STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505033	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2024
NAME OF PROVIDER OR SUPPLIER: Rockwood South Hill		STREET ADDRESS, CITY, STATE, ZIP CODE: East 2903 25th Avenue, Spokane, WA 99223	

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to notify the physician and the resident representative of a change in condition experienced by 1 of 5 sampled residents (Resident 15) reviewed for unnecessary medications. This failure placed the resident at risk for delayed decisions for treatment by the legal representative and the physician/practitioner. Findings included . Review of an 08/08/2024 quarterly assessment showed Resident 15 admitted to the facility on [DATE] with medically complex conditions, to include high blood pressure (BP) and arrhythmia (an irregular heartbeat). This assessment showed Resident 15 had severe cognitive impairment. The medical record showed Resident 15 had an appointed power of attorney (POA) for healthcare. According to the National Heart, Lung and Blood Institute (NIH), a normal BP is less than 120 systolic (the top number in a BP reading) pressure and less than 80 diastolic (the lower number in a BP reading) pressure. The NIH defined a hypertensive crisis (a medical emergency) as a higher than 180 systolic pressure or higher than 120 diastolic pressure and to, Contact your provider immediately. A hypertensive crisis can lead to life-threatening health problems, like a heart attack or stroke. Review of the November 2024 Medication Administration Record (MAR) showed an as needed order for Hydralazine every 6 hours since 02/28/2024, if the staff assessed Resident 15's systolic BP was greater than 160. Review of a 10/23/2024 2:56 PM progress note showed that after the staff showered Resident 15, the resident, stopped engaging with staff and other residents and Right side of bottom lip was slightly drooped. Resident was able to answer questions but took some time to respond and seemed to stare off into the distance. The staff assessed the resident, Appeared lethargic throughout shift. A subsequent 7:14 PM progress note showed Resident 15 was sleeping on afternoon shift and it was difficult for the staff to rouse the resident. When the bedtime medication pass arrived, the nurse documented the resident took a small amount of medication but spat them out again and that, This is concerning because res [resident] BP is elevated at 194/95. The staff documented they notified Staff C and D (both Resident Care Manager, RCM). Review of the October 2024 MAR showed the staff administered the as needed Hydralazine order at 7:36 PM. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505033	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2024
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a subsequent 10/23/2024 9:04 PM note, the nurse documented that after Resident 15 was in bed, the resident took only one medication from the nurse, the as needed Hydralazine, as their BP remains high. The nurse showed they assessed Resident 15's BP slightly lower at 189/89. Record review showed no documentation the staff notified the provider or the resident's representative of the ineffective Hydralazine dose, or the continued elevated BP. Record review showed no additional progress notes that supported the staff monitored Resident 15's status to ensure no adverse effects from the elevated blood pressures, until 10/24/2024 at 9:59 AM, 12 hours later. The above findings were shared with Staff C on 12/09/2024 at 9:25 AM. Staff C acknowledged the lack of physician and POA notification and stated that if the nurse identified the as needed Hydralazine was ineffective, they expected the nurse to, call the doctor and see what else we can do and let them know of all the interventions attempted and notify the POA. Reference WAC 388-97-0320.

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	505033	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockwood South Hill	East 2903 25th Avenue Spokane, WA 99223

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 40297 Based on interview and record review, the facility failed to provide the required beneficiary notices for 2 of 3 sampled residents (Resident 1 and 83) reviewed for required notices and associated choices related to Medicare services ending. This failure placed the residents at risk of not being fully informed of the potential cost of continued services. Findings included . Review of the Skilled Nursing Facility (SNF) Advanced Beneficiary Notice (ABN) form showed it provided information to Medicare beneficiaries so that they could decide if they wished to continue receiving the skilled services that might not be paid for by Medicare and assume financial responsibility. The form was required when a resident had skilled benefit days remaining, was being discharged from Medicare Part A services, and continued living in the facility. <Resident 83> Review of a Notice of Medicare Non-Coverage (NOMNC) form showed Resident 83's last day of Medicare Part A services ended on 08/22/2024. The resident discharged from the facility on 09/04/2024. Record review showed no documentation the facility provided a SNF ABN to Resident 83. The facility explained on a SNF Beneficiary Notification Review Form the reason for no provision of the SNF ABN Form to Resident 83 was because the resident, utilized [their] ten free contract days then discharged . <Resident 1> Review of a NOMNC form showed Resident 1's last day of Medicare Part A services ended on 06/07/2024. Record review showed Resident 1 currently resided in the facility. Record review showed no documentation the facility provided a SNF ABN to Resident 1. The facility explained on a SNF Beneficiary Notification Review Form the reason for no provision of the SNF ABN Form to Resident 1 was because the resident utilized [their] 10 free days contract SNF agreement with cost. On 12/09/2024 at 3:36 PM, the SNF Beneficiary Notification Review forms were reviewed with Staff B, Director of Nursing. Staff B stated that the SNF ABN were not given to Residents 1 and 83, because of this contract with the retirement community of 10 free days that is in their SNF agreement with cost. They know very well what their costs are. No further information was provided. Reference WAC 388-97-0300(1)(e), (5), (6).

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to implement their Abuse and Neglect Prohibition Policies and Procedures to include, not reporting or investigating elopement episodes and the discovery of a skin injury for 1 of 2 sampled residents (Resident 30) reviewed for accident hazards. This failure placed the resident at risk for repeated elopement and precluded the state agency (SA) from being aware of and investigating the circumstances surrounding the resident's elopements and skin injury. Findings included . Review of a 2019 facility policy titled Abuse, Neglect and Exploitation showed, the facility provided protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibited and prevented abuse, neglect, exploitation and misappropriation of resident property. The policy showed the facility completed an immediate investigation when suspicion of or actual abuse, neglect or exploitation occurred. The policy showed the facility identified and interviewed all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations and focused the investigation on determining if abuse, neglect, exploitation, and/or mistreatment occurred, the extent, and cause. The policy instructed the staff to provide a complete and thorough documentation of the investigation. The reporting time frame of all alleged violations to the Administrator, state agency (SA), and to all other required agencies was immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury. The policy instructed the facility Administrator to follow up with government agencies to confirm the initial report was received and report the results of the investigation within five working days of the incident as required by SA. Review of Appendix D in the October 2015 Nursing Home Guidelines (The Purple Book) showed, it instructed the facility to log elopements or a missing resident in the SA Log within five days of event discovery. Review of a 10/31/2024 comprehensive admission assessment showed Resident 30 admitted to the facility on [DATE] with a traumatic brain injury, restlessness and agitation, and Parkinson's disease (a progressive neurological disorder). This assessment showed the staff assessed Resident 30 had severe cognitive impairment. Review of a 10/29/2024 progress note showed that after the staff got res [resident] up to chair, the resident disappeared, and that Resident 30 was supposed to have wonder guard [sic] in place but may have removed it and was able to go all the way to [their] apartment on the 4th floor [an independent living area not associated with the skilled nursing unit]. The note showed the staff placed a new wonder guard [sic] on the resident's wheelchair to prevent wandering outside the unit. A WanderGuard system relied on a bracelet worn by the resident, sensors that monitored doors, and a technology platform that sent safety alerts to the staff in real time. When a resident with a bracelet approached a monitored door, the system alerted the staff. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility October 2024 SA Reporting Log showed no documentation the facility reported the event to the SA or investigated the circumstances of Resident 30's disappearance from the unit to determine the extent and cause of the elopement and if abuse or neglect contributed to the event. Review of a 10/31/2024 progress note showed the staff observed Resident 30 packed their belongings, looked for an exit, and used their walker for mobility. This note showed the staff identified, an open skin tear on the side of the resident's elbow approximately half a centimeter (a measurement) in diameter, not currently bleeding. Review of the facility SA Reporting Log showed no documentation the facility reported the event to the SA, investigated the circumstances and cause of Resident 30's skin tear, or determined if abuse or neglect contributed to the event. Review of an 11/18/2024 progress note showed the staff observed Resident 30 exit seeking most of shift. managed to get off unit via fireside door and was found wandering around at Rocky's [a cafe inside the building but separate from the unit] and returned to unit with friend who came to visit and was able to find [the resident]. Staff added that Resident 30, again escaped and was found by the dumpster downstairs near maintenance office. Review of the facility November 2024 SA Reporting Log showed no documentation the facility reported the event to the SA or investigated the circumstances of Resident 30's elopement from the unit twice on 11/18/2024, determine the extent and cause of the elopements, or if abuse or neglect contributed to the events. The above findings were shared with Staff B, Director of Nursing, on 12/09/2024 at 11:51 AM. Staff B acknowledged the elopement events and skin injury were not investigated or reported to the SA. No further information was provided. Reference WAC 388-97-0640(2). .

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 46115 Based on interview and record review, the facility failed to ensure a resident's medical record contained documentation of a transfer to the hospital, or that the receiving hospital had received information of the resident's condition, for 2 of 2 sampled residents (Residents 24 and 22), reviewed for hospitalization . This failure placed the resident at risk for a delay in treatment and unmet care needs. Findings included . Per the 10/31/2024 admission assessment, Resident 24 had diagnoses which included high blood pressure, heart failure and thrombocytopenia (abnormally low platelets in the blood). A 11/26/2024 progress note showed the resident was assessed, due to complaints of pain. Resident 24 was weak, lethargic and had a blood pressure of 76/52. The resident's family member was notified, and the resident was sent to the hospital. A review of Resident 24's record showed no order was obtained to send the resident to the hospital or that information had been communicated to the receiving hospital. A 12/04/2024 progress note showed the resident was assessed, due to complaints of pain. Resident 24 had chest and upper abdominal pain. The resident and their family member had decided Resident 24 needed to go to the hospital. A review of Resident 24's record showed no order was obtained to send the resident to the hospital or that information had been communicated to the receiving hospital. In an interview on 12/09/2024, Staff C, Resident Care Manager (RCM), stated a transfer form was completed when a resident was transferred to the hospital, and it was a part of their medical record. During an interview on 12/09/2024 at 8:33 AM, Staff B, Director of Nursing, stated the expectation was for nursing staff to call the hospital and give report on the resident's condition. Staff B confirmed there was no documentation to show that the hospital had been informed of Resident 24's condition. 50027 <Resident 22> Per the 08/22/2024 discharge assessment, Resident 22 had diagnoses which included sepsis (a life-threatening complication of infection) and Dementia. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An 08/22/2024 progress note showed Resident 22 had vomited a moderate amount of undigested food throughout the day and complained of abdominal pain. The resident's oxygen level was at 79-85% on room air afterwards. Resident 22's family was notified, and the resident was sent to the hospital with no physician orders. A review of Resident 22's record showed no order was obtained to send the resident to the hospital on 08/22/2024 or that information had been communicated to the receiving hospital. In an interview on 12/09/2024 at 11:14 AM, Staff D, RCM, stated that a transfer form should have been sent with Resident 22 to the hospital. Staff D confirmed there was no documentation that showed the receiving hospital had been informed of the resident's condition. Reference WAC 388-97-0120.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 46115 Based on interview and record review, the facility failed to ensure the Office of the State Long-Term Care Ombudsman received written notification of a hospital transfer, for 2 of 2 sampled residents (Resident 24 and 22), reviewed for hospitalization /discharge. This failure placed the resident at risk of not having access to additional advocacy services from the State Long-Term Care Ombudsman. Findings included . The 11/26/2024 discharge assessment documented Resident 24 was cognitively intact to make decisions regarding their care and had diagnoses which included heart failure, pneumonia (an infection that inflames air sacs in one or both lungs) and thrombocytopenia (abnormally low platelets in the blood). Review of Resident 24's record showed an 11/26/2024 nursing progress note which documented the resident had experienced pain, was lethargic and had a low blood pressure. Additional record review found no documentation that showed the State Long-Term Care Ombudsman had been notified of the resident's transfer to the hospital. A 12/04/2024 progress note showed the resident had chest and abdominal pain and was sent to the hospital. Additional record review found no documentation that showed the State Long-Term Care Ombudsman had been notified of the resident's transfer to the hospital. In an interview on 12/09/2024 at 9:59 AM, Staff J, Medical Records, stated the nurses kept a log of residents who discharged and notified the Ombudsman. During an interview on 12/09/2024 at 10:02 AM, Staff C, Resident Care Manager, stated they were sure Medical Records notified the Ombudsman of resident discharges. In an interview on 12/09/2024 at 10:06 AM, Staff B, Director of Nursing, stated the Ombudsman should have been notified of the resident's discharges to the hospital. 50027 <Resident 22> Per the 08/22/2024 discharge assessment, Resident 22 was not cognitively intact to make decisions regarding their care and had diagnoses which included sepsis (a life-threatening complication of infection) and Dementia. Review of Resident 22's record showed an 08/22/2024 progress note documented the resident had experienced vomiting, abdominal pain and below normal oxygen levels. Additional record review found no documentation that showed the State Long-Term Care Ombudsman had been notified of the resident's transfer to the hospital. Reference WAC 388-97--0120 (2)(a-d) -0140 (1)(a)(b)(c)(i-iii).

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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. 46115 Based on interview and record review, the facility failed to provide a bed-hold notice, a notice that informed the resident of their right to pay the facility to hold their room/bed while they were hospitalized , to the resident and/or their representative at the time of discharge, or within 24 hours of transfer to the hospital, for 2 of 2 sampled residents (Resident 24 and 22), reviewed for hospitalization . This failure placed the residents at risk for a lack of knowledge regarding the right to a bed-hold, while they were hospitalized . Findings included Per the 10/31/2024 admission assessment, Resident 24 had diagnoses which included high blood pressure, heart failure, thrombocytopenia (abnormally low platelets in the blood), was cognitively intact and able to make decisions regarding their care. Review of Resident 24's record showed an 11/26/2024 nursing progress note which documented the resident had experienced pain, was lethargic and had a low blood pressure. The resident was assessed and was sent to the hospital for evaluation. Additional record review found no documentation that showed the resident had been provided a bed-hold notice as required. A 12/04/2024 progress note showed the resident had chest and abdominal pain and was sent to the hospital. Additional record review found no documentation that showed the resident had been provided a bed-hold notice as required. In an interview on 12/09/2024 at 8:33 AM, Staff B, Director of Nursing, stated bed holds were offered upon admission in the admission agreement. Staff B stated the form was not offered every time a resident was sent to the hospital, as required. 50027 <Resident 22> Per the 08/22/2024 discharge assessment, Resident 22 had diagnoses which included sepsis (a life-threatening complication of infection) and Dementia. Review of Resident 22's record showed an 08/22/2024 progress note documented the resident had experienced vomiting, abdominal pain and below normal oxygen levels. The resident was assessed and sent to the hospital for evaluation. Additional record review found no documentation that showed the resident had been provided a bed-hold notice as required. Reference WAC 388-97-0120 (4).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on observation, interview and record review, the facility failed to develop comprehensive person-centered care plans to address all aspects of care for 4 of 16 sampled residents (Resident 15, 19, 24 and 8) whose care plans were reviewed. Failure to address the individualized needs of each resident placed them at risk for inadequate care and a diminished quality of life. Findings included . <Resident 15> Review of an 08/08/2024 quarterly assessment showed Resident 15 admitted to the facility on [DATE] with medically complex conditions, to include high blood pressure (BP) and arrhythmia (an irregular heartbeat). Review of the November 2024 Medication Administration Record (MAR) showed the staff administered the medications amlodipine for high BP since 05/15/2024, hydrochlorothiazide for both high BP and edema (fluid retention) since 10/23/2024, and an as needed order for Hydralazine every six hours since 02/28/2024, if the staff assessed Resident 15's systolic (the top number in a BP reading) BP was greater than 160. Review of Resident 15's BP showed the staff obtained multiple readings with a systolic BP above 160 (10/04/2024, 10/06/2024, 10/08/2024, 10/25/2024, 10/26/2024, 11/05/2024, 11/09/2024, 11/12/2024, 11/24/2024, and 11/30/2024). Review of Resident 15's medical record showed no documentation the facility developed a care plan to include the active diagnoses of high BP and arrhythmia. In an interview on 12/09/2024 at 9:27 AM, Staff C, Resident Care Manager (RCM), acknowledged a care plan for active and currently treated diagnoses of high BP and arrhythmia was not but should have been developed. <Resident 19> Review of an 08/30/2024 quarterly assessment showed Resident 19 admitted to the facility on [DATE] with medically complex conditions to include Alzheimer's disease. The staff assessed Resident 19 had severe cognitive impairment. Review of the November 2024 MAR showed the staff administered Melatonin Oral Tablet daily as a supplement. Review of the expanded physician orders showed the Melatonin was for sleep aid since 07/11/2024. In an interview on 12/09/2024 at 8:34 AM, Staff D, RCM, stated that if a resident is on a medication for sleep, It probably needs to have a care plan for it. Staff D acknowledged Resident 19's comprehensive care plan did not but should have included a resident-centered care plan for sleep disturbance. 46115 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 24> Per the 10/31/2024 admission assessment, Resident 24 had diagnoses which included high blood pressure, heart failure and thrombocytopenia (abnormally low platelets in the blood, increasing risk of bruising and bleeding). The resident was cognitively intact and needed supervision to touching assist with transfers and ambulation. In an observation on 12/03/2024 at 8:10 AM, Resident 24 was sitting in their wheelchair, and wore a short-sleeved shirt and had significant bruising on bilateral arms. Resident stated the bruising was related to their low platelet count. A review of the 12/03/2024 comprehensive care plan showed there was no care plan interventions for Resident 24's fragile skin related to their diagnosis of thrombocytopenia. In an interview on 12/09/2024 at 8:01 AM, Staff K, Licensed Practical Nurse, stated residents that were high risk for bruising and bleeding were given protective sleeves to wear, lambs wool for their wheelchairs, pads on the floor, and instruction to the staff would be found in the care plan. When Staff K was asked if Resident 24 had any interventions in place to protect their arms, they stated they did not think so. In an interview on 12/09/2024 at 8:27 AM, Staff C, RCM, stated interventions for residents that were high risk for bruising and bleeding included gentle care and protective or long sleeves. When asked if Resident 24 had interventions in place to protect them, they stated no they do not. During an interview on 12/09/2024 at 8:33 AM, Staff B, Director of Nursing, stated residents with fragile skin were monitored, and wore protective or long sleeves. Staff B stated there should have been interventions in the care plan to address Resident 24's skin and need for gentle care. 50027 <Resident 8> Per the 10/01/2024 quarterly assessment, Resident 8, had diagnoses which included Alzheimer's Disease and bilateral hearing loss. The resident was moderately cognitively impaired, had moderate difficulty with hearing and understood others when wearing their hearing aids. A review of the 03/25/2024 comprehensive care plan showed no documentation related to Resident 8's hearing loss. In an observation on 12/04/2024 at 11:18 AM, Resident 8 was in the dining room and did not wear their hearing aids. Staff G, Nursing Assistant, loudly spoke directly into the resident's ear, asking them to order food options for lunch. Resident 8 looked perplexed and did not answer. Staff G then decided to choose the resident's food options for them. Staff G did not inquire about Resident 8's hearing aids and no visual aid i.e. menu was provided. Subsequent observations were made of Resident 8 without their hearing aids being worn were made on: 12/05/24 at 07:33 AM and 11:05 AM. On 12/06/2024 at 12:08 PM, the resident was only wearing their right hearing aid. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/09/2024 at 9:15 AM, Resident 8 stated that it was important for both of their hearing aids to work because they wore them daily and cannot hear without them. The resident stated that their hearing aids do not work properly when they do not remember to charge them. Resident 8 stated the nursing staff does not help with managing their hearing aids daily. During an interview on 12/09/2024 at 02:19 PM, Staff N, Nursing Assistant, confirmed via review of the individual service plan that there were no interventions in place related to Resident 8's hearing aids. In an interview on 12/09/2024 at 2:39 PM, Staff D, Resident Care Manager, confirmed that Resident 8's care plan showed no documentation addressing their hearing device. Staff D stated that it was important for the resident to have interventions in place for their hearing loss due to maintaining their communication skills and quality of life. Reference WAC 388-97-1020(1), (2)(a)(b).

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NAME OF PROVIDER OR SUPPLIER Rockwood South Hill		STREET ADDRESS, CITY, STATE, ZIP CODE East 2903 25th Avenue Spokane, WA 99223	

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to implement a physician order for the treatment of elevated blood pressures for 1 of 5 sampled residents (Resident 15) reviewed for unnecessary medications. This failure placed the resident at risk for a negative outcome from a high blood pressure. Findings included . Review of an 08/08/2024 quarterly assessment showed Resident 15 admitted to the facility on [DATE] with medically complex conditions, to include high blood pressure (BP) and arrhythmia (an irregular heartbeat). Review of the November 2024 Medication Administration Record (MAR) showed an as needed order for Hydralazine every 6 hours since 02/28/2024, if the staff assessed Resident 15's systolic (the top number in a BP reading) BP was greater than 160. Review of Resident 15's medical record showed the staff obtained multiple readings with a systolic BP above 160 (10/04/2024, 10/06/2024, 10/08/2024, 10/24/2024, 10/25/2024, 10/26/2024, 11/05/2024, 11/09/2024, 11/12/2024, 11/24/2024, and 11/30/2024). Review of the October and November 2024 MAR showed no documentation the staff implemented the physician order to administer the as needed Hydralazine for a systolic BP over 160. The above findings were shared with Staff C, Resident Care Manager, on 12/09/2024 at 9:25 AM. Staff C confirmed there was no documentation to show the staff implemented the physician order for the as needed Hydralazine and stated that the staff should have administered the as needed Hydralazine because [the BPs] are all over 160. Staff C acknowledged the medical record showed no instruction that cued the staff if or when Resident 15 required an as needed dose of hydralazine every six hours and that the order required clarification. Reference WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 46115 Based on observation, interview, and record review, the facility failed to consistently provide grooming for 1 of 2 sampled residents (Resident 25), reviewed for activities of daily living (ADL's). This failure placed the resident at risk for not being groomed according to their preferences, and a diminished quality of life. Findings included . According to the 10/18/2024 quarterly assessment, Resident 25 was cognitively impaired and needed partial to moderate assistance from staff for ADL's, such as personal hygiene. Per the 04/11/2024 care plan, Resident 25 needed assistance with personal hygiene. Review of the personal hygiene task from 11/10/2024 through 12/13/2024 documented Resident 30 had their facial hair removed on 11/10/2024, 11/17/2024, 11/22/2024 and 12/08/2024 and had not refused cares. In an observation on 12/03/2024 at 9:11 AM, Resident 25 was sitting in their wheelchair and had hair on their chin that was approximately a centimeter long. Subsequent observations of Resident 25 with hair on their chin were made on 12/04/2024 at 07:38 AM, 10:25 AM, and 2:33 PM, 12/05/2024 at 7:31 AM, and 12/06/2024 at 7:05 AM. In an interview on 12/09/2024 at 9:03 AM, Staff L, Nursing Assistant, stated shaving was completed when needed. During an interview on 12/09/2024 at 10:10 AM, Staff B, Director of Nursing, stated facial hair was removed during bathing and it was a dignity issue if it was not completed. Reference: WAC 388-97-1060 (2)(c)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to follow up on a resident's request to change their code status (level of intervention a resident chooses if their heart or breathing stops) for 1 of 1 sampled resident (Resident 17) reviewed for Cardiopulmonary Resuscitation (CPR, the act of performing chest compressions and providing breaths to mimic heartbeat and breathing). This failure placed Resident 17 at risk to have CPR initiated when their legal representative requested to change their code status to No CPR. Findings included . Review of a [DATE] quarterly assessment showed Resident 17 admitted to the facility on [DATE] with medically complex conditions. This assessment showed Resident 17 had severe cognitive impairment and the family participated in the completion of this assessment. Review of a [DATE] progress note showed the facility held a care conference for Resident 17. Present in the care conference were several members of the facility and the resident's family, to include their Power of Attorney (POA, legal representative). In this care conference, the facility discussed the resident's POLST form (Physician Order for Life-Sustaining Treatment, an order for the specific treatments desired during a medical emergency). The note showed the facility changed Resident 17's code status from CPR/Full treatment to Do Not Resuscitate/Selective Treatment. The note said the new POLST form was signed by the POA and selections marked. The progress note showed the facility faxed the POLST form to the provider for their signature. Review of the medical record showed a [DATE] POLST form scanned in the electronic medical record. This POLST form showed the code status was full CPR and full treatment, contrary to the [DATE] decision made by the POA for a Do Not Resuscitate/Selective Treatment choice. Additionally, the resident identifier section of the electronic medical record (EMR) directed the staff that Resident 17's code status was CPR. On [DATE] at 8:08 AM, Staff M, Registered Nurse, was asked to explain how they identified a resident's code status. Staff M stated that, We put the code status on a piece of paper, on the roster. When Staff M showed the surveyor the resident roster, it showed no code status of any resident and Staff M stated, Most everybody is a DNR [Do Not Resuscitate] here but I would start rescue breathing and CPR until confirmed with the [CPR] book. Staff M stated that the CPR book was located at the Nurses Station and a resident's code status could also be confirmed in the EMR. Staff M located Resident 17's POLST, dated [DATE], in the CPR book which directed the staff to start CPR in the event the staff found Resident 17 without a pulse and not breathing, contrary to the choice made by the POA on [DATE]. Staff M confirmed the EMR also instructed the staff to start CPR. The above findings were shared with Staff C, Resident Care Manager, on [DATE] at 9:44 AM. Staff C acknowledged the code status in the electronic medical record and POLST did not reflect the choice made on [DATE] by Resident 17's POA. Reference WAC [DATE] (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. 40297 Based on interview and record review, the facility failed to ensure the staff implemented the bowel protocol for the management of constipation for 3 of 5 sampled residents (Resident 14, 28, and 30) reviewed for unnecessary medications and monitor non-pressure injury and a fall with injury for 1 of 2 sampled residents (Resident 30) reviewed for accidents. These failures placed the residents at risk for unmet needs and complications from constipation and injuries. Findings included . 50027 According to the Bowel Protocol policy, dated 04/22/2019 (reviewed on 12/06/2024, staff was to initiate the following procedures on a regular basis for the resident to ensure adequate function and/or need for intervention: 1. Give Lax Loaf (type of laxative given by mouth) daily as needed 2. Give Milk of Magnesia (MOM, type of laxative given by mouth) on the evening of the second day if no bowel movement (BM). 3. Administer Dulcolax (Bisacodyl, a suppository laxative inserted rectally) on the night shift of the third day if no BM. <Resident 14> Per the 08/27/2024 quarterly assessment, Resident 14 had diagnoses including neurogenic bladder (a condition that causes bladder control issues due to nerve, spinal cord or brain problems) and Dementia. The resident was frequently incontinent of bowel and bladder and required maximum assistance with toileting. Review of the November 2024 Medication Administration Record (MAR) documented on 05/21/2024, the physician had ordered a laxative (Lax Loaf) to be offered daily for constipation and an additional laxative (Milk of Magnesia) to be given on evening shift of the second day if the resident had not had a BM. There was no physician's order documented for medication to be given on the third day if the resident did not have a BM. Review of the bowel records from 11/06/2024 through 12/05/2024, showed Resident 14 had no BM's from 11/10/2024 through 11/12/2024 (3 days), 11/20/2024 through 11/21/2024 (2 days) and 11/23/2024 through 11/24/2024 (2 days). Additional review of the November 2024 MAR showed no documentation that Resident 14 received bowel medications as ordered during the above time frames and no documentation was found in their record that stated the reason for omission of the medications listed in the bowel protocol. (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 12/09/2024 at 1:37 PM, Staff D, Resident Care Manager (RCM), confirmed Resident 14 did not have a BM on the above dates and the bowel protocol should have been followed. <Resident 28> Per the 10/09/2024 admission assessment, Resident 28 had diagnoses including urinary tract infection and Dementia. The resident was dependent with toileting and occasionally incontinent of bowel and bladder. Review of the November to December 2024 Medication Administration Records (MARs) documented on 10/03/2024, the physician had ordered a laxative (Lax Loaf) to be offered daily for constipation, an additional laxative (Milk of Magnesia) to be given on evening shift of the second day if the resident had not had a BM and a suppository laxative (Dulcolax) to be given on the night shift of the third day if the resident had not had a BM. Review of the bowel records from 11/07/2024 through 12/05/2024, showed Resident 28 had no BM's from 11/10/2024 through 11/13/2024 (4 days), 11/25/2024 through 11/27/2024 (3 days),11/29/2024 through 12/01/2024 (3 days) and 12/03/2024 through 12/05/2024 (3 days). Additional review of the November to December 2024 MARs showed no documentation that Resident 28 received laxatives as ordered during the required time frames. In an interview on 12/09/2024 at 11:26 AM, Staff D confirmed Resident 28 did not have a BM on the above dates and the bowel protocol should have been followed. Staff D stated that this was important so that residents do not get constipated, or develop associated complications. bowel blockages and/or further medical complications. <Resident 30> Review of Bowel Records between 11/04/2024 to 12/05/2024 showed the staff did not identify Resident 30 experienced a BM on 11/10/2024, 11/11/2024, and 11/12/2024. Review of the November 2024 MAR showed a physician order that instructed the staff to administer Magnesium Hydroxide Suspension (MOM) orally as needed for constipation on evening shift of 2nd [second] day no BM. The orders also instructed the staff to administer a Dulcolax as needed for constipation, on night shift of 3rd [third] day no BM. Review of the November 2024 MAR showed no documentation the staff implemented the orders to address Resident 30's absence of bowel movements on day two (11/11/2024) and three (11/12/2024). The above findings were shared with Staff C, RCM, on 12/09/2024 at 9:38 AM. Staff C acknowledged the staff did not implement the orders to address the absence of bowel movements on days two and three. Staff C stated that they expected the nurses to offer the laxative to Resident 30 and, I don't see anything in [their] notes to show the staff implemented the bowel protocol as ordered. <Monitoring After a Fall and Skin Injury> (continued on next page)

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	505033	A. Building B. Wing	12/09/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a 10/31/2024 progress note showed the staff observed Resident 30 packed their belongings, and is looking for an exit. The note showed the staff assessed Resident 30 had, an open skin tear on the side of their right elbow, that measured approximately .5 cm [centimeter, a unit of measurement] in diameter, not currently bleeding. Review of the medical record showed no additional documentation the staff monitored the status of the skin tear. Review of a November 2024 facility reporting log showed Resident 30 sustained a fall with injury on 11/17/2024. Review of an 11/17/2024 associated investigation showed the 11/17/2024 fall was witnessed. The investigation showed the staff assessed Resident 30 had an abrasion up [their] back. No measurement or description of the abrasion were included. Review of the progress notes showed no documentation the fall occurred, the type and extent of the abrasion, or subsequent monitoring of the fall for any latent effects or the abrasion. The above findings were shared with Staff B, Director of Nursing, on 12/09/2024 at 11:43 AM. Staff B confirmed the staff failed to show documentation they monitored Resident 30 when they identified a skin tear and witnessed a fall with injury. Staff B stated that they expected the staff to show documentation in the medical record they monitored the resident after the fall with injury or identification of the skin tear for at least 72 hours after the incident discovery. Reference WAC 388-97-1060 (1).

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 46115 Based on observation, interview, and record review, the facility failed to assess the need for restorative services (a program available in nursing homes that helps residents maintain any progress they've made during therapy treatments or enables them to function at their highest capacity), for 1 of 1 sampled residents (Resident 7), reviewed for range of motion. This failure placed the resident at risk for a further decline in range of motion, due to limitations in their lower extremities and unmet care needs. Findings included . A 10/20/2024 significant change assessment documented Resident 7 had diagnoses including dementia and abnormalities of gait and mobility (the way a person walks and moves around). Per the assessment, the resident had impaired range of motion to their lower extremities, needed substantial to total assistance to complete activities of daily living (ADL), and received physical and occupational therapy. A 10/15/2024 physical therapy evaluation showed Resident 7 was hospitalized from 10/09/2024 through 10/14/2024 and needed therapy related to new or worsened neuromuscular impairments (a range of motion disease that affected the peripheral nervous system which controls muscles and sensory information), high tone (a condition in which there is too much muscle tone so that arms or legs are stiff and difficult to move) in bilateral lower extremities, and limitations to their knees, hips and ankles. An 11/01/2024 discharge therapy note stated Resident 7 had range of motion impairments to their bilateral ankles and feet. Further record review did not show the resident had been assessed or referred for restorative services, to determine if the range of motion in their bilateral lower extremities could prevent further decline, despite the physical therapy evaluation identifying Resident 7 having impairments. A review of Resident 7's current care plan did not show interventions related to the limitations of their lower extremities, or directions for the provision of range of motion/restorative exercises. On 12/04/2024 at 10:27 AM, Resident 7 was observed sitting in their wheelchair in the dining room. The resident had their legs stretched out under the table and their left foot was pointing upward. Similar observations of the resident's legs stretched out and foot pointing upward were made on 12/04/2024 at 12:12 PM and 2:28 PM, 12/05/2024 at 11:09 AM and 3:37 PM. In an interview on 12/09/2024 at 9:30 AM, Staff R, Nursing Assistant, stated residents were placed on restorative programs to restore movement and Resident 7 had limitations to their lower extremities. During an interview on 12/09/2024 at 9:49 AM, Staff S, Licensed Practical Nurse/Restorative Nurse, stated Resident 7 was not on a restorative program. (continued on next page)

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	505033	A. Building B. Wing	12/09/2024

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/09/2024 at 10:12 AM, Staff S stated Resident 7 worked with therapy in October and they had not received a referral for a restorative program. During an interview on 12/09/2024 at 10:13 AM, Staff T, Physical Therapy Assistant, stated if a resident was high risk for a contracture they would be put on a restorative program after completion of therapy. Staff T added the resident should have been placed on a restorative program. Staff S stated the resident was on a restorative program three times per week prior to their hospitalization in October 2024. Staff S added they would coordinate with Staff T to put the resident back on an appropriate restorative program. In an interview on 12/09/2024 at 1:09 PM, Staff B, Director of Nursing, stated restorative programs should be resumed for residents with impairments to prevent contractures and restorative was important to maintain their current level of functioning. Reference: WAC 388-97-1060 (3)(d).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46115 Based on observation, interview, and record review, the facility failed to provide supervision during a coughing episode for 1 of 2 residents (Resident 183) reviewed for supervision. This failure placed Resident 183 at risk for choking and a diminished quality of life. Findings included . Per the 11/26/2024 admission assessment, Resident 183 had diagnoses including dementia and a stroke. The resident had severe cognitive impairments and needed total assistance with eating. The 11/20/2024 physician's order prescribed Resident 183 a mechanical soft diet (soft, easily chewable foods designed for people who have difficulty swallowing or chewing) with nectar thick liquids. The 12/03/2024 care plan documented Resident 183 had difficulties swallowing and received an altered textured diet and required one to one feeding assistance. The resident needed to sit upright to consume food and fluids and required small sips and to swallow between bites. The staff were instructed to remind the resident to tuck their chin to swallow. During an observation on 12/05/2024 at 11:20 AM, Staff U, Nursing Assistant, assisted Resident 183 to eat and fed them a bite of salad and the resident coughed. In an observation on 12/05/2024 at 11:41 AM, Staff V, Nursing Assistant, assisted the resident to eat a sandwich, after a couple of bites Staff V left the table. During an observation on 12/05/2024 at 11:47 AM, Staff V assisted the resident to consume fluids and they coughed continuously. Staff H, Nursing Assistant, entered the dining room at 11:49 AM and patted the resident on the back and told them to lean forward. Staff H asked Staff V to get the nurse. On 12/05/2024 at 11:53 AM, Staff H removed the resident from the dining room and met the nurse in the hallway and stated Resident 183 had been coughing on nectar thick liquids. Staff W, Registered Nurse, stated they were going to talk to the resident care manager to get a swallow evaluation. On 12/05/2024 at 11:54 AM, Staff H left the resident in their room alone sitting in their wheelchair. Resident 183 coughed and tried to clear their throat and stopped coughing at 11:56 AM. Staff H returned to the resident's room at 11:57 AM. Review of Resident 183's record for 12/05/2024 showed no documentation in regard to the coughing episode they had and the resident was not assessed by Speech Therapy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/06/2024 at 8:06 AM, Staff K, Licensed Practical Nurse, gave Resident 183 a bite of oatmeal and they coughed. The resident was given a drink, and they coughed. Staff K asked the resident if they could clear their throat, and they continued coughing. Staff K removed the oatmeal and fluid and notified the resident care manager. Staff K stated they had gotten in report that Resident 183 was starting to cough more. Staff K requested the resident be evaluated by Speech Therapy. A 12/06/2024 progress note at 12:41 PM, documented Speech Therapy assessed the resident, and they needed a modified barium swallow (a test used to evaluate safe swallowing). A 12/06/2024 progress note at 3:19 PM by Speech Therapy, documented they were approached by Staff K regarding Resident 183's cough, swallowing difficulties and an increased runny nose and had requested an emergent swallow evaluation. An order was received for a barium swallow and the resident was assessed, a day after their initial coughing episode. During an interview on 12/09/2024 at 9:42 AM, Staff L, Nursing Assistant, stated a resident that had been coughing should not be left alone in their room. Staff L stated the resident should have been monitored. In an interview on 12/09/2024 at 11:47 AM, Staff K stated a change in condition such as coughing on fluids needed to be communicated to therapy and the providers as soon as possible. Staff K added the resident needed to be assessed and a progress note should have been written. When Staff K was asked if Resident 183 should have been left in their room alone when continuing to cough, they stated no. During an interview on 12/09/2024 at 12:23 PM, Staff B, Director of Nursing, stated coughing on thickened liquids needed to be reported to therapy and the providers after it occurred, and a progress note should have been written. Staff B stated Speech Therapy needed to evaluate the resident for possible changes to their diet. Reference: WAC 388-97-1060 (3)(g)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to establish a system to ensure the availability of a physician to timely coordinate the procurement of controlled substances during afterhours for 1 of 3 sampled residents (Resident 31) reviewed for closed records. This failure placed the resident at risk for unmet needs at end of life. Findings included . Review of a 01/21/2021 contract between a physician services group and the facility showed that if the designated physician was unable to provide services due to illness, disability, vacation or any other reason, then the group designated a replacement group physician to provide the services. This policy also showed the Medical Director aided in arranging for continuous physician coverage for medical emergencies, developed procedures for emergency treatment of residents, and became the primary physician in the absence of the resident's primary physician unless the resident or physician designated the responsibility to other physicians. Review of the medical record showed Resident 31 readmitted to the facility on [DATE] from the hospital. An 11/14/2024 progress note showed the goal of Resident 31's re-admission was comfort care related to the resident's recent rapid decline in health. The staff described Resident 31 as, alert and talkative but very confused and speech is mostly incoherent. Review of an 11/14/2024 8:50 PM note showed, Resident not eating and only few sips of water after Medication given. Resident restless and somewhat agitated medicated with MS [morphine] as ordered and is effective. Morphine is a controlled substance used to ease a resident's shortness of breath, pain and discomfort when actively dying. An 11/16/2024 8:03 AM note showed, the staff witnessed Resident 31, awake and trying to get out of bed. Very anxious pulling at covers. Legs out of bed. The staff administered morphine as ordered. Record review showed the staff administered morphine at 10:35 AM when they observed Resident 31, starting to get anxious again, trying to get out of bed . has lower legs out of the bed. The staff described that they attempted to get Resident 31 back in bed, but the resident was still trying to get out. Review of Medication Administration Record (MAR) progress notes showed the staff administered morphine at 2:45 PM on 11/16/2024. Review of an 11/16/2024 progress note showed Staff F, Registered Nurse, assessed Resident 31 developed a diffuse rash to their back and Morphine was not working to control [their] symptoms. Staff F described Resident 31, remained anxious and agitated even though Morphine given approx [approximately] every 1.5 hrs [hours] per family request. Staff F wrote that they called Staff I, who was Resident 31's primary physician and the Medical Director of the facility, and left Staff I a message with the physician answering service at approximately 4:00 PM. Review of MAR progress notes showed the staff administered Resident 31 morphine at 4:16 PM. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Rockwood South Hill		STREET ADDRESS, CITY, STATE, ZIP CODE: East 2903 25th Avenue Spokane, WA 99223	

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 11/16/2024 progress notes showed that because Staff F did not receive a call back from Staff I, they called again at 5:00 PM. The answering service for Staff I informed Staff F that Staff I, was no longer on duty and a nurse practitioner (NP) was covering for the provider. Staff F explained to the answering service that they, really needed to speak to Staff I and not the NP as Staff F wanted to request a change to the medications, from Morphine to Dilaudid [another controlled substance]. Staff F reported to the answering service that the resident was allergic to a medication prescribed for anxiety (Ativan). Despite Staff F's specific instructions to the answering service that they required to speak to Staff I to request the change in the controlled substance, the NP called back instead and Staff F had to explain again that they really needed to speak with Staff I. At 5:30 PM, Staff I called the facility and told Staff F that they were not in a position to, call order in to pharmacy for an hour to an hour and a half. Staff I instructed Staff F to continue to, use the Morphine until we were able to get the Dilauded [sic] ordered and delivered. Review of MAR progress notes showed the staff administered Resident 31 morphine at 5:37 PM and 6:34 PM. The above findings were shared with Staff B, Director of Nursing, on 12/09/2024 around 12:05 PM. Staff B stated that they were unaware of the concern with delayed physician response. Staff B stated, I've just never had that problem and that they expected their nurses to firmly tell the provider that they needed the order, Now. When asked if the facility had any kind of process the nurses used to facilitate prompt physician response, Staff B stated that none was in place. On 12/09/2024 at 12:07 PM, Staff I was asked about the delayed response to staff's request for changes to controlled substances used for Resident 31's end-of-life needs. Staff I stated, I recall getting the phone call and was not in the spot to take care of it at the moment. Staff I stated, The NPs will not call the pharmacy for any controlled substances. I generally return the calls in 20 or 30 minutes. There's no other back-up provider. [The physician services group] has other providers but the NPs are the ones on-call and do not [manage orders for] controlled substances. Reference WAC 388-97-1260 (3)(b).

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 46115 Based on interview and record review, the facility failed to ensure sleep medications were consistently monitored for 1 of 5 sampled resident (Resident 183) reviewed for unnecessary medications. This failure placed the residents at risk for potential adverse side effects and medical conditions. Findings included . Per the 11/26/2024 admission assessment, Resident 183 had diagnoses which included dementia and weakness. Review of the Active Order Report documented the physician prescribed a medication for sleep (Melatonin) on 11/20/2024 to be given every day at bedtime. The November 2024 and December 2024 medication administration records documented the resident received the Melatonin every night at bedtime. In an interview on 12/09/2024 at 11:47 AM, Staff K, Licensed Practical Nurse, stated residents who received Melatonin needed a sleep monitor to ensure the medication was effective. During an interview on 12/09/2024 at 12:23 PM, Staff B, Director of Nursing, confirmed the resident should have had a sleep monitor in place to ensure the medication was effective. Reference (WAC): 388-97-1060 (3)(k)(i)

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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. 46115 Based on observation, interview, and record review, the facility failed to maintain temperatures to ensure medications were properly stored. This failure placed residents at risk for receiving compromised or ineffective medication. Findings included . During an observation of the medication room on 12/06/2024 at 10:40 AM, with Staff D, Registered Nurse, the refrigerator in the medication room contained a vial of Tubersol (medication injected under the skin to determine exposure to Tuberculosis) and respiratory synticial virus vaccines (vaccine used to treat a severe respiratory infection). Review of the refrigerator temperature logs for September 2024, October 2024 and November 2024 showed the temperatures were not monitored consistently as required. The temperatures were monitored 14 days in September, 16 days in October and 16 days in November. The medication room did not have a thermometer to monitor the temperature the medications were stored at. In an interview on 12/06/2024 at 11:03 AM, Staff B, Director of Nursing, stated the temperature of the refrigerator should have been monitored to ensure the efficacy of the medications and maintenance had been notified about the temperature gauge for the medication room. Reference: WAC 388-97-1300 (2)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50027 Based on observation, interview, and record review, the facility failed to ensure nursing staff had the required qualifications (current Washington State Food Worker Cards) for 3 nursing staff (Staff N, AA, BB). This failed practice had the potential risk for unsafe food handling practices and placed all residents at risk for developing foodborne illness. Findings included . During an observation on [DATE] at 11:14 AM, Staff G, Nursing Assistant, served meals from the steam table in the north dining room. Staff G wore no hair covering throughout the entire meal service observation. In an interview on [DATE] at 10:54 AM, Staff Z, Cook, stated nursing assistants served food from the steam table when the dietary staff was unavailable. On [DATE], a copy of dietary and nursing staff's current Washington State Food Worker cards were requested, and none were provided. Review of dietary cards on [DATE] at 4:32 PM showed the following nursing assistants: Staff N (expired on [DATE]), Staff BB (expired on [DATE]), and Staff CC (no information). Reference WAC [DATE].

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40297

Based on observation, interview and record review, the facility failed to ensure the staff performed the required hand hygiene and wore hair coverings during food preparation and meal service for 2 of 2 dining rooms observed. Additionally, the facility failed to ensure the staff discarded expired foods, labeled food items, monitored the temperatures of foods being served, and were competent on preparation of thickened liquids. This failure placed the residents at risk for foodborne illnesses and aspiration (accidental inhalation of liquid into the lungs).

Findings included .

<North Dining Room>

An observation of meal services in the North Dining Room on [DATE] at 11:14 AM showed, Staff G, Nursing Assistant (NA), serving meals from the steam table for other staff to deliver to the residents in the North Dining Room. Staff G wore no hair covering throughout the entire meal service period observation.

An unidentified aide was observed to touch the table where Resident 27 was seated at.The aide brought a spoonful of food to the resident's mouth with gloved hands, then went to the steam table, picked up a bowl of soup, and [NAME] it to Resident 27. No removal of gloves and hand hygiene were observed prior to going to the steam table and picking up a food item.

Staff H, NA, observed with gloved hands, delivered two covered food items from the steam table to a table with residents. Staff H then took an order slip and went to another table with the same gloved hands to take a meal order. Staff H then went to a family member at another table with an order slip on hand, then went to the cupboard in proximity to the steam table, took a plate out, and Staff G placed a muffin on the plate. With the same gloved hands, Staff H set down the plate on the countertop and took a tong and a spoon out. Staff H then moved to prepare sandwiches on the same countertop with the same gloves on and added meat, condiments, lettuce, and tomatoes to the bread. No hairnets were observed in use.

Staff H went to another table, then walked to the steam table where they got a bowl of soup with the same gloves on, delivered the soup, then went to the countertop area to pick up prepped meal plates, dropped them off at a table, still with the same gloves on.

Staff H then went to another table with the same gloved hands, touched the table and a resident's wheelchair arm rest, moved to another table and with same gloved hands, touched the table surface and another resident's wheelchair arm rest. Staff H removed their gloves and washed their hands at 11:25 AM

Staff H then put gloves back on, picked up a sandwich plate, went to and set the plate on the steam table, then opened the cupboard, grabbed a bag of chips, then delivered the plate and the chips to a resident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Staff H moved to another table where they placed their gloved hands on the table surface while they took a meal order, walked to the steam table with same gloved hands, then to the cupboard where they took out plates. Staff H then picked up bread slices with same gloved hands, put on condiments and made a sandwich with cheese, tomato, lettuce, and meat at 11:30 AM. Staff H then went to the steam table, dropped off the sandwich plate there, and walked away with soup and the plate of sandwich and dropped it off at a table with residents. With the same gloved hands, Staff H went to dispense fluids and delivered it to a table with residents at 11:32 AM. With the same gloved hands, Staff H went to prepare another sandwich after getting a plate out of the cupboard. Then, after prepping the sandwich, took the plate of sandwich to the steam table, then delivered it to a family member seated at the same table as other residents. Staff H then walked to a male resident at 11:35 AM, asked them what they wanted for lunch, then with the same gloved hands, went to the cupboard, took a plate out, dispensed iced water, and took the water to the male resident. Staff H then walked away, gloves still on, went back to the cupboard, took another plate out, placed a sandwich on it, took the sandwich to a female resident and removed gloves at 11:37 AM. Staff H removed their apron, hung it up on the door, dropped off gloves in the trash can, washed their hands, and left the dining room. Staff H returned to the dining room at 11:44 AM with gloved hands, dropped off a covered plate on the countertop, put on an apron, and with the same gloved hands took a plate out of the cupboard, then turned to the steam table where Staff G placed a muffin and soup on the plate. Staff H added a sandwich and took the plate to a table with residents. At 11:45 AM, Staff H removed their gloves, took the apron off, and washed their hands. In an interview on [DATE] at 11:50 AM, Staff G stated that when the kitchen staff was not available, Nursing Assistants served meals from the steam table. Staff G stated that the training they received related to food safety involved getting a food handlers card. Staff G stated that they kept food safe during meal services by making sure food was covered in transit to the resident, making sure gloves are on, and I try and wash hands in between serving [the resident]. When asked if they were educated to wear a hair covering when serving meals from the steam table, Staff G stated that the dietary staff usually wears a hair net, and that they did not receive instruction to wear hair covering when they served food from the steam table in the dining room. In an interview on [DATE] at 1:24 PM, Staff H stated that handwashing should occur when entering and leaving the dining room and in between preparing a course meal. Staff H stated that gloves should be worn after washing hands when entering the dining room, that they are changed or removed before they leave the dining room. Staff H stated that hand hygiene should occur, between feeding and serving residents. Staff H was asked at what point staff removed their gloves and washed their hands when serving food to the residents. Staff H stated, Umm . wait 'til done serving and then wash hands at the end . I hope so. Staff H was asked what they would do if they touched the table surface and the wheelchair during the serving of meals between residents, and they replied, Take off gloves and wash hands then put new ones on. 46115 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	<South Dining Room> In an observation of the meal service in the south dining room on [DATE] at 11:10 AM, Staff X, Nursing Assistant, touched a resident's sweater with their gloves, then touched another resident's clothing protector, gave residents napkins and served their plates. Staff X's gloves were not changed and no hand hygiene was performed. On [DATE] at 11:12 AM, Staff W touched a resident's arm with their gloves, then opened a package of crackers, and crushed them and put them into another resident's bowl. Staff W's gloves were not changed, and no hand hygiene was performed. On [DATE] at 11:19 AM, Staff W patted a resident on the arm with their gloves, then served a resident their plate and opened their napkin, picked up their cornbread to cut it, rubbed the resident's arm, and touched the cornbread to put butter on it. Staff W's glovers were not changed, and no hand hygiene was performed. During an observation on [DATE] at 11:20 AM, Staff R, Nursing Assistant, put on a pair of gloves, placed chips and a sandwich onto a plate, served the plate and removed their gloves. Staff W continued to serve plates, and no hand hygiene was performed. In an observation on [DATE] at 11:29 AM, Staff U, Nursing Assistant, put on a pair of gloves, touched a resident's shoulder, fed them some soup, pushed their wheelchair up to the table, gloves were not removed and hand hygiene was not performed. During an observation on [DATE] at 11:34 AM, Staff R sat at a table with a resident and wore gloves. Staff R got up and put soup in a bowl from the steam table, served the soup to a resident, removed the bowl of soup that a resident had eaten, removed their gloves and hand hygiene was not performed. Staff R placed another pair of gloves on and sat down with a resident and fed them soup. In an observation on [DATE] at 11:39 AM, Staff Y, Dietary Aide, wore gloves, plated desserts, with the same pair of gloves opened the refrigerator, touched the tip of the whip cream can and placed the whipped cream on the dessert, no hand hygiene was performed. During an interview on [DATE] at 11:57 AM, Staff Y stated they should have changed their gloves after they opened the refrigerator, and this was important to prevent cross contamination. In an interview on [DATE] at 11:58 AM, Staff U stated gloves should have been changed when switching between residents, removing dirty plates, touching things like wheelchairs and clothing and prior to the resident's being fed. Staff U added hand hygiene needed to be performed after their gloves were removed. During an interview on [DATE] at 1:25 PM, Staff X stated they should have changed their gloves after the resident was touched, prior to the crackers being crushed and placed in a bowl. Staff X stated this was important to prevent cross contamination. During an observation on [DATE] at 11:08 AM, Staff V filled a bowl of soup from the steam table and did not wear a hair net. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an observation on [DATE] at 11:08 AM, Staff U filled a bowl of soup from the steam table and did not wear a hair net. During an observation on [DATE] at 11:23 AM, Staff U wore gloves and prepared a drink. Staff U with the same gloves opened the refrigerator, got a straw and placed it in the resident's drink, gloves were not removed and no hand hygiene was performed. In an observation on [DATE] at 11:33 AM, Staff V asked a resident if they wanted a straw, and they said, yes. Staff V opened the cabinet with gloves on, obtained a straw, opened the straw and placed it in the cup, no hand hygiene was performed. During an interview on [DATE] at 11:58 AM, Staff V stated they were not required to wear a hairnet when they served from the steam table. Staff V added gloves needed to be changed after touching cabinet doors because other people touched them and that left germs. During an observation in the north dining room on [DATE] at 11:28 AM, Staff G, NA, wore gloves while serving a resident a brownie on a plate. Still wearing the same gloves, Staff G went to the freezer, retrieved an ice cream cone and served it to a different resident. Staff G proceeded to return to the freezer, retrieved an additional ice cream cone and served it to another resident. At 11:29 AM, Staff G walked out of the dining room, removed their gloves and disposed of them in the hallway. In an observation on [DATE] at 11:31 AM, Staff G returned to the dining room, touched their pants and went to the refrigerator. Staff G retrieved a mayonnaise jar and threw it in the garbage. Staff G put on gloves and began bussing dishes without their hands washed. In an observation on [DATE] at 11:37 AM, Staff G walked over to assist a resident with their meal while wearing the same gloved hands they used to bus dishes. Staff G began to feed the resident with their fork, wiped their mouth with their shirt protector and continued to feed the resident bites of food. At 11:39 AM, Staff G stopped feeding the resident and removed their gloves. Staff G proceeded to wheel another resident out of the dining room. During an interview on [DATE] at 3:28 PM, Staff O stated that all staff (dietary and nursing) was required to wear a hair net and beard net when prepping and serving food from the steam table. Staff O stated that this should have been done and is important to prevent cross contamination. During an interview on [DATE] at 5:06 PM, Staff B, Director of Nursing, stated nursing staff had been trained on proper hand hygiene. Staff B stated hand hygiene should have been done and this was important for infection control. Staff B stated they were unaware of the regulations for wearing hairnets and this was important to keep hair out of the food. Staff B stated they were unaware that temperatures were not being measured for all food items served from the steam table. Staff B stated that this should have been done and was important for infection control and prevention of illness. 50027 <Food temperatures> (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the undated facility policy titled, Health Center Daily Temperature Procedures showed the dietary department would check food temperatures on all items prepared by the dietary department, hot foods should be held at 135 degrees Fahrenheit (F) or above, and potentially hazardous cold food kept at or below 41 degrees F. The policy instructed staff to measure and record food temperatures on a temperature log for every meal. The policy instructed staff to clean, sanitize and calibrate the food thermometer used to verify food temperatures. Hot food temperatures should be checked when placed on the steam table. Food that did not meet the food code standard temperatures were not to be served. During an observation of tray line service held in the south dining room on [DATE] at 11:09 AM, Staff Q, Dietary Aide, began using a digital thermometer to check the temperatures of the food items resting on the steam table. Staff Q checked the food temperatures for the regular textured food items which included hot dogs, vegetable soup, and clam chowder. Staff Q did not check the food temperatures for the mechanical soft and pureed food items (grounded up hot dog on a bun, mashed potatoes with gravy) located in the holding compartment drawer of the steam table, prior to serving. Staff Q did not check the temperatures of the mechanical soft and pureed food items when prompted by this surveyor and continued to serve. In an interview on [DATE] at 11:16 AM, Staff Q stated the facility did not normally check temperatures for mechanical soft and pureed food items. Staff Q stated that it was important to check temperatures for all food items to make sure food is edible and not in the danger zone for bacterial growth. Per record review on [DATE] of the temperature logs from [DATE] through [DATE] in both dining rooms (north and south), showed no documentation of temperatures for mechanical soft and pureed food items. During an interview on [DATE] at 11:55 AM, Staff O, Food Services Director, stated temperatures for all food items on the steam table are checked before serving in the dining rooms. Staff O stated that the temperatures for the mechanical soft and pureed food items should have been checked and not have been served until completed. Staff O stated this was important so residents do not become ill. <Food Storage> Review of the U.S. Food and Drug Administration (FDA) Food Code 2022 revised [DATE], showed that food must be labeled with the date the food was prepared, the package opened, and the date the food must be discarded as directed by the food manufacturer's use-by-date. During a kitchen observation and interview on [DATE] at 8:03 AM, the walk-in refrigerator contained an extra-large, uncovered pan of rice pilaf labeled with a date of ,d+[DATE]. The rice pilaf was sitting on a top shelf near the entrance of the refrigerator door. Staff O acknowledged that the rice pilaf was from last night's dinner and held there uncovered. In an observation and interview on [DATE] at 8:13 AM, the walk-in refrigerator had a bag of Italian style 5-cheese blend that was opened with no date. Staff O stated the cheese should have been labeled. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an observation and interview on [DATE] at 8:16 AM, the walk-in freezer had the following items labeled with a date on a holding cart near the entrance of the refrigerator door, each uncovered on separate metal sheets: approximately 5 pieces of raw tuna, shrimp, two medium sized cooked turkeys split in half lying flat. Staff O acknowledged the food items were uncovered. Staff O stated it was important to cover food to prevent contamination. During an observation and interview on [DATE] at 8:41 AM, the kitchen dry storage room contained two boxes of wheat crackers individually packaged with an expiration date of [DATE] and [DATE]. Staff CC, Kitchen Supply Manager, acknowledged the expiration dates on the wheat crackers and was unsure of the shelf life. Staff CC tasted a cracker and decided to discard them. Staff CC stated that this was important so that the food quality is maintained and does not cause illness. In an observation on [DATE] at 10:05 AM, the north nourishment refrigerator and freezer contained the following items: 1 carton (46 fluid ounces) of thickened cranberry juice, with no open date 1 carton (46 fluid ounces) of thickened water, with no open date 1 carton (32 fluid ounces) of soy milk, with no open date 1 carton (quart) of half and half, with no open date 1 Ziploc bag of individual butter - with no expiration date 1 Ziploc bag of individual cream cheese -with no expiration date 2 cream cheeses in small cup with a lid, labeled with an expiration date of ,d+[DATE] 1 applesauce in small cup with a lid, labeled with an expiration date ,d+[DATE]-,d+[DATE] 1 pitcher bottle of Lax Loaf labeled with an open date of ,d+[DATE] 1 opened package of frozen waffles, with no expiration date 1 opened package of frozen wontons, with no expiration date In an observation and interview on [DATE], Staff DD acknowledged that the food and drink items should have been labeled, dated and discarded by the expiration date so that items did not spoil and residents do not become ill. In an observation on [DATE] at 9:24 AM, the south nourishment refrigerator and freezer contained the following items with no open date: 1 gallon of Whole Milk, 1 gallon of Reduced Fat Milk, and 3 opened packages of frozen waffles. There was a container of opened powdered thickener (thickening agent used for thickening liquids) on top of the refrigerator with an expiration date of [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505033	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2024
NAME OF PROVIDER OR SUPPLIER Rockwood South Hill		STREET ADDRESS, CITY, STATE, ZIP CODE East 2903 25th Avenue Spokane, WA 99223	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on [DATE] at 12:05 PM, Staff O acknowledged the food and drink items in the nourishment refrigerators and freezers should have been labeled, dated and discarded by the expiration date. <Thickened Liquids> In an interview on [DATE] at 11:35 AM, Staff X, NA, stated the nursing assistants used thickener for residents when making thickened liquids and added it to food items, such as soups when needed. In an interview on [DATE] at 12:05 PM, Staff O stated the nursing staff served and prepared thickened liquids for residents, the kitchen only supplied pre-thickened liquids (commercially packaged thickened liquids already made to the desired consistency) and powdered thickener. In an interview on [DATE] at 12:31 PM, Staff N, NA, stated it takes time to thicken liquids using thickener and it was difficult to determine the thickness level with the directions on the thickener container. In an observation and interview on [DATE] at 12:33 PM, Staff N began to demonstrate how to make honey thick liquids using the thickener that was in the north dining room. Staff N added an unknown amount of water to a tall drinking glass and used a portion cup to add an unknown amount of thickener to the water. Staff N continued to stir the mixture with a spoon and add thickener in increments. Staff N did not use the measuring scoop provided in the thickener container. Staff N stated they were unable to determine if the results were a honey thick liquid consistency, and stated, I haven't really looked at the directions. The fork drip test method (a method used for measuring the thickness and cohesiveness of thickened liquids) was performed. Staff N was still unable to determine if the honey thick liquid consistency was accurate. In an observation and interview on [DATE] at 12:52 PM, Staff N was prompted by the surveyor to compare pre-thickened nectar thick liquids poured into a glass with the outcome of the honey thick liquids they prepared in a glass. Staff N compared both liquids and determined that there was no difference in the level of consistency amongst the two glasses of thickened liquids. Staff N stated their mixture of honey thick liquids was a nectar thick liquid consistency, comparable to the pre-thickened nectar thick liquids. In an interview on [DATE] at 1:16 PM, Staff B stated the facility had thickener for the nursing staff to use when needed, based on the resident's prescribed diet. Staff B stated that thickener was added to thicken liquids according to the resident's preference of flavor or if the level of consistency of pre-thickened liquids was unavailable. During an interview on [DATE] at 1:28 PM, Staff P, Registered Dietician, stated they were unsure of the procedures the nursing staff used to accurately measure the thickener resulting in the level of consistency required. Staff P confirmed that all employees have not been educated on thickening liquids. Per record review on [DATE], the Altered Diet menu (updated on [DATE]), showed no resident received honey thick liquids. Reference WAC [DATE] (3), -2980.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 40297 Based on interview and record review, the facility failed to maintain complete and accurate records for 2 of 5 sampled residents (Resident 15 and 19) reviewed for unnecessary medications and 1 supplemental resident (Resident 17). Failure to ensure complete informed consents for psychotropics (drugs that affect a person's mental state), placed the residents at risk of not having their needs met. Findings included . <Resident 15> Review of Resident 15's November 2024 Medication Administration Record (MAR) showed the staff administered Nuplazid (an antipsychotic) daily, Trazodone (an antidepressant) at bedtime, and citalopram (an antidepressant) daily. Review of 05/02/2023 consents for Trazodone and Nuplazid showed the staff did not identify the drug class categories the psychotropics belonged to. Additionally, the consent for Nuplazid did not show the symptoms the medication was prescribed for and instead showed, of psychosis. <Resident 17> Review of Resident 17's November 2024 MAR showed the staff administered citalopram daily, Nuplazid daily, buspirone (an antianxiety agent) twice a day, and quetiapine (an antipsychotic) twice a day. Review of the 01/23/2024 citalopram and buspirone consents showed the staff did not identify the drug class categories the psychotropics belonged to. The above findings were shared with Staff C, Resident Care Manager (RCM), on 12/09/2024 at 8:58 AM. Staff C acknowledged the drug class categories and symptoms did not show but should be indicated in the psychotropic consents. Staff C stated, I do not see it. It hasn't been getting done. <Resident 19> Review of Resident 19's November 2024 MAR showed the staff administered quetiapine, sertraline (an antidepressant), Trazodone daily, and Valium (a sedative/hypnotic) three times a week. Record review showed 11/22/2023 consents for sertraline, quetiapine, and Trazodone with no indication of the drug class category they belonged to. Additionally, the sertraline and quetiapine consents showed no symptoms the medications were being used for. In an interview on 12/09/2024 at 9:03 AM, Staff D, RCM, acknowledged the consents should have but did not include the drug class categories of the medications to show a complete consent. Staff D stated that the consent for Nuplazid should show, delusions and hallucinations and helps with sleep. It should be listed there. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference WAC 388-97-1720 (1)(a)(i-iv)(b).

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to follow an established Antibiotic Stewardship Program (ASP) to promote the appropriate use of antibiotics (ABX) and reduce the risk of unnecessary ABX use for 2 of 2 months of infection control records reviewed. This failure increased resident risk for development of multidrug organisms (germs that are resistant to many ABX) and adverse outcomes associated with the inappropriate/unnecessary use of ABX. Findings included . Review of a 09/01/2024 policy titled Antibiotic Stewardship Policy showed its purpose was to develop ABX use protocols and a system to monitor their use. The policy showed the facility would assess residents for infections using the McGeer Criteria (a nationally recognized standard for defining infections), Centers for Disease Control and Prevention guidelines, and their local health jurisdiction. The policy showed that when residents were placed on ABX empirically (the initial antibiotic selected in the absence of definitive identification and testing), the facility would reassess its appropriateness and necessity, factoring in diagnostics tests, laboratory reports and/or changes in the clinical status of the resident. The policy showed the system to monitor ABX use also included a review of ABX prescribed to residents upon their admission or transfer to the facility and those during the course of evaluation by a prescribing practitioner who was not part of the facility staff. Review of an Order Listing Report, generated on 12/03/2024 by the facility for the months of October and November 2024, showed the name of the residents, the ABX prescribed, and the reason the ABX were prescribed. Review of the report showed: <Resident 12> Review of the medical record showed Resident 12 was prescribed Augmentin (an ABX) twice a day for pneumonia for 10 days on 10/16/2024. Review of a 10/17/2024 ABX note showed the Infection Type: Augmentin and Z Pak (an ABX). This note showed no answer to the duration of the ABX therapy, the type of testing completed to support the use of the ABX, or if the signs and symptoms (s/sx) met the surveillance definition for pneumonia according to the McGeer Criteria. A subsequent ABX note dated 10/24/2024 showed the infection type was pneumonia but again showed no documentation the facility reviewed if the s/sx met the surveillance definition for pneumonia according to the McGeer Criteria to support the use of the ABX. <Resident 28> (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record showed Resident 28 admitted to the facility on [DATE] with a prescription for Bactrim (an ABX) twice a day for 2 days for cystitis (a common, painful inflammation of the bladder that's usually caused by a bacterial infection). Review of a 10/05/2024 progress note showed Resident 28 admitted to the facility for therapy services secondary to weakness and for a UTI [urinary tract infection] without symptoms. On 10/06/2024, a prescription for Macrobid (an ABX) was issued twice a day for a UTI. Record review showed no documentation the facility reviewed if Resident 28's s/sx met the surveillance definition for a UTI according to the McGeer Criteria to support the use of the ABX. <Resident 17> Review of the medical record showed Resident 17 was prescribed nitrofurantoin (an ABX) twice daily for a UTI for 5 days on 10/26/2024. Review of a 10/26/2024 ABX note showed, Infection Type: uti, the s/sx were behaviors, anxiety, agitation, urinary incontinent. Review of the progress notes showed no documentation whether the urinary incontinence was increased, a requirement for consideration of a UTI definition according to the McGeer criteria. Behaviors, anxiety, agitation did not meet the definition of a UTI according to the McGeer Criteria. <Resident 2> Review of the medical record showed Resident 2 was prescribed azithromycin (an ABX) on 10/08/2024 daily until 10/15/2024 and Levaquin (an ABX) daily for 10 days on 10/16/2024 for pneumonia. Review of a 10/11/2024 ABX note for azithromycin showed, Infection Type: preventive measures to prevent pneumonia. The s/sx included coughing. The Testing Completed/Follow-up: was left unanswered. The facility gave no answer to McGeers +/-:, to show whether Resident 2's s/sx met the McGeer surveillance definition for pneumonia. Review of a 10/17/2024 ABX note for Levaquin showed, the infection type was pneumonia, the s/sx were cough. Both the Testing Completed/Follow-up: and McGeers +/-: sections were left unanswered. The facility showed no documentation it adequately evaluated whether Resident 2's s/sx met the surveillance definition for pneumonia according to the McGeer Criteria. <Resident 29> Review of the medical record showed Resident 29 admitted on [DATE] with a prescription for cefuroxime (an ABX) twice a day for pneumonia for four days. Review of the medical record showed no documentation the facility reviewed the ABX prescribed upon the resident's admission to the facility and evaluated whether Resident 29 met the McGeer Criteria surveillance definition for pneumonia. <Resident 7> Review of the medical record showed Resident 7 was started on Macrodantin (an ABX) four times a day for a UTI on 10/14/2024, after their return from the emergency room . Record review showed no documentation the facility evaluated whether Resident 7's s/sx met the McGeer Criteria surveillance definition for a UTI. <Resident 21> (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record showed Resident 21 admitted to the facility from the hospital with a prescription for Augmentin (an ABX) twice a day for sinus on 10/08/2024. A 10/08/2024 progress note showed the resident was, on sinus precautions. Record review showed no documentation the facility evaluated whether Resident 21's s/sx met surveillance definition for the use of an ABX. <Resident 24> Review of the medical record showed Resident 24 was started on Nystatin (an antifungal) Mouth wash for thrush (a yeast infection that occurs in the mouth) four times a day on 10/30/2024. Review of the McGeer Criteria showed the staff must confirm the presence of both raised white patches on inflamed mucosa (moist, inner lining of the mouth) or plaques on oral mucosa and a medical or dental diagnosis. Record review showed no documentation the staff identified raised white patches or plaques to Resident 24's oral cavity preceding, during, or after treatment with the Nystatin mouthwash. Record review showed no documentation the facility evaluated whether Resident 24 met the surveillance definition for the treatment of thrush. Review of an 11/26/2024 progress note showed Resident 24 experienced a change in condition and was transferred to the hospital. An 11/29/2024 progress note showed the resident returned from the hospital with an order for Bactrim (an ABX) for three days for a UTI. Record review showed no documentation the facility evaluated whether Resident 24 s/sx met the McGeer Criteria surveillance definition for the treatment of a UTI. The above findings were shared with Staff E, Infection Preventionist, on 12/09/2024 at 10:35 AM. Staff E acknowledged the lack of documentation to support the facility reviewed each resident for clinical s/sx and laboratory reports to determine if they met the McGeer Criteria surveillance definition of an infection and appropriate use of the ABX, or if adjustments to therapy should be made, to include residents who returned or were transferred from a hospital. No further information was provided. No Associated WAC.

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	505033	A. Building B. Wing	12/09/2024

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to ensure 1 of 5 sampled residents (Resident 183) reviewed for unnecessary medications, received information on and were offered the recommended vaccinations for pneumonia based on the current recommendations from the Centers for Disease and Control Prevention.This failure placed the resident at risk for contracting pneumonia with its associated complications of infection. Findings included . Review of a 10/19/2022 facility policy titled Immunizations showed the facility offered the pneumococcal (a bacteria) series vaccines unless medically contraindicated, to all residents upon admission. The pneumococcal vaccine protected against the bacteria which could cause many illnesses, including pneumonia, meningitis (a serious infection that causes inflammation of the membranes that protect the brain and spinal cord), sepsis (a life-threatening medical emergency that occurs when the body has an extreme response to an infection), and ear and sinus infections. The staff assessed the residents for eligibility to receive the vaccine upon admission and annually, and counseled them on the benefits and adverse effects of the vaccine. The policy showed a consent would be obtained and if the resident refused the vaccination, it would be documented in the consent form as a refusal. The consent would be uploaded in the Miscellaneous section of the electronic medical record (EMR). Review of an 11/26/2024 comprehensive admission assessment showed Resident 183 admitted to the facility on [DATE]. This assessment asked the staff, Is the resident's Pneumococcal vaccination up to date? and If Pneumococcal vaccine not received, state reason. No answer was given. Review of the Immunizations sections in the EMR showed no documentation Resident 183 was up to date or received an immunization for pneumonia. Review of the Miscellaneous section for uploaded files showed no documentation the staff assessed Resident 183's eligibility to receive the pneumonia vaccine or offered it to the resident. The above information was shared with Staff E, Infection Preventionist, on 12/09/2024 at 10:35 AM. No further information was provided. Reference WAC 388-97-1340 (1), (2), (3).