM NUMBER]> Observation on 08/14/2024 at 8:30 AM showed room [ROOM NUMBER]'s door had Contact Enteric Precautions sign. Contact Enteric Precaution sign was directed staff to wear gown and gloves before entering the room. Observations on 08/19/2024 at 10:46 AM showed Staff K (Registered Nursing Assistant - NAR) went to room [ROOM NUMBER] to provide care to the resident. Staff K was not wearing a gown while inside room [ROOM NUMBER], the door was open, and Staff K pulled the privacy curtain inside the room to assist the resident. In an interview on 08/19/2024 at 10:50 AM, Staff K stated they should have followed the sign posted outside the door to wear gown and gloves before entering the room, but they forgot to do so. In an interview on 08/20/2024 at 12:00 PM, Staff R stated they expected staff to follow the sign posted outside the door and wear gown and gloves prior to entering the room to prevent spreading the infection. <Resident 127> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/15/24 01:54 PM Resident 127 stated they had a stomach infection that was slowly improving. Review of a revised 08/06/2024 actual infection care plan showed Resident 127 was on contact enteric precautions for a contagious bacterial infection that causes nausea and diarrhea. Observations on 08/19/2024 at 7:30 AM showed Staff Y (CNA) delivering meal trays on the first floor. Staff Y carried a meal tray to room [ROOM NUMBER] and entered the room. At the door was a posted sign indicating the resident in the room was on contact enteric precautions (a set of measures used to prevent the spread of germs for infections that can be spread through contact with their fecal matter, vomit, or through contact with contaminated objects in their environment). The sign directed staff to perform hand hygiene and put on a gown and gloves prior to entering the room. The sign gave directions to wash hands with soap and water, rather than hand sanitizer, upon exit of the room. Staff Y did not put on the required personal protection equipment as directed by the sign. Staff Y set down the tray on the resident's overbed table, touched their television remote, and touched and moved their overbed table for the resident. After touching the potentially contaminated objects in the resident's environment, Staff Y left the room, and only used hand sanitizer before continuing to enter other resident rooms. Staff did not wash their hands with soap and water as directed by the posted sign. In an interview on 08/20/2024 at 3:57 PM, Staff R stated their expectation was for staff to follow the TBP precautions listed on the sign posted at the door. Staff R stated staff should always put their gown and gloves on prior to entering a room with contact enteric precautions, even to deliver meal trays. Staff R stated staff should wash their hands upon exit with soap and water, rather than sanitizer, to prevent the spread of infections to other residents. <Enhanced Barrier Precautions> Observation on 08/14/2024 at 10:02 AM showed a resident in room [ROOM NUMBER] bed 2 with a urinary catheter. There was no EBP sign posted on the door to instruct staff about the precautions. Observations on 08/14/2024 at 11:00 AM, on 08/15/2024 at 3:02 PM, and on 08/19/2024 at 9:04 AM showed Resident 96 (who had pressure ulcers - an open wound caused by pressure). There was no EBP sign posted on the door. Observations on 08/14/2024 at 11:05 AM, on 08/15/2024 at 3:05 PM, and on 08/19/2024 at 10:28 AM showed Resident 55 was lying in their bed. Resident 55 had a pressure ulcer. There was no EBP sign posted on the door. Observations on 08/14/2024 at 9:30 AM, on 08/15/2024 at 1:22 PM, and on 08/16/2024 at 11:25 AM showed a resident in room [ROOM NUMBER] bed one with a feeding tube providing liqud nutrition. There was no EBP sign posted on the door to instruct staff about the precautions. In an interview on 08/20/2024 at 10:55 AM, Staff R stated they were supposed to initiate EBP for residents with certain health statuses such as open wounds, feeding tubes, or catheters. Staff R stated EBP was necessary to help prevent the spread of infections. Staff R stated they did not but should have placed EBP signs outside the rooms of residents with conditions requiring EBP. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505017	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Care Center	2821 South Walden Street Seattle, WA 98144

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Staff Wearing Gloves in the Hallways> Observation on 08/15/2024 at 9:36 AM showed Staff L provided care to Resident 55 and walked out from the room with two bags of dirty linens. Staff L was wearing gloves in the hallways while went to the dirty utility to drop the dirty linens. Observation on 08/15/2024 at 10:04 AM showed Staff U (CNA) was walking in the hallways with bag of dirty linens towards the dirty utility room to drop the dirty linens. Staff U was wearing gloves in the hallways. In an interview on 08/15/2024 at 10:08 AM, Staff U stated they would remove the gloves and walked away. In an interview on 08/20/2024 at 12:05 PM, Staff R stated they expected staff not to wear gloves in the hallways. REFERENCE: WAC 388-97-1320 (1)(a), -1320 (2)(b), -1320 (1)(c). 42203 43642 51149