STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505042	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ballard Center	820 Northwest 95th Street Seattle, WA 98117

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on interview, and record review, the facility failed to initiate and resolve a grievance for 2 of 4 residents (Residents 44 & 36), reviewed for grievances. The failure to resolve grievances for missing personal items and discharge planning placed the residents at risk for frustration, unmet care needs, and a diminished quality of life. Findings included . Review of the facility's policy titled, Grievance/Concern, dated on 08/25/2021, showed that the purpose of the policy was To assure prompt receipt and resolution of Resident/Representative grievance/concern. It further showed, Upon receipt of the grievance/concern, the Grievance/Concern Form will be initiated by the staff member receiving the concern and documented on the Grievance/Concern Log. When the formal grievance/concern is logged, the Administrator and appropriate department manager will be notified. Immediate action will be taken to prevent further potential violations of any resident right while the alleged violation is being investigated .The department manager will: Contact the person filing the grievance to acknowledge receipt. Investigate the grievance. Take corrective actions, as needed .Notify the person filing the grievance of resolution and/or status within 72 hours. RESIDENT 44 Review of the Quarterly Minimum Data Set (MDS-an assessment tool) dated 10/17/2024, showed Resident 44 was cognitively intact. In an interview on 01/03/2025 at 11:43 AM, Resident 44 stated that their personal television remote control was missing and that they had to replace it themselves. Resident 44 stated that they reported it to Staff F, Social Services Assistant, and that they never got reimbursed. Resident 44 further stated that staff looked for it, and they could not find it and that it's been a month now. Review of the facility's grievance log for August 2024 through December 2024 did not show that a grievance was logged for Resident 44's missing television remote control. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/06/2025 at 10:45 AM, Staff F stated that when grievances were handed to them, they would go over it with the Administrator, evaluate it and send the grievance to the correct department. Staff F stated that when they resolved a grievance, they would follow up with the resident. Staff F stated when Resident 44's television remote control was missing, I was still new and that they did not know about the reimbursement process. Staff F stated they were not sure if there was a grievance filed for Resident 44's missing television remote control and believed it happened in the beginning of November 2024. When asked if Resident 44 was reimbursed for their missing remote control, Staff F stated, I don't think so. In an interview and joint record review on 01/07/2025 at 3:33 PM, Staff C, Interim Administrator, stated that they expected grievances were resolved in a timely manner, investigated and come to a good conclusion that residents were happy with. Staff C stated that they expected a grievance to be filed for Resident 44's missing television remote control. Joint record review for August 2024 through December 2024 grievance log did not show a grievance was logged for Resident 44's missing television remote control. Staff C stated that they were not aware that Resident 44's was missing a remote control and were not aware if a grievance was filed. Staff C further stated they would fill out a grievance for Resident 44 and reimburse them. 51090 RESIDENT 36 Resident 36 readmitted to the facility on [DATE]. Review of Resident 36's Significant Change of Condition Assessment (SCSA - a comprehensive MDS) dated [DATE], showed Section C (Cognitive Patterns) item C0500 (BIMS -Brief Interview for Mental Status) was scored at 15, indicating that Resident 36's cognitive function was intact. It further showed that Section Q (Participation in Assessment and Goal Setting), item Q0400 was coded 0 to indicate that active discharge planning was not already occurring for the resident to return to the community. Item Q0500 (Return to Community) was coded 1 to indicate that Resident 36 wanted to talk to someone about the possibility of leaving the facility to return to live and receive services in the community. In an interview on 01/03/2025 at 8:41 AM, Resident 36 stated they have had issues with the facility not returning phone calls to Collateral Contact 2 (CC2) who wanted to be involved with Resident 36's discharge planning. Resident 36 stated their goal was to transfer to another facility to be near CC2. In a phone interview on 01/03/2025 at 8:41 AM, CC2 stated they have not been contacted by the facility to participate in Resident's 36's plan of care since October 2024 and that they have not received returned phone calls from the facility to discuss discharge planning. CC2 further stated that they filled out a grievance form in December 2024 related to their concern about Resident 36's discharge planning process. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a grievance form dated 10/30/2024 showed that the grievance was reported to social services and was submitted by Resident 36. The nature of the concern showed that [Resident 36] says that [they] are not happy here at [the facility]. It showed that Staff F was the employee assigned to address the grievance and that Staff F's department findings, was that Found out that [Resident 36] just wanted to be close to [CC2]. The findings of this grievance were undated by Staff F. It further showed that Staff F's action plan, dated 11/08/2024, was that Planning discharge for another facility closer to [CC2] .when [CC2] and social services finds a facility. Review of the facility 's grievance log dated December 2024 showed that a grievance was submitted for Resident 36 on 12/08/2024 and that the disposition of the complaint did not show it was resolved. Further review of the facility's grievance log for December 2024 showed that a grievance was logged/received on 12/23/2024 for an incident that took place on 12/08/2024 and that it was submitted by CC2 (15 days after the grievance was logged). Review of the grievance form dated 12/08/2024 showed that the grievance was reported to Staff F and submitted by CC2. It showed that the nature of concern was that I have been contacting Social Services since October 24 [2024]. They never call back. They tell [Resident 36] that they do. I only want to help get [Resident 36] transferred closer to their family, which I feel will help with [Resident 36's] care and morale. It further showed that Staff F was the employee assigned to address the grievance and that Staff F's action plan to address the grievance was completed on 12/30/2024. The grievance form did not show that complete resolution/satisfaction was achieved. Review of Resident 36's comprehensive care plan printed on 01/05/2025, showed Resident 36's discharge care plan was created on 10/02/2024 and was last revised on 12/31/2024. It further showed that Resident 36's discharge care plan goal was that Resident/Patient will have an ongoing discharge plan that provides for a safe and effective discharge. It did not show a resident centered discharge goal consistent with Resident 36's and CC2's stated goal. In an interview on 01/06/2025 at 2:26 PM, Staff F stated they were responsible for arranging care conferences to discuss discharge planning, as well as to send out referrals related to the discharge planning process. Staff F further stated that they were responsible for addressing grievances assigned to social services. In an interview and joint record review on 01/07/2024 at 1:15 PM, Staff F stated they addressed the grievance form dated 12/08/2024 for Resident 36. Staff F stated Yes, it was done by me, I was new and didn't get it until 12/23/2024. Joint record review of a grievance form dated 12/08/2024 for Resident 36 showed it was addressed on 12/30/2024. Staff F stated, This grievance [dated 12/08/2024] was put in my mailbox, instead of giving it to me directly. Staff F was asked if they expected grievances to be addressed timely and Staff F replied, Right away, if I get a grievance like this, I would [will] show the administration right away. Staff F was asked if the grievance dated 12/08/2024 was addressed timely, Staff F replied, I saw that [grievance dated 12/08/2024] on 12/23/2024 and I didn't email [CC2] until [12/24/2024]. Further joint review of the grievance form showed that the concern was that CC2 did not receive communication from the facility to discuss Resident 36's discharge planning from 10/24/2024 through 12/08/2024. Staff F stated they could not remember receiving communication from CC2 at those times. Joint record review of Resident 36's progress notes from 10/24/2024 through 12/29/2024 showed there was no documentation of communication between social services and CC2 to discuss discharge planning. Staff F stated, I don't think so. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/07/2025 at 2:24 PM, Resident 36 stated that their discharge goal had been to transfer to another facility closer to CC2. When asked if Resident 36 had a discharge goal of returning home alone with a caregiver, Resident 36 answered, No, I don't want to, my number one choice is to be closer to [CC2]. Resident 36 was tearful and stated I don't think [the facility] has done enough to try to get me transferred because I'm still here. I'm sad that I'm not near my [CC2] and it's not good for my morale, it's not good! My situation is upsetting. I don't feel like they're working hard enough to get me transferred. In an interview on 01/08/2024 at 3:15 PM, Staff A, Administrator, stated that they expected grievances to be logged timely, investigated thoroughly, and that the goal was to complete them within 72 hours. Staff A was asked if they expected the grievances for Resident 36 to have been addressed or acted upon timely, Staff A replied, I expect all grievances to be addressed timely. In a phone interview on 01/08/2025 at 5:27 PM, Staff C was asked if they were aware of Resident 36's grievance submitted on 12/08/2024 and Staff C replied, I expect [social services] to speak with the resident in a timely manner, and that the length of time for Resident 36's grievance to have been addressed was lengthy. Staff C further stated that their expectation was not met, and that Resident 36's grievance should have been addressed timely. Reference: (WAC) 388-97-0460 (2)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 51090 Based on interview and record review, the facility failed to implement their abuse policy and procedure by not ensuring reference checks were conducted prior to hire for 4 of 5 staff (Staff Y, Z, AA & BB), reviewed for reference checks. This failure placed the residents at risk for abuse, neglect, exploitation, and misappropriation of property. Findings included . Review of the facility's policy titled, Abuse Prohibition Policy and Procedure, reviewed on 02/23/2021, showed, The Center will implement an abuse prohibition program through the following: screening of potential hires .The center will screen potential employees for a history of abuse, neglect, or mistreating patients/residents, including attempting to obtain information from previous employers. Review of employee records for Staff Y, Certified Nursing Assistant, Staff Z, Weekend Registered Nurse Manager, Staff AA, Nursing Assistant Registered, and Staff BB, Smoking Aide, did not show that reference checks were conducted by the facility prior to their respective hire dates. In an interview on 01/06/2025 at 12:34 PM, Staff A, Administrator, stated that reference checks were not completed for Staff Y, Z, AA and BB prior to their hire in year 2024. Staff A provided an undated document titled, Personal Reference Checks, and stated the facility used this document for completion of reference checks. Staff A further stated that Staff Y, Z, AA and BB did not have a completed reference check document in their employee files. Review of the facility's blank and undated document titled Personal Reference Checks, showed that instructions for completion of the form included, State law, Federal law, and company policy require a minimum of 2 reference checks for each new hire. In an interview on 01/08/2025 at 8:22 AM, Staff W, Accounts Payable/Payroll/Human Resources, stated the facility's personal reference checks form was used by the facility and that there was a process in place to complete reference checks for potential hires since January 2023. Staff W further stated that reference checks were not completed for Staff Y, Z, AA and BB. In another interview on 01/08/2025 at 11:45 AM, Staff A stated that they expected reference checks to be competed for potential hires. Staff A further stated that It's part of the hiring process, we shouldn't hire staff without doing them. Reference: (WAC) 388-97-0640(2)(a)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on interview and record review, the facility failed to ensure resident to resident altercations were thoroughly investigated for 3 of 5 residents (Residents 44, 55 & 46), reviewed for abuse investigations. This failure placed the residents at risk for repeated incidents, unidentified abuse, and inappropriate corrective actions. Findings included . Review of the facility's policy titled, Abuse Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised in September 2022, showed, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. The policy further showed that the individual conducting the investigation at minimum .interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. Review of the Nursing Home Guidelines, The Purple Book, Sixth Edition, dated October 2015, showed, Requirements for reporting resident to resident assaults to the Department are the same as the reporting requirements for any incident of physical assault against a resident. It showed under Appendix D-Reporting Guidelines to Nursing Homes that resident to resident mental abuse with psychological harm, physical abuse/assault with bodily harm/injury, physical abuse with psychological harm, sexual abuse/assault and misappropriation/exploitation were to be called in to the department's hotline and logged within 5 days. It further showed, mental abuse without psychological harm and physical abuse without bodily or psychological harm were to be logged within 5 days. Additionally, it showed under The investigation Process that All alleged incidents of abuse, neglect, abandonment, mistreatment, injuries of unknown source, personal and/or financial exploitation, or misappropriation of resident property must be thoroughly investigated. The investigation is done to determine, as far as possible: What occurred; and to make necessary changes to the provision of care and services to prevent reoccurrence. A thorough investigation is a systematic collection and review of evidence/information that describes and explains an event or a series of events. It seeks to determine if abuse, neglect, abandonment personal and/or financial exploitation or misappropriation of resident property occurred, and how to prevent further occurrences. RESIDENT 44 A review of the Quarterly Minimum Data Set (MDS-an assessment tool) dated 10/17/2024, showed Resident 44 was cognitively intact. In an interview on 01/03/2025 at 11:18 AM, Resident 44 stated that Resident 95 verbally assaulted them, that they reported it to the facility staff and filed a grievance. When asked if it was their choice to file a grievance, Resident 44 stated it was not their choice to file a grievance, it was just filed as a grievance. In a follow up interview at 2:23 PM, Resident 44 stated that the incident happened on 12/22/2024. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/05/2025 at 8:33 AM, Resident 44 stated that the incident was reported to Staff S, Licensed Practical Nurse (LPN). Resident 44 stated that the original incident occurred in front of Station 1 Nursing Station and that no one intervene until Staff S stepped in. Resident 44 further stated Staff S did everything they could, none of the other nurses bothered to step in. In an interview on 01/06/2025 at 9:10 AM, Resident 44 stated that Resident 95 told them they were not allowed in the hallway, and that Resident 95 stated, this is my hall. Resident 44 stated that Resident 95 would not let them pass and that Resident 95 tried to get in their way when they tried to pass. Resident 44 stated that Resident 95 would say, this is my space, you're [you are] not allowed here. Resident 44 stated that an unknown staff that was there did not do anything to stop Resident 95 and when they had enough, they said they were going to call the police, and that was when the unknown staff stood up and asked Resident 44 why they were going to call the police. Resident 44 further stated that Staff S was the only one that stood up and helped. A review of the grievance report dated 12/22/2024 initiated by Resident 44, showed, I am complaining about [Resident 95]. I was trying to go past the hallway, going to my room, she kept going into my way, telling me I can't go. Nobody stopped her. I said I'm [going to] call the police and the nurse stopped her. A review of Resident 44's nursing progress notes dated 12/22/2024 did not show progress notes related to an altercation with Resident 95. A review of Resident 44's assessment tab in their Electronic Health Record (EHR) did not show that a change of condition assessment was completed [when there was a resident to resident altercation] on 12/22/2024. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A joint record review and interview on 01/08/2025 at 11:45 AM with Staff S, showed a grievance report dated 12/22/2024 initiated by Resident 44. Staff S stated that it was not the one that they had filled out for Resident 44. Staff S stated that they filled out a grievance for the resident for the same week and that they did not remember the day but may have been before the grievance report dated 12/22/2024 that was shown to them. Staff S stated that there was an incident where Resident 46 was down the hall, Resident 95 was behind Resident 44. Staff S stated they heard someone yelling, Resident 95 was standing in front of Resident 46 and Resident 44. Resident 44 and Resident 95 were yelling at each other, back and forth. Staff S stated that they intervened, told them to quiet down and calm them both down. Staff S stated that Resident 46 and Resident 44 wanted to file a grievance because Resident 95 was harassing them. Staff S stated that Resident 44 stated they wanted to talk to Resident 46 in private, but Resident 95 started following them and that was when they started arguing. Staff S stated that was when they came in and attempted to calm them down. Staff S stated they filed a grievance for both Resident 46 and Resident 44 the same day and was not the grievance form dated 12/22/2024 that was shown to them. When asked what their definition of a resident to resident altercation was, Staff S stated, altercation means physical with each other. When asked what they thought about residents yelling at each other, Staff S stated they thought of it as a disagreement or dispute. When asked if Resident 44 reported to them that they were verbally assaulted, Staff S stated that Resident 44 stated they felt like they were being attacked. When asked if they reported it to anyone, Staff S stated they completed a grievance report and that they notified the other charge nurse and Social Worker about it. Staff S stated they did not believe that [Interim] Administrator [Staff A], or Director of Nursing [Staff B], were notified of the incident. Staff S stated that they did not have time to write a progress note and that they were dealing with a lot of things. Staff S stated that Resident 95 was moved to a different room that day because they did not want any physical altercation between them. Staff S further stated that at that time they did not think of it as a resident to resident altercation because their definition of an altercation was physical, Staff S stated, they were yelling at each other. In an interview and joint record review on 01/08/2025 at 12:15 PM, Staff B stated that they used the Purple Book as a guide for reporting abuse. Staff B stated that their process for resident to resident altercation was to immediately intervene, notify the Administrator, Director of Nursing and Social Services, offer room change, report to the State Agency, complete an investigation and interview residents. When asked for some examples of a resident to resident altercation, Staff B stated that residents yelling at each other or not having normal conversations. Staff B stated that if a resident reported a resident yelled at me, they would investigate it. Staff B stated that they would expect resident to resident altercations to be logged in the incident log and expect it to be investigated. Staff B was informed of Resident 44's concern of being verbally assaulted, Staff B stated that they were already investigating it. Joint record review of the grievance report dated 12/22/2024 that the facility provided showed, I am complaining about [Resident 95]. I was trying to go past the hallway, going to my room, [they] kept going into my way, telling me I can't [cannot] go. Nobody stopped [them]. I said I'm [going to] call the police and the nurse stopped [them]. Staff B stated it was a different grievance report that was written by Staff S. Staff B stated that Staff S should have notified the Administrator and that it should have been communicated to them. Staff B stated that Staff S should have followed their process and should have notified them and the Administrator when a resident to resident altercation happened. When asked what they would have done if it was reported to them, Staff B stated they would have investigated it and followed their process. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the grievance report for Resident 44 dated 12/22/2024 [received by Staff S that day], and provided to the survey team on 01/08/2025, showed Patient 533A [Resident 95] complained of the walls and wanted the patient to make false report. Patient [Resident 44] states 533A [Resident 95] followed him and took notes when talking to roommate 533B [Resident 46]). Patient [Resident 44] states he has been harassed by 533A [Resident 95]. In an interview on 01/08/2025 at 1:46 PM, Staff A, Administrator, stated that they followed the guidance in the Purple Book for resident to resident altercation. Staff B stated they expected staff to separate them, keep them safe, and if they were roommates, separate them. Staff B further stated they would complete an investigation and would notify the family and the provider. Staff A stated there were verbal, physical and sexual resident to resident altercations. Staff A stated that they would have expected staff to notify them and Staff B of the altercation between Resident 44 and Resident 95 and that they would have expected it to be investigated. RESIDENT 55 A review of the admission record showed Resident 55 admitted to the facility on [DATE] and that they were in room [ROOM NUMBER]B. A review of the Quarterly MDS dated [DATE], showed Resident 55 was cognitively intact. In an interview on 01/03/2025 at 2:43 PM, Resident 55 stated that their former roommate (Resident 39) threw a fork at them, missed them by a little and that it scared me. Resident 55 stated that staff were aware and moved their roommate to a different room. Resident 55 further stated that it happened around August 2024. A review of Resident 55's nursing progress notes dated 08/01/2024 through 08/31/2024, did not show a progress note of an altercation with their roommate. A review of the August 2024 grievance log did not show that a grievance was logged for Resident 55. A review of the August 2024 incident log did not show that a resident to resident altercation was logged for Resident 55. Review of Resident 39's census tab in the EHR showed that they were in room [ROOM NUMBER]A from 06/24/2024 and was transferred to room [ROOM NUMBER]B on 08/31/2024. Review of Resident 39's nursing progress note dated 08/31/2024 showed, [Resident 39] is expected to transfer rooms on Reason for transfer: altercation with roommate. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 01/07/2025 at 2:09 PM, Staff EE, LPN/Charge Nurse, stated that their process for resident to resident altercation was to report it to Staff A and Staff B, complete a risk management and change of condition assessment. Staff EE further stated that they would assess the resident, investigate what happened and that if it was the roommate, they would have to transfer the roommate to another room. When asked what types of residents to resident altercation, Staff EE stated it can be verbal and/or physical altercation. A joint record review of Resident 55's assessment tab in the EHR did not show that a change of condition was completed. Staff EE stated, I don't see anything completed. A joint record review of Resident 55's August 2024 nursing progress notes did not show documentation of any resident to resident altercation. Staff EE stated, I don't [do not] see any notes for the resident to resident altercation. A joint record review of Resident 39's progress notes showed, [Resident 39] is expected to transfer rooms on Reason for transfer: altercation with roommate. Staff EE stated, yes, it's [it is] there. Staff EE further stated that no change of condition was completed for 08/31/2024 and that if it was completed, the change of condition would have shown if the administrator, provider and if the resident representative was notified. Staff EE further stated that there was no documentation showing that Staff A or Staff B were notified of the altercation. In an interview on 01/08/2025 at 8:14 AM, Staff T, Charge Nurse, stated that Resident 55 reported to them that their previous roommate (Resident 39) threw a fork at them. Staff T reported that they did an incident report, change in condition, investigation was called in and reported to the authorities. Joint record review of Resident 39's census and progress note dated 08/31/2024 showed, [Resident 39] is expected to transfer rooms on Reason for transfer: altercation with roommate. Staff T stated they were not sure what happened on 08/31/2024, but when it was brought to their attention on 10/15/2024, that was when they did an investigation, change of condition, and notified the appropriate authorities. In an interview and joint record review on 01/08/2025 at 12:15 PM, Staff B stated that the altercation between Resident 55 and Resident 39 was investigated in October 2024. Joint record review of Resident 39's progress note dated 08/31/2024, showed, [Resident 39] is expected to transfer rooms on Reason for transfer: altercation with roommate. Staff B stated they see it and that Resident 39 had behaviors. When asked if they would have expected staff to notify them on 08/31/2024, Staff B stated, Definitely, if there was an altercation, definitely. Staff B further stated that if they were notified of the altercation, they would have followed their process, they would have investigated and notified the State Agency. In an interview on 01/08/2025 at 1:46 PM, Staff A stated that they expected to be notified of resident to resident altercations and expected it to be investigated. 46912 RESIDENT 46 In an interview on 01/03/2025 at 1:26 PM, Resident 46 stated that on 12/21/2024 or 12/22/2024, their previous roommate (Resident 95) had jumped on me in bed and kissed me on the lips. Resident 46 stated I didn't [did not] ask for it and it was unwanted. (continued on next page)

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	505042	A. Building B. Wing	01/08/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/08/2025 at 6:29 PM, Staff A provided the completed investigation documents and stated, it's locked, so yes it's complete. When asked if this was everything, Staff A stated, yes. Review of the investigation report showed no documentation that staff interviews or additional resident interviews were done as part of the investigation. It further showed that the investigation summary did not include that abuse had been ruled out. In an interview on 01/08/2025 at 6:34 PM, Staff T stated that they had completed part of the investigation and prepared the report. Staff T stated that the allegation made by Resident 46 of inappropriate touching/kissing was considered abuse and that they conducted an abuse investigation. When asked if they expected to have interviews from additional residents and staff members as part of the investigation, Staff T stated that would be great, to get more information to support the investigation. When asked if the investigation summary showed that abuse was ruled out, Staff T stated, I don't see it there. I should have put it there. When asked if it was a thorough investigation, Staff T stated, it would be better to interview other residents to prevent other occurrences. In an interview on 01/08/2025 at 6:55 PM, Staff A stated that they were the abuse coordinator and I signed off on the investigation. Staff A stated that they would consider it [Resident 46's allegation] sexual abuse. Staff A stated that they expected an abuse investigation to include interview staff members who have taken care of them [alleged victim] and other residents to see if they had seen or heard anything about it [abuse allegation]. When asked if staff and additional resident interviews were done, Staff A stated, I think it was done. I don't [do not] see it in the report. I will look for the interviews. Staff A further stated that I expect it [the abuse investigation report] to say that it was ruled out. A review of an email communication received on 01/09/2025 at 5:04 PM, showed additional documentation for the investigation for Resident 46's abuse allegation, which included the alleged victim and alleged perpetrators statements. Staff A stated that the records provided was what they had. Further review of the email did now show include staff or additional resident interviews. Reference: (WAC) 388-97-0640 (6)(a)(b)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51090 Based on interview and record review, the facility failed to accurately assess 1 of 26 residents (Resident 36), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessments regarding collecting information during the entire look-back period for MDS Section L (Oral/Dental Status), Section N (Medications), Section O (Special Treatments, Procedures, and Programs), Section P (Restraints and Alarms) and Section Q (Participation in Assessment and Goal Setting), placed the residents at risk for unidentified and/or unmet care needs, and a diminished quality of life. Findings included . According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.19.1, dated October 2024, showed, The Observation Period (also known as the Look-back period) is the time-period over which the resident's condition or status is captured by the MDS and ends at 11:59 PM on the day of the Assessment Reference Date (ARD or assessment period). Most MDS items themselves require an observation period, such as seven or 14 days, depending on the item. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the observation period must also cover this time period. When completing the MDS, only those occurrences during the look-back period will be captured. RESIDENT 36 Resident 36 readmitted to the facility on [DATE]. Review of Resident 36's Significant Change in Status Assessment (SCSA) dated 10/21/2024, showed Section Z (Assessment Administration) revealed that item Z0400 (Signature of Persons Completing the Assessment), included the following instruction: I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. It further showed that Section Z0400 had signatures from Staff D, MDS Coordinator, dated 10/18/2024 for Sections L, N, O, P and Q. In an interview and joint record review on 01/08/2025 at 9:11 AM, Staff D stated they followed the RAI Manual for coding accuracy and that they had access to the RAI Manual October 2024 version whenever they completed an MDS. Staff D further stated that the observation period was the ARD plus six days before. Joint record review of Resident 36's SCSA dated 10/21/2025 showed that Section Z0400 had signatures from Staff D dated 10/18/2024 for Sections L, N, O, P and Q. Staff D stated Resident 36's SCSA Sections L, N, O, P and Q were not accurate because they were completed before the end of the entire observation period (10/15/2024 through 10/21/2024). In an interview on 01/08/2025 at 1:25 PM, Staff B, Director of Nursing, stated that the facility followed the RAI Manual for MDS completion. Staff B further stated they expected the MDS to be completed accurately. Reference: (WAC) 388-97-1000(1)(b)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50891 Based on interview and record review, the facility failed to ensure accurate Preadmission Screening and Resident Reviews (PASARR-an assessment to ensure individuals with Serious Mental Illness [SMI] or Intellectual/Developmental Disabilities [ID/DD] are not inappropriately placed in nursing homes for long term care) form was accurate and sent out for a Level II PASARR referral for 2 of 6 residents (Residents 103 & 22), reviewed for PASARR screening. This failure placed the residents at risk for not receiving the care and services appropriate for their needs. Findings included . Review of the facility's policy titled, PASRR Completion Policy, revised on 9/30/2024, showed the facility will make sure that all admissions have the appropriate PASARR completed. The policy showed the facility's administrator would designate either the admissions director or the social worker to make sure the PASARR was done on all potential residents. The policy further showed the administrator would be accountable for monitoring the process of completing the necessary paperwork for the admission and that the Business Office Manager must have copies of the PASARR in the Business Office resident file. RESIDENT 103 Review of the face sheet showed Resident 103 admitted to the facility on [DATE] with a diagnosis of bipolar disorder (a mental health condition characterized by periodic, intense emotional states affecting a person's mood, energy, and ability to function). A review of Resident 103's PASARR form showed the Level 1 PASARR was completed on 12/05/2024 and that Resident 103 met the criteria for an exempted hospital discharge. The Level I PASARR further showed that a Level II PASARR evaluation must be completed if Resident 103's scheduled discharge did not occur. In an interview on 01/07/2025 at 10:04 AM, Staff F, Social Services Assistant, stated that the facility was unable to discharge Resident 103 as planned because Resident 103 had pneumonia (lung infection). In an interview and joint record review on 01/07/2025 at 10:16 AM, with Staff E, Social Services Director, stated that they sent the Level II PASARR when the resident had diagnosis of anxiety (characterized by excessive fear and worry that are strong enough to interfere with one's daily activities) or any SMI indicated on the form. Joint record review of the Level I PASARR showed Resident 103's was exempted when discharged from the hospital and the facility had 30 days to send the Level II PASARR. Further review of Resident 103's electronic health record did not show the facility sent the Level II PASARR to the PASARR State Coordinator by 01/05/2025. Staff E stated that they would send out Resident 103's PASARR today [01/07/2025] for a Level II evaluation. In an interview on 01/08/2025 at 12:42 PM, Staff A, Administrator, stated that they expected PASARR forms to be completed timely. Staff A further stated that for PASARR Level II, if it was needed, then that assessment needs to get done in a timely manner. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47680 RESIDENT 22 Review of the admission record printed on 01/07/2025 showed that Resident 22 had diagnoses that included anxiety and major depressive disorder (mental illness that involves a persistent low mood and loss of interest in activities) with an onset date of 02/02/2018. Review of Resident 22's Level I PASARR dated 01/30/2023, showed that they were marked yes for SMI indicators for mood disorders and anxiety disorders. Further review showed, No level II evaluation indicated. In an interview and record review on 01/06/2025 at 10:38 AM, Staff E stated when a resident admits with a Level I PASARR and needs a Level II PASARR evaluation, they would send it to the PASARR evaluator. When asked if a resident was marked with an SMI, would they need a Level II PASARR referral, Staff E stated, Yes, they will need a Level II for evaluation. Joint record review of Resident 22's Level I PASARR showed that they were marked for SMI and no Level II PASARR evaluation was indicated. Staff E stated, I do see that. Staff E further stated that they had completed a new Level I PASARR for Resident 22 and sent it to the PASARR evaluator. When asked for a copy, Staff E stated that they were not able to find a copy and that they would send an email to the PASARR evaluator to see if they had a copy of Resident 22's updated Level I PASARR form. In a follow up phone interview on 01/07/2025 at 3:04 PM, Staff E stated that the PASARR evaluator did not have Resident 22's updated Level I PASARR and that they submitted a new Level I PASARR for Resident 22 on 01/06/2025. Staff E further stated that if a resident were to have an inaccurate PASARR, they would have expected staff to complete an accurate PASARR and submit it to the PASARR evaluator. In an interview on 01/07/2025 at 3:27 PM, Staff C, Interim Administrator, stated they expected PASARRs to be reviewed in a timely manner, before and after admission and periodically if there was a significant change. Staff C stated that if a Level II PASARR was needed, it would be submitted to the PASARR evaluator. Staff C further stated they expected that if Resident 22's inaccurate Level I PASARR was identified by staff, they would have expected staff to correct it and send it to the PASARR evaluator. Reference: (WAC) 388-97-1915 (2); 1975(1)(2)(3)

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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** 49619 Based on observation, interview, and record review, the facility failed to develop and/or implement care plans for 4 of 26 residents (Residents 39, 89, 17 & 99), reviewed for comprehensive care plans. The failure to implement care plans for edema (swelling caused by buildup of fluid in the body's tissues), nutrition, Range of Motion (ROM) and discharge planning placed the residents at risk for unmet care needs, complications, and a diminished quality of life. Findings included . Review of the facility's policy titled, Care Plan Comprehensive, dated 08/25/2021, showed the facility's Interdisciplinary Team, in coordination with the resident or representative must develop and implement a comprehensive person-centered care plan for each resident. RESIDENT 39 Resident 39 admitted to the facility on [DATE] with a diagnosis of Lymphedema (a chronic condition that causes swelling in the body due to a buildup of lymph [fluid that is part of the body's immune system] fluid). Review of Resident 39's edema care plan initiated on 12/27/2023 showed an intervention for applying and removing compression stockings (used to help prevent swelling in the legs and ankles and improve circulation) as ordered. Multiple observations on 01/04/2025 at 12:23 PM, on 01/05/2025 at 10:42 AM, on 01/06/2025 at 11:34 AM, and on 01/07/2025 at 8:43 AM, showed Resident 39's bilateral (both) lower legs were swollen and was not wearing any compression stockings. Joint observation and interview on 01/07/2025 at 3:31 PM with Staff G, Registered Nurse (RN), showed Resident 39's bilateral lower legs were swollen and that the resident did not have any compression stockings. Staff G stated that it was their responsibility to ensure that the treatment was implemented and that they did not on 01/07/2025. Joint record review and interview on 01/08/2025 at 9:10 AM with Staff H, RN, showed Resident 38's edema care plan had an intervention to apply and remove compression stockings as ordered. Staff H stated that staff should have followed the care plan. RESIDENT 89 Resident 89 admitted to the facility on [DATE]. Review of Resident 89's nutrition care plan initiated on 12/11/2024, showed that Resident 89 was at a nutritional risk and had a significant weight gain of 15.6% since their admission. The care plan further showed an intervention to alert the dietitian and physician to any significant weight loss or gain. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the summary for providers note dated 12/16/2024, showed the provider recommended to send out Resident 89 to the emergency room for anasarca (severe swelling of the body's tissues caused by a buildup of fluid) evaluation and treatment. Review of Resident 89's electronic health record (EHR) showed no documentation that the physician/provider had been notified of Resident 89's significant weight gain prior to 12/16/2024. On 01/07/2025 at 11:18 AM, Staff I, Nurse Practitioner (NP), stated that Resident 89 had gained twenty pounds since their admission. Staff I stated that staff had not reported to them that Resident 89 was gaining weight, further stating, not before I found it. Staff I further stated that they would expect to get report on a change like this, but they had not. On 01/08/2025 at 7:55 AM, Staff J, Physician, stated that if there was weight gain the staff would let the NP know, and that they had not been made aware of the significant weight gain. Staff J further stated that the staff should have let the provider know and that they provided 24-hour services a day. On 01/08/2025 at 2:35 PM, Staff B, Director of Nursing (DON), stated that their expectation was for staff to follow the resident's care plan. Staff B further stated that the provider should have been notified immediately of Resident 89's significant weight gain and that they did not document that the provider was notified. 46912 RESIDENT 17 Review of the quarterly Minimum Data Set (MDS-an assessment tool), dated 12/04/2024, showed that Resident 17 had limited ROM in their upper extremity on one side. Review of Resident 17's ROM care plan revised on 04/16/2020, showed interventions that included LN [Licensed Nurse] applies right rigid resting splint for 3-4 hours and PROM [Passive ROM] to RUE [right upper extremity] .AROM [Active ROM] to LUE [left upper extremity]. Review of Resident 17's EHR showed no documentation for splint use and no documentation that PROM and AROM was provided for Resident 17. Observations on 01/03/2025 at 9:09 AM and on 01/04/2025 at 2:08 PM, showed Resident 17 was not wearing any splints. In an interview on 01/06/2025 at 9:05 AM, Staff N, Certified Nursing Assistant (CNA), stated that Resident 17 had ROM impairment in their arms and legs. Staff N stated that they did not perform any ROM exercises for Resident 17. Staff N further stated that Resident 17 had splints and that they had not been wearing them recently. (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 and joint record review on 01/06/2025 at 9:23 AM, Staff L, RN, stated that nursing was responsible for putting on splints. Staff L stated that Resident 17 was supposed to wear splints. A joint record review of Resident 17's ROM care plan showed that LN applies right hand splint for 3-4 hours and PROM to RUE and AROM to LUE. Staff L stated, I can't [cannot] say it is consistently being done. Staff L further stated that they expected the ROM care plan to be followed. In an interview and joint record review on 01/07/2025 at 2:05 PM, Staff B stated that they did not have a restorative program, and they expected CNAs to do exercises recommended by therapy and that nursing was responsible for implementing the splint program. Staff B stated that if a resident had limitations in ROM, they need to do exercises to maintain or prevent decline. Joint record review of Resident 17's ROM care plan showed to apply right hand splint for 3-4 hours and to provide PROM to RUE and AROM to LUE. Staff B stated that ROM exercises should be done and I will work on finding documentation. Joint record review of the Medication Administration Record and the Treatment Administration Record showed no documentation that splints were applied for Resident 17. Staff B stated that they expected splints to be applied for Resident 17. Staff B further stated that they expected the ROM care plan to be followed. In a follow up interview on 01/08/2025 at 8:13 AM, Staff B stated, just to confirm we cannot find documentation for the PROM and AROM for Resident 17. 50891 Resident 99 A review of Resident 99's face sheet showed Resident 99 admitted to the facility on [DATE]. A review of Resident 99's comprehensive care plan did not include a discharge care plan. In an interview on 01/06/2025, Staff F, Social Services Assistant, stated that they were in the process of planning Resident 99's discharge. Staff F further stated that they did not include a discharge plan in the comprehensive care plan because they did not know where the resident was going to discharge. In a joint record review and interview on 01/06/2025 at 10:42 AM with Staff D, MDS Coordinator, showed Resident 99's comprehensive care plan did not have a discharge plan. Staff D stated Resident 99's comprehensive care plan did not have a discharge care plan and that the social worker usually completed this section in the care plan. In an interview on 01/08/2025 at 10:38 AM, Staff B stated that they expected discharge planning started at admission and should have a preliminary discharge plan within 48 to 72 hours. Staff B further stated that the discharge plan should be included in the comprehensive care plan. Reference: (WAC) 388-97-1020 (1)(2)(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51090 Based on observation, interview, and record review, the facility failed to develop and revise the comprehensive care plans for 3 of 26 residents (Residents 36, 87 and 91), reviewed for care plan timing and revision. The failure to develop comprehensive care plans for discharge planning, smoking behaviors and oxygen use, placed the residents at risk for unmet care needs, burns, injury, and potential negative outcomes. Findings included . Review of the Resident Assessment Instrument (RAI) 3.0 User's Manual (a guide directing staff on how to accurately assess the status of residents), Version 1.19.11, revised in October 2024, showed that The comprehensive care plan is an interdisciplinary (IDT) communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically .The overall care plan should be oriented towards: assisting the resident in achieving their goals, managing risk factors to the extent possible or indicating the limits of such interventions, involving the resident, resident's family and other representative as appropriate .The seven day requirement for completion or the modification of the care plan applies to the Admission, SCSA (Significant Change in Status Assessment) and or Annual RAI assessments .Care Plan Completion Date No Later Than CAA (Care Area Assessment) completion date plus seven calendar days. RESIDENT 36 Resident 36 readmitted to the facility on [DATE]. Review of Resident 36's SCSA dated 10/21/2024, Section C (Cognitive Patterns) item C0500 (BIMS -Brief Interview for Mental Status) was scored at 15, indicating that Resident 36's cognitive function was intact. Section Z (Assessment Administration) showed that item Z0500 (Signature of RN Assessment Coordinator Verifying Assessment Completion) showed Resident 36's SCSA and CAAs were signed as completed on 10/29/2024. Review of Resident 36's care plan showed the focus care plans for pressure ulcer, surgical wound, risk for fall, anticoagulation (blood thinner medication) therapy, risk for psychosocial (relating to the relation of social factors and individual thought and behavior) distress, risks for cardiovascular (refers to the heart and blood vessels) symptoms or complications, and physical therapy, were created/revised by Staff D, MDS Coordinator, on 11/12/2024 (seven days late after the completion of Resident 36's SCSA and CAAs worksheet). In a phone interview on 01/03/2025 at 8:41 AM, Collateral Contact 2 (CC2) stated they have not been contacted by the facility to participate in Resident's 36's plan of care since October 2024. CC2 further stated that the facility was not following a plan of care and that they have not seen Resident 36's care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/05/2025 at 8:25 AM, Resident 36 stated that their care plan had not been discussed with them. In an interview on 01/07/2024 at 4:19 PM, Staff B, Director of Nursing, stated that the facility IDT was involved in care planning. Staff B further stated they expected initial care conferences with the resident and their representative would be scheduled within 72 hours [of admission]. Staff B further stated that during the initial conference, the resident's care plan would be discussed, and copies would be offered. In an interview and joint record review on 01/08/2024 at 9:11 AM, Staff D stated that they were part of the IDT that was responsible for developing Resident 36's comprehensive care plan. Joint record review of Resident 36's care plans for pressure ulcer, surgical wound, risk for fall, anticoagulation therapy, risk for psychosocial distress, risks for cardiovascular symptoms or complications, and physical therapy were developed or revised on 11/12/2024. Staff D further stated that Resident 36's comprehensive care plan was not completed within seven days of Resident 36's SCSA completion. When asked if the resident or their representative participated in the development of Resident 36's comprehensive care plan, Staff D stated they discussed it with Resident 36 but that they did not contact CC2 to participate. When asked to show documentation of the care plan discussion with Resident 36, Staff D stated that they did not document their discussion with Resident 36. In an interview on 01/08/2024 at 1:25 PM, Staff B stated they expected comprehensive care plans to be completed timely. RESIDENT 87 Resident 87 admitted to the facility on [DATE] with diagnoses that included generalized muscle weakness and repeated falls. Review of Resident 87's nursing progress note dated 12/16/2024 showed that Resident outside smoking with roommate pushing wheelchair. SS [Social Services] educated resident on smoking policy. Review of Resident 87's smoking evaluation dated 12/17/2024 showed that Resident 87 was marked yes to have used oxygen, was marked yes to be able to safely hold a cigarette, was marked no to dispose of ashes or butts properly, and was marked no to resident could smoke safely without use of a smoking apron. It further showed that Resident not allowed to smoke and that the reason was unsafe to smoke. Review of Resident 87's physician orders showed an order for O2 [oxygen] concentrator set to two liters/min [l/min - unit of measurement] every day and every evening for O2 supplement to enhance breathing, dated 08/08/2024. Review of Resident's 87's comprehensive care plan printed on 01/07/2025 did not show care plan revision was completed to include smoking behaviors identified on 12/16/2024. It further showed that Resident 87 did not have a care plan related to oxygen use. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 01/07/2025 at 4:08 PM, Staff H, Registered Nurse, stated they were involved in care planning for Resident 87. Joint record review of Resident 87's care plan did not show Resident 87 had a care plan related to oxygen therapy or smoking behaviors. Staff H stated, I don't see it. When asked if there should be a care plan for residents who are on oxygen and are known to have smoked, Staff H stated Yes, there's [there are] hazards, oxygen explodes when you smoke with it. In an interview on 01/07/2024 at 4:19 PM, Staff B stated they expected a resident's care plan would reflect identified smoking behaviors and a care plan related to oxygen use. Staff B stated Yes, they shouldn't be smoking while using oxygen, the staff will follow the plan of care. RESIDENT 91 Resident 91 admitted to the facility on [DATE]. Review of Resident 91's progress note dated 12/16/2024 showed that Resident pushing [their] roommate in wheelchair to smoke. SS [Social Services (Staff E)] educated resident on smoking policy. Review of Resident 91's comprehensive care plan printed on 01/02/2025 did not show that Resident 91's comprehensive care plan was revised to include smoking behaviors identified on 12/16/2024. Review of Resident 91's December 2024 and January 2025 medication administration record (MAR) showed a physician's order for nicotine patch one time a day for smoking cessation was started on 12/18/2024. It further showed that Resident 91 refused their nicotine patch on 12/18/2024 through 12/20/2024 and refused again from 12/23/2024 through 01/02/2025. Review of a smoking evaluation dated 12/17/2024 showed that Resident 91 was marked yes for having a history of unsafe smoking habits and a history of sharing/selling cigarettes or smoking material. It further showed that Resident 91's smoking evaluation decision was that supervised smoking was required and that the reason was [Resident 91 was] unsafe to smoke. It further showed that the evaluation was not signed by Resident 91. Observation on 01/02/2025 at 8:17 AM showed Resident 91 walked through the lobby unaccompanied and headed toward the facility entrance. Further observation showed Resident 91 smoked a cigarette while in the facility's entrance lot. In an interview on 01/02/2025 at 8:49 AM, Resident 91 stated I don't just stand in the middle of the parking lot most of the time. I know the smoking policy. I'm working on the patch, but it's not something I can do today or overnight. My nurse offers it to me, but I'm not ready. In an interview on 01/08/2025 at 12:28 PM, Staff H stated they completed Resident 91's smoking evaluation dated 12/17/2024. When asked how a smoking evaluation was conducted, Staff H stated they asked Resident 91 for answers to specific questions on the evaluation form. Staff H stated that Resident 91 answered yes, when asked if they shared smoking materials. Joint record review of Resident 91's comprehensive care plan did not show care plan revision, prior to 01/02/2025, included smoking behaviors identified after the smoking evaluation was completed on 12/17/2024. Staff H stated, I can't remember, if it's not there, I probably didn't [did not revise]. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/08/2025 at 1:34 PM, Staff B stated they were aware of the staff observation on 12/16/2024 of Resident 91 to have smoked with their roommate and that the incident prompted a smoking evaluation to be completed on 12/17/2024. When asked if they expected Resident 91's care plan to have been revised once smoking behaviors were identified on 12/16/2024 and the smoking evaluation completion on 12/17/2024, Staff B stated, Yes, I agree, we should care plan everything. Joint record review of Resident 91's comprehensive care plan did not show revision to include identified smoking behaviors before 01/02/2025. Staff B stated, I don't see anything. Reference: (WAC) 388-97-1020 (2)(a)(c)(5)(b)

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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** 50891 Based on observation, interview, and record review, the facility failed to follow physician's order in accordance with professional standards when administering medications for 3 of 11 residents (Resident 42, 43 & 46), reviewed for medication administration. These failures placed the residents at risk for medication errors, negative outcomes, and a diminished quality of life. Findings included . A review of the facility's policy titled, Physician Orders, effective date 03/22/2022, showed they would ensure that all physician orders were complete and accurate. The policy showed that the Medical Records Department would verify that physician orders were complete, accurate and clarified as necessary. Whenever possible, the Licensed Nurse receiving the order would be responsible for documenting and implementing the order. Medication/treatment orders will be transcribed onto the appropriate resident administration record. Orders pertaining to the other health care disciplines will be transcribed on the appropriate communication system for that discipline. The policy further showed that supplies and medications required to carry out the physician order would be ordered. A review of the facility's policy titled, Administering Medication, revised in April 2019, showed medications were to be administered in a safe and timely manner, as prescribed. The policy further showed that medications were administered in accordance with prescriber orders, including any required time frame. RESIDENT 42 A review of Resident 42's December 2024 Medication Administration Record (MAR) showed an order for Sertraline (medication that treats depression) 25 milligram (mg-a unit of measurement) to be given with Sertraline 100 mg to equal 125 mg a day. The order showed it started on 10/21/2023 and was discontinued on 12/26/2024. The MAR further showed a new order for Sertraline 100mg one tablet daily to start on 12/27/2024. A review of Resident 42's January 2025 MAR showed an order for Sertraline 100mg one tablet daily. On 01/05/2025 at 8:09 AM, Staff DD, Licensed Practical Nurse (LPN), was observed preparing medications for Resident 42. Staff DD did not have Resident 42's MAR up and stated, I have to go fast in the morning or else it's hard to find them [residents]. Staff DD pulled the bingo card (medications that are bubble packed per dose on a card) for Sertraline 100 mg then started searching for the Sertraline 25 mg bingo card. Staff DD stated that Resident 42 gets a 100 mg [tablet] with a 25 mg [tablet]. When asked to check the Sertraline order, Staff DD could not find an order for Sertraline 125 mg to be given at this medication pass. In another interview on 01/05/2025 at 2:04 PM, Staff DD stated she found the [new] order for Sertraline, it was 100 mg. RESIDENT 43 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 43's January 2025 MAR showed they admitted to the facility on [DATE]. The MAR showed an order for Multivitamin (supplement) one tablet daily. In an observation and interview on 01/05/2025 at 8:13 AM, Staff DD pulled out a bottle of a multivitamins with minerals. Staff DD stated that they had been giving the multivitamin with minerals because the facility's house supply of multivitamin only came with minerals. Staff DD further stated that the order had been inputted incorrectly and needed to be corrected to reflect what was available in their house supply. In an interview on 01/05/2025 at 9:08 AM, Staff DD stated that they had spoken to another coworker and was informed that the facility did have a house supply of multivitamins without minerals. Staff DD stated, the doctor had told us we had to give what is in the house, what we have available. I've never seen it [multivitamin without minerals] before. In an interview on 01/05/2025 at 2:04 PM, Staff DD stated that their medication administration process included the six rights of medication pass. Staff D was able to name three of these six rights but was unable to recall the rest. Staff DD stated they were fast because they had 30 residents to pass medications to. Staff DD further stated that they try to check the orders and when they give medications, they sometimes goes by the label on the bingo card, but technically if the order changed, we should get another bingo card. In an interview on 01/05/2025 at 3:02 PM, Staff B, Director of Nursing, stated that staff should be checking the new orders and placing them on alert charting. Staff B stated that multivitamins and multivitamins with minerals were not the same. Staff B further stated that they [Staff DD] should have stopped and clarify the order. 46912 BLOOD PRESSURE MEDICATION Review of the facility's policy titled, Administering Medications, revised in April 2019, showed that vital signs [measurements of the body's essential functions], if necessary, are checked/verified for each resident prior to administering medications. RESIDENT 46 Resident 46 admitted to the facility on [DATE] with diagnoses that included hypertension (high blood pressure [BP]). Review of Resident 46's January 2025 MAR showed Resident 46 had an order for Hydralazine (medication to treat hypertension) to be given two times a day and with the parameters to hold for Systolic BP (SBP-the pressure in the arteries when the heart contracts) less than 110 or heart rate less than 60. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and record review on 01/07/2025 at 10:30 AM, Staff L, Registered Nurse, stated that if an order showed parameters to hold a BP medication for SBP less than 110 or pulse less than 60, then you should hold the medication. Staff L stated that vital signs should be checked prior to each medication that had parameters for administration. Joint record review of the January 2025 MAR showed Resident 46 was given hydralazine twice a day. A joint record review of the vital signs tab in the Electronic Health Record (EHR), showed Resident 46 had their BP checked in the mornings prior to their morning dose of hydralazine and no documentation that their BP was checked prior to their evening dose. Staff L stated that based on looking at this [vital signs tab] it did not show that Resident 46's BP was checked prior to getting their evening dose of hydralazine. In an interview and record review on 01/07/2025 at 2:05 PM, Staff B stated that they expected licensed nurses to follow parameters for medication administration. Staff B stated if an order showed parameters to hold a BP medication for SBP less than 110 or pulse less than 60, then vital signs should be checked before each dose. Staff B stated that if hydralazine was given twice a day, they expected vitals to be taken before each time it was given. Joint record review of the vital signs tab in the EHR, showed no documentation that Resident 46 had their vitals done prior to their evening dose of hydralazine. Staff B stated that they expected there to be documentation of vital signs. Reference: (WAC) 388-97-1620 (2)(b)(i)(ii)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51090 Based on interview and record review, the facility failed to ensure an effective resident centered discharge plan was in place for 1 of 5 residents (Resident 36), reviewed for discharge planning. The failure to develop a discharge care plan consistent with the resident's needs and/or the resident representative's expressed discharge goals, placed the resident at risk for unmet care needs, decreased self-morale, sadness, and a diminished quality of life. Findings included . Review of the facility's undated policy titled, Transfer or Discharge Resident-Initiated, showed that Resident-initiated transfer or discharge means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility. It further showed, The comprehensive care plan contains the resident's goals for admission and desired outcomes, which will be in alignment with the discharge if it is resident-initiated. RESIDENT 36 Resident 36 readmitted to the facility on [DATE]. Review of Resident 36's Significant Change in Condition Assessment (SCSA) dated 10/21/2024, Section C (Cognitive Patterns) item C0500 (BIMS -Brief Interview for Mental Status) was scored at 15, indicating that Resident 36's cognitive function was intact. It further showed that Section Q (Participation in Assessment and Goal Setting), item Q0400 was coded 0 to indicate that active discharge planning was not already occurring for the resident to return to the community. Item Q0500 (Return to Community) was coded 1 to indicate that Resident 36 wanted to talk to someone about the possibility of leaving the facility to return to live and receive services in the community. Review of a grievance form dated 10/30/2024 showed that the grievance was reported to social services and was submitted by Resident 36. The nature of the concern showed that [Resident 36] says that [they] are not happy here at [facility]. It showed that Staff F, Social Services Assistant, was the employee assigned to address the grievance and that Staff F's department findings was that Found out that [Resident 36] just wanted to be close to [Collateral Contact (CC2)]. It further showed that Staff F's action plan was that Planning discharge for another facility closer to [CC2] .when [CC2] and social services finds a facility. Review of Resident 36's comprehensive care plan printed on 01/05/2025, showed Resident 36's discharge care plan was created on 10/02/2024 and was last revised on 12/31/2024. It further showed that Resident 36's discharge care plan goal was that Resident/Patient will have an ongoing discharge plan that provides for a safe and effective discharge. It did not show a resident centered discharge goal consistent with Resident 36 and CC2's stated goal. In an interview on 01/03/2025 at 8:41 AM, Resident 36 stated they have had issues with the facility not returning phone calls to CC2 who wanted to be involved with Resident 36's discharge planning. Resident 36 stated their goal was to transfer to another facility to be near CC2. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview on 01/03/2025 at 8:41 AM, CC2 stated they have not been contacted by the facility to participate in Resident's 36's plan of care since October 2024 and that they have not received returned phone calls from the facility to discuss discharge planning. CC2 further stated that they filled out a grievance form in December 2024 related to their concern about Resident 36's discharge planning process. Review of the grievance form dated 12/08/2024 showed that the grievance was reported to Staff F and submitted by CC2. It showed that the nature of concern was that I have been contacting Social Services since October 24 [2024]. They never call back. They tell [Resident 36] that they do. I only want to help get [Resident 36] transferred closer to their family, which I feel will help with [Resident 36's] care and morale. It further showed that Staff F was the employee assigned to address the grievance and that Staff F's action plan to address the grievance was completed on 12/30/2024. The grievance form did not show that complete resolution/satisfaction was achieved. In an interview on 01/06/2025 at 2:26 PM, Staff F stated they were responsible for arranging care conferences to discuss discharge planning with the resident, the IDT (Interdisciplinary team) and the resident's representative, as well as to send out referrals related to the discharge planning process. Staff F stated that discharge planning starts from the resident's admission to the facility and that a resident's discharge goal was identified by completing a social services assessment. Staff F further stated that discharge planning was discussed with the resident and their representative during a care conference. Review of Resident 36's social services assessment dated [DATE] showed that Resident 36 planned to be discharged home alone with a caregiver. Review of Resident 36's Post Admission Resident/Resident Representative Conference, dated 11/18/2024, showed that the objective of the conference was to Review and communicate the person-centered baseline care plan and identify further resident and family expectations. It did not show that Resident 36 or CC2 attended the conference. It showed that Resident 36's post SNF (skilled nursing facility) disposition was marked as undetermined. It further showed that the Post Admission Resident/Resident Representative Conference was completed by Staff E, Social Services. In an interview and joint record review on 01/07/2025 at 1:15 PM, Staff F stated that Resident 36's discharge goal was that they wanted to transfer to another facility to be close to family. When asked if they expected that the discharge care plan would be updated timely when there are updates to a resident's discharge goal, Staff F answered, Yes. Joint review of Resident 36's discharge care plan, revised on 12/31/2024, did not show it included Resident 36's discharge goal to transfer to another facility to be closer to family. When asked if Resident 36's discharge care plan reflected Resident 36's stated goal, Staff F stated, I don't see it on here and that Resident 36's discharge care plan should have been updated to include Resident 36's stated discharge goal. Staff F further stated that they expected Resident 36 and CC2 would have been included in the care conference held on 11/08/2024. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/07/2025 at 2:24 PM, Resident 36 stated that their discharge goal had been to transfer to another facility closer to CC2. When asked if Resident 36 had a discharge goal of returning home alone with a caregiver, Resident 36 answered, No, I don't want to, my number one choice is to be closer to [CC2]. Resident 36 was tearful and stated, I don't think [the facility] has done enough to try to get me transferred because I'm still here. I'm sad that I'm not near [CC2] and it's not good for my morale, it's not good! My situation is upsetting. I don't feel like they're working hard enough to get me transferred. In a phone interview on 01/08/2025 at 11:18 AM, Staff E, Social Services, stated they completed Resident 36's Post Admission Resident/Resident Representative Conference, dated 11/18/2024 and that Resident 36 and CC2 did not attend the conference. Staff E stated CC2 was not offered to attend the conference and that they were not sure if Resident 36 was offered to attend. Staff E stated they could not find documentation in Resident 36's progress notes that showed Resident 36 was offered to attend the conference. Staff E stated both Resident 36 and CC2 should have been invited to attend the conference. When asked if Resident 36's discharge care plan, revised on 12/31/2024, reflected Resident 36 and CC2's goal to transfer Resident 36 to another facility to be close to family, Staff E stated, It does not. Staff E further stated that the discharge care plan should be updated periodically to reflect the resident's discharge goal and to include interventions that support that goal. In an interview and joint record review on 01/08/2025 at 1:20 PM, Staff B, Director of Nursing, stated that the facility's process on discharge planning was that whenever there is a discharge goal or changes in [the resident's] discharge goal, this triggers discharge planning to start. Staff B stated they expected that the resident or their representative would be included in the discharge planning process and that care conferences were scheduled to discuss discharge planning with the resident and/or their representative. Joint record review of Resident 36's Post Admission Resident/Resident Representative Conference, dated 11/18/2024, did not show that Resident 36 or CC2 attended the conference. Staff B stated they expected that Resident 36 and CC2 would have been offered to attend the conference. Staff B further stated they expected that Resident 36's discharge care plan would have been updated to include the resident centered discharge goal and when community referrals were made to support the goal. Reference: (WAC) 388-97-0080 (2)(a)(d)(e)(i)(ii) (4)(a)(5)(6)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on observation, interview, and record review, the facility failed to provide necessary assistance with Activities of Daily Living (ADL) for 2 of 4 residents (Residents 8 & 65), reviewed for ADLs. The failure to provide residents who were dependent on staff for assistance with getting out of bed, showers, and nail care, placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility's policy titled, Activities of Daily Living (ADLs), Supporting, revised in March 2018, showed, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. It showed that support and assistance with hygiene included, bathing, dressing, grooming, and oral care. It further showed that support and assistance with mobility included, transfer and ambulation. RESIDENT 8 TRANSFERRED OUT OF BED Review of the quarterly Minimum Data Set (MDS-an assessment tool) dated 11/26/2024, showed Resident 8 required substantial/maximal assistance (helper does more than half the effort) with transfers and bathing. It further showed that Resident 8 was dependent for getting in and out of the tub/shower. Review of Resident 8's ADL care plan, revised on 10/26/2024, showed that Resident requires assistance with ADL cares. Observations on 01/03/2025 at 9:07 AM, on 01/04/2025 at 9:29 AM, on 01/05/2025 at 1:17 PM, and on 01/06/2025 at 8:56 AM, showed Resident 8 in bed. In an interview on 01/05/2025 at 12:20 PM, Resident 8's representative asked Resident 8 if they would like to get into their wheelchair, Resident 8 stated, yes, I would. Resident 8's representative stated, they haven't got her out of bed since [Resident 8] came back from the hospital. In an interview on 01/06/2025 at 9:05 AM, Staff N, Certified Nursing Assistant (CNA), stated that Resident 8 needed help to get out of bed. In an interview on 01/06/2025 at 9:23 AM, Staff L, Registered Nurse, stated they expected that all residents be offered every day to see if they wanted to get out of bed. Staff L further stated that the last time Resident 8 got up out of bed was a few weeks ago and they should be offering [it] every day. SHOWERS (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's document titled, Task: BATHING, for the dates from 12/07/2024 through 01/05/2025, showed no documentation that Resident 8 was given a shower. In an interview on 01/05/2025 at 12:20 PM, Resident 8's representative stated that Resident 8, hasn't [has not] had a shower since she came back from the hospital. When asked if they would like a shower, Resident 8 stated, of course. In an interview on 01/06/2025 at 9:05 AM, Staff N stated, I haven't given [Resident 8] a shower in a while. When asked when Resident 8's last shower was, Staff N stated, I don't know. In an interview and joint record review on 01/06/2025 at 9:23 AM, Staff L stated that Staff NN, Scheduler, scheduled the showers for residents. Staff L stated that if a resident refused a shower, the nurse will document the refusal. Staff L stated that Resident 8 had no history of refusing showers. A joint record review of the Task: BATHING, for the dates from 12/07/2024 through 01/05/2025, showed no documentation that Resident 8 had been given a shower and showed N/A (not applicable). Staff L stated, I use it [N/A] for when not you're not supposed to do [the task]. Staff L further stated that it was not appropriate to chart N/A. In an interview and joint record review on 01/06/2025 at 11:01 AM, Staff NN stated that every resident should be scheduled for a shower. Staff NN stated that Resident 8 was scheduled for a shower every Friday. Joint record review of two documents titled, Mandatory shower sign off sheet, dated 12/06/2024 and 12/20/2024, showed Resident 8 refused a shower on 12/06/2024 and 12/20/2024. Staff NN stated that these were the only ones [Mandatory shower sign off sheet] for the last 30 days that documented Resident 8's showers or refusals. In an interview and joint record review on 01/07/2025 at 2:05 PM, Staff B, Director of Nursing, stated that we offer everybody to get out of bed and that was their expectation. Staff B stated they expected showers to be done per patient preference and that the facility will offer once or twice a week. Staff B stated that if a resident refused a shower, they would document the refusal in a progress note. Joint record review of the Task: BATHING, for the dates from 12/07/2024 through 01/05/2025, showed no documentation that Resident 8 had been given a shower and showed N/A. Staff B stated it was not appropriate to chart N/A, and it did not look like Resident 8 had a shower from 12/07/2024 through 01/05/2025. Joint record review of Resident 8's progress notes showed no documentation that Resident 8 had refused any showers. Staff B stated, it should be documented when getting a shower and/or a bed bath. 47680 NAIL CARE RESIDENT 65 Review of the significant change of condition MDS dated [DATE], showed that Resident 65 had diagnoses that included diabetes mellitus (high blood sugar). (continued on next page)

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	505042	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ballard Center	820 Northwest 95th Street Seattle, WA 98117

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 65's January 2025 MAR showed an order for a weekly body check, fingernails/toenails trim/care every evening shift, every Thursday, dated 11/28/2024. Further review showed that Resident 65 was marked to have received a weekly body check, fingernails/toenails trim/ care on 01/02/2025. Observation and interview on 01/03/2025 at 9:24 AM, showed Resident 65's third, fourth and fifth fingernails on their left hand were long and curving inwards with brown discoloration under their fingernails. Resident 65's fingernails on their right hand were long and curving inwards with brown discoloration under their fingernails. Resident 65 stated that they had asked staff several times to cut their fingernails. Additional observations on 1/04/2025 at 1:04 PM, on 01/05/2025 at 9:13 AM and on 01/06/2025 at 9:31 AM, showed Resident 65's third, fourth and fifth fingernails on their left hand were long and curving inwards with brown discoloration under their fingernails. Resident 65's fingernails on their right hand were long and curving inwards with brown discoloration under their fingernails. In an interview and joint observation on 01/06/2025 at 2:20 PM, Staff L stated that residents who had an order for nail care received nail care weekly. Staff L further stated that nurses provided nail care to residents with diabetes and CNAs provided nail care for residents who did not have diabetes. Joint observation showed Resident 65 hand long fingernails to both hands. Staff L stated, it's long and that [Resident 65] needs nail care. Joint record review of the January 2025 MAR showed Resident 65 was marked to have received fingernails/toenails trim care on 01/02/2025. Staff L further stated that Resident 65's fingernails should have been trimmed. In an interview on 01/06/2025 at 4:21 PM, Staff B stated that nail care should be done. You cannot sign it [MAR] if it's not done. Staff B further stated, only sign what you done. Reference: (WAC) 388-97-1060 (1)(2)(c)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49619 Based on observation, interview and record review, the facility failed to ensure residents received care and services in accordance with professional standards of practice for 3 of 5 residents (Residents 39,89 & 46), reviewed for quality of care. The failure to follow treatment orders for edema (swelling) and bowel management and/or the failure to notify medical providers for a significant weight gain placed the residents at risk for unmet care needs, pain/discomfort, and related complications. Findings included . Review of the facility's policy titled, Skin Integrity Management, dated 05/26/2021, showed that the implementation of an individual resident's skin integrity management occurred within the care delivery process. Review of the facility's undated policy titled, Weight Management, showed it was the facility's policy to obtain a baseline weight and identify a significant weight change and determine possible causes of the significant weight change. The policy showed that in the event of a patterned or significant, unplanned weight loss/gain of at least 2 percent (%) in a week, 5% in 30 days, 7.5% in 90 days, or 10% in 180 days, nursing staff should notify the physician, family member/responsible party. The policy further showed that the facility Interdisciplinary team would collaborate to determine the need for initiation/discontinuation of weights other than weekly or ordered by the physician. Review of the facility's policy titled, Administering Medications, revised in April 2019, showed medications are administered in accordance with prescribers' orders, including any required time frame. Review of the facility's policy titled, Change in Condition: Notification of, dated 08/25/2021, showed the facility must immediately inform the resident, consult with the resident's physician/nurse practitioner (NP), and notify, when there is a significant change in the resident's physical, mental, or psychosocial status (deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications.) The policy further showed that the physician/NP should be notified of a decision to transfer or discharge the resident from the center. RESIDENT 39 Resident 39 admitted to the facility on [DATE] with a diagnosis of Lymphedema (a chronic condition that causes swelling in the body due to a buildup of lymph [fluid that is part of the body's immune system] fluid). Review of Resident 39's order summary showed an order for BLE [bilateral (both) lower extremities] compress with Tubi-grips ([Tubigrip, a bandage used to help with swelling] start from foot NOT including toes extending two fingers below knee), in the morning with a start date of 02/23/2024. The order summary further showed an order to remove BLE Tubigrip at bedtime for lymphedema. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 39's edema care plan initiated on 12/27/2023 showed an intervention for applying and removing compression stockings (used to help prevent swelling in the legs and ankles and improve circulation) as ordered. Multiple observations on 01/04/2025 at 12:23 PM, on 01/05/2025 at 10:42 AM, on 01/06/2025 at 11:34 AM, and on 01/07/2025 at 8:43 AM, showed Resident 39's bilateral lower legs were swollen and was not wearing any compression Tubigrip/stockings. Review of Resident 39's January 2025 Treatment Administration Record (TAR) showed the orders for Tubigrip compression had been applied in the morning on 01/04/2025, 01/05/2025, 01/06/2025, and 01/07/2025. The TAR further showed that the Tubigrip had been removed at night on 01/04/2025, 01/05/2025, 01/06/2025, and 01/07/2025. Joint observation and interview on 01/07/2025 at 3:31 PM with Staff G, Registered Nurse (RN), showed Resident 39's bilateral lower legs were swollen and that the resident did not have any compression Tubigrip/stockings. When asked if Resident 39 had any treatment in place for the swelling to the lower extremities, Staff G stated, I think [Resident 39] has compression socks. Staff G stated that they had finished all the TAR documentation for the day. Staff G stated that they were responsible for carrying out the physician's orders. Staff G stated that they did not carry out the order to apply the Tubigrip compression that day and they documented that they had. Staff G further stated that their documentation was inaccurate, and that they should have paid attention to what they were documenting. On 01/08/2025 at 9:10 AM, Staff H, RN, stated that staff should have followed the physician order to apply and remove the Tubigrip as ordered and documented it correctly. On 01/08/2025 at 2:35 PM, Staff B, Director of Nursing, stated that they expected staff to follow the physician's orders. Staff B further stated that if staff did not complete an order, they should only document on things that they did. RESIDENT 89 Resident 89 admitted to the facility on [DATE]. Review of Resident 89's weights from 11/29/2024 through 12/16/2024 while in the facility showed the following: - 11/29/2024 - weighed 168 pounds (lbs. - unit of measurement). - 12/02/2024 - weighed 181.2 lbs. - 12/06/2024 - weighed 194.2 lbs. Resident 89 gained 26.2 lbs. in one week since admission to the facility. Review of Resident 89's nutrition care plan initiated on 12/11/2024, showed that Resident 89 was at a nutritional risk and had a significant weight gain of 15.6% in less than one month since their admission. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/05/2025 at 12:44 PM, Collateral Contact 1 (CC1), stated that Resident 89 had called them very early in the morning stating that they could not feel their feet, and to please call 911 to transport them to the hospital. CC1 stated that Resident 89 said that they really needed to go to the emergency room (ER) and no one was listening. CC1 further stated that staff called them to report that the resident had gained a lot of water weight and was going to go to the ER. Review of Resident 89's nursing progress note dated 12/16/2024 at 6:41 AM, showed that Resident 89 wanted to be discharged to the hospital. The progress note stated that Resident 89 thought, [they] should be at the hospital due to [their] condition. The note showed that 911 had called to inquire about the resident's condition because CC1 had called 911 to come and transport the resident to the hospital. The note showed that Resident 89 had, no c/o [complaints of] pain/any distress, edema 3+ [Deep pitting, significant indentation (6 millimeter-a unit of measurement), takes about 30 seconds to rebound] to all extremities (baseline [or a minimum or starting point for comparison]), pass on for day nurse to let house provider visit the resident during rounds. Further review of the note showed the provider was not notified at this time of the above. Review of Staff I, NP, provider note date of service of 12/16/2024, showed they had noted Resident 89 with increased weight and edema of bilateral upper and lower extremities and that they had gained more than twenty pounds in the last two weeks. Further review of the note showed that Staff I discussed this with Resident 89 and their representative and would send the resident out to the ER for further evaluation of anasarca (severe swelling of the body's tissues caused by a buildup of fluid). Review of Resident 89's electronic health record showed no documentation that the physician/provider had been notified of Resident 89's significant weight gain prior to 12/16/2024. In an interview on 01/07/2025 at 11:18 AM, Staff I stated that Resident 89 had gained twenty pounds since their admission. Staff I stated that staff had not reported to them that Resident 89 was gaining weight, further stating, not before I found it. Staff I further stated that they would expect to get report on a change like this, but they had not. On 01/08/2025 at 7:55 AM, Staff J, Physician, stated that if there was a weight gain the staff would let the NP know, and that they had also not been made aware of the significant weight gain. Staff J further stated that the staff should have let the provider know and that they provided 24-hour services a day. On 01/08/2025 at 1:37 PM, Staff EE, Licensed Practical Nurse, stated that they were the assigned nurse for Resident 89 on 12/16/2024. Staff EE stated that they had received report that the resident wanted to go to the hospital, and that CC1 had called wanting the resident to be sent out, but that the previous nurse did not mention why CC1 wanted Resident 89 to be sent out. Staff EE stated that they were not familiar with Resident 89's baseline as it was their first time working with them, but did note edema to their arms, face, and legs and notified the NP that was in the facility at the time. Staff EE stated that if a resident or their representative wanted them to go to the hospital, or if there was a significant weight change, they should notify the provider. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/08/2025 at 2:44 PM, Staff B stated that if a resident requested to go to the hospital their expectation was for staff to complete an assessment, notify the provider and family, and do their due diligence as a facility before sending the resident out. Staff B stated that ultimately the resident had the right to go to the ER. Staff B further stated that the provider should have been notified immediately of Resident 89's significant weight gain and that they did not document that the provider was notified [prior to 12/16/2024]. 46912 RESIDENT 46 Review of Resident 46's constipation care plan, revised on 12/19/2024, showed interventions to ask [Resident 46] if she has gone independently for documentation: document bowel movements [BMs] q [every] shift. It showed to start bowel protocol if no bowel movement within 9 shifts. Review of the facility's document titled, Task: PERSONAL HYGIENE: Toileting, dated 12/10/2024 through 01/08/2025, showed Resident 46 did not have a BM from 12/16/2024 through 12/26/2024 (10 days). It showed Resident 46 did not have a BM from 12/28/2024 through 01/02/2025 (five days). It further showed Resident 46 did not have a BM from 01/03/2025 through 01/06/2025 (four days). Review of Resident 46's December 2024 Medication Administration MAR (MAR) showed no documentation that any as needed (PRN) medications were given for not having a BM from 12/16/2024 through 12/26/2024 and from 12/28/2024 through 01/02/2025. Review of Resident 46's January 2025 MAR showed no documentation that any PRN medications were given for not having a BM from 12/28/2024 through 01/02/2025 and from 01/03/2025 through 01/06/2025. In an interview on 01/05/2025 at 8:35 AM, Resident 46 stated that several times .I've had to ask for medication like a suppository for constipation. Resident 46 stated that they were not sure if the aides were keeping up with the charting of BMs. In an interview on 01/08/2025 at 8:20 AM, Staff N, Certified Nursing Assistant (CNA), stated that Resident 46 had constipation quite frequently. In an interview and joint record review on 01/08/2025 at 8:30 AM, Staff L, RN, stated that if a resident went three days without a BM, it triggers a clinical alert, and someone goes around and will tell us that the resident has had no BM for three days and to start PRN medications as part of the bowel protocol. Joint record review of the Task: PERSONAL HYGIENE: Toileting, dated 12/10/2024 through 01/08/2025, showed Resident 46 did not have a BM from 12/16/2024 through 12/26/2024. Staff L stated it showed nine or 10 days without a BM. Staff L stated that BMs should be documented, but aides might not be charting. It showed that Resident 46 did not have a BM from 12/28/2024 through 01/02/2025 and from 01/03/2025 through 01/06/2025. Staff L stated Resident 46 did not have a BM according to these records. Joint record review of the December 2024 and January 2025 MARs showed no documentation that Resident 46 received any PRN bowel medications for having no BM on those dates. Staff L stated that Resident 46 should have had PRN bowel medications based off the documentation. (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 and joint record review on 01/08/2025 at 4:43 PM, Staff B stated that CNAs/direct staff are responsible for documenting when a resident had a BM. Joint record review of the Task: PERSONAL HYGIENE: Toileting, dated 12/10/2024 through 01/08/2025, showed Resident 46 did not have a BM from 12/16/2024 through 12/26/2024. It showed that Resident 46 did not have a BM from 12/28/2024 through 01/02/2025 and from 01/03/2025 through 01/06/2025. Staff B stated that they did not expect that many days for a resident to not have a BM. Staff B further stated that they expected BMs to be documented and that even if the resident did not want to be asked about their BMs, they expected staff to check with the patient or document if they refused to say if they had one. 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. 46912 Based on observation, interview, and record review, the facility failed to ensure services were consistently provided to increase Range of Motion (ROM) and/or to prevent decrease in ROM for 1 of 3 resident (Resident 17), reviewed for ROM and mobility. This failure placed the resident at risk for unmet care needs, a decline in ROM, and a diminished quality of life. Findings included . Review of the quarterly Minimum Data Set (an assessment tool) dated 12/04/2024, showed Resident 17 had limited ROM in their upper extremity on one side. Review of Resident 17's ROM care plan revised on 04/16/2020, showed interventions that included, LN [Licensed Nurse] applies right rigid resting splint for 3-4 hours and PROM [Passive ROM] to RUE [right upper extremity] .AROM [Active ROM] to LUE [left upper extremity]. Review of Resident 17's electronic health record showed no documentation for splint use and no documentation that PROM and AROM was provided for Resident 17. Observations on 01/03/2025 at 9:09 AM and on 01/04/2025 at 2:08 PM, showed Resident 17 was not wearing any splints. In an interview on 01/06/2025 at 9:05 AM, Staff N, Certified Nursing Assistant (CNA), stated that Resident 17 had ROM impairment in their arms and legs. Staff N stated that they did not perform any ROM exercises for Resident 17. Staff N further stated that Resident 17 had splints and that they had not been wearing them recently. In an interview and joint record review on 01/06/2025 at 9:23 AM, Staff L, Registered Nurse, stated that nursing was responsible for putting on splints. Staff L stated that Resident 17 was supposed to wear splints. A joint record review of Resident 17's ROM care plan showed that LN applies right hand splint for 3-4 hours and PROM to RUE and AROM to LUE. Staff L stated, I can't [cannot] say it is consistently being done. In an interview and joint record review on 01/07/2025 at 2:05 PM, Staff B, Director of Nursing, stated that they did not have a restorative program and that they expected CNAs to do exercises recommended by therapy and that nursing was responsible for implementing the splint program. Staff B stated that if a resident had limitations in ROM, they need to do exercises to maintain or prevent decline. Joint record review of Resident 17's ROM care plan showed to apply right hand splint for 3-4 hours and to provide PROM to RUE and AROM to LUE. Staff B stated that ROM exercises should be done and I will work on finding documentation that it was done. Joint record review of the Medication Administration Record and the Treatment Administration Record showed no documentation that splints were applied for Resident 17. Staff B stated that they expected splints to be applied for Resident 17. In a follow up interview on 01/8/2025 at 8:13 AM, Staff B stated, just to confirm we cannot find documentation for the PROM and AROM for Resident 17. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51090 Based on observation, interview, and record review, the facility failed to follow and implement smoking assessment and care plan, and did not ensure smoking materials were securely maintained for 1 of 10 residents (Resident 91), and failed to ensure side rails were secured and maintained for 1 of 2 residents (Resident 34), reviewed for accident hazards. These failures placed the residents at risk of potential burns, injury, potential harm and other negative outcomes. Findings included . In a meeting with Staff C, Interim Administrator, Staff A, Administrator and Staff B, Director of Nursing, on 01/02/2025 at 10:40 AM, a request for documentation of the facility's list of residents who smoke, designated smoking times, locations as well as the facility's smoking policy. Staff C and Staff B stated that the facility was a Smoke-Free Center, and that their current list of residents who smoked were grandfathered participants. Documentation of the facility's smoking policy was not provided. Review of the facility's admission agreement packet showed an undated document titled, Smoke-free Center Acknowledgement Form. It further showed that recipients of this document were asked to acknowledge that the facility is a smoke-free environment and agree not to smoke while residing in the Center. Review of the facility's admission agreement packet showed an undated documented titled, Facility Rules, showed that the facility prohibited items such as possession of common incendiary devices such as matches or lighters since these represent a fire hazard. If any of these items are found, they will be secured by the facility and asked to be picked up by the family. Review of the facility's document titled Smoking Audit, dated 01/02/2025 showed a list of current 12 residents who smoked. Further review of the list did not show Resident 91 was listed. RESIDENT 91 Resident 91 admitted to the facility on [DATE] with diagnoses that included unsteadiness, muscle weakness, and generalized anxiety (constant feeling of unease, worry and nervousness) disorder. Review of Resident 91's nursing progress note dated 12/16/2024 showed that Resident pushing [their] roommate in wheelchair to smoke. SS [Social Services (Staff E)] educated resident on smoking policy. Review of Resident 91's comprehensive care plan printed on 01/02/2025 did not show that Resident 91's care plan was revised to include smoking behaviors identified on 12/16/2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 91's December 2024 and January 2025 medication administration record showed a physician's order for nicotine patch one time a day for smoking cessation was started on 12/18/2024. It further showed that Resident 91 refused their nicotine patch on 12/18/2024 through 12/20/2024 and refused again from 12/23/2024 through 01/02/2025. Review of a smoking evaluation dated 12/17/2024 showed that Resident 91 was marked yes for having a history of unsafe smoking habits and a history of sharing/selling cigarettes or smoking material. It showed that Resident 91's smoking evaluation decision was that supervised smoking was required and that the reason was [Resident 91 was] unsafe to smoke. It further showed that the evaluation was not signed by Resident 91. Observation on 01/02/2025 at 8:17 AM showed Resident 91 walked through the facility entrance lobby unaccompanied and smoked a cigarette while in the facility's entrance lot. Further observation at 8:22 AM showed Resident 91 entered the facility through the front lobby and Resident 91 did not provide their smoking materials to staff for safe storage, prior to entering their room. In an interview on 01/02/2025 at 8:49 AM, Resident 91 stated, I don't just stand in the middle of the parking lot most of the time. I know the smoking policy. I'm working on the patch, but it's not something I can do today or overnight. My nurse offers it to me, but I'm not ready. Observation on 01/02/2025 at 8:58 AM showed Resident 91's roommate, Resident 87, had a portable oxygen concentrator placed between Resident 91 and Resident 87's bed. In an interview and joint record review on 01/08/2025 at 12:28 PM, Staff H, Registered Nurse, stated they completed Resident 91's smoking evaluation dated 12/17/2024. When asked how a smoking evaluation was conducted, Staff H stated they asked Resident 91 for answers to specific questions on the evaluation form. Staff H stated that Resident 91 answered, yes, when asked if they shared smoking materials. When asked if Resident 91 was asked during the smoking evaluation, where they stored their smoking materials, Staff H stated, [Resident 91] didn't want to answer. When asked if the Resident 91 should have signed the smoking evaluation completed on 12/17/2024, Staff H stated, [Resident 91] didn't sign and date it. Joint record review of Resident 91's care plan did not show that their care plan was revised prior to 01/02/2025 to include smoking behaviors identified after the smoking evaluation was completed on 12/17/2024. When asked if Resident 91's care plan should have been revised after the smoking evaluation, Staff H answered, I can't remember, if it's not there, I probably didn't [did not revise]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 01/08/2025 at 1:34 PM, Staff B stated they were aware of the staff observation on 12/16/2024 of Resident 91 and their roommate to have smoked and that the incident prompted a smoking evaluation to be completed on 12/17/2024. Joint record review of Resident 91's smoking evaluation dated 12/17/2024 showed that Resident 91 was marked yes for having a history of unsafe smoking habits and a history of sharing/selling cigarettes or smoking material. It further showed that Resident 91's smoking evaluation decision was that supervised smoking was required and that the reason was [Resident 91 was] unsafe to smoke. Staff B stated that it was the facility's policy that smoking materials were kept in a cart with the smoking aid. When asked if they expected smoking materials to be managed/stored by residents independently, Staff B stated No, residents cannot keep it in the room. We would offer to lock it in a safe. When asked if there should have been an attempt from staff to determine where Resident 91 kept their smoking material once the smoking evaluation was completed on 12/17/2024, Staff B stated, I don't see any [progress] note regarding it. When asked if the potential for Resident 91 keeping smoking materials on their person posed a risk for a hazard to themselves and others in the building, Staff B stated, Yes, that's why we educate them to keep it safely stored. When asked if they expected Resident 91's care plan to have been revised once smoking behaviors were identified on 12/16/2024 and the smoking evaluation completion on 12/17/2024, Staff B stated, Yes, I agree, we should care plan everything. Joint record review of Resident 91's care plan did not show it was revised to include identified smoking behaviors before 01/02/2025. Staff B stated, I don't see anything. 50891 Review of the facility's policy titled, Bed Safety, dated 03/22/2022, showed, the bed safety policy's purpose was to strive to prevent/reduce hazards such as resident entrapment associated with hospital beds when side rails were required. The policy further showed that the facility would provide a properly working bed, and properly fitting mattress and/or side rails to reduce the hazard of resident entrapment. RESIDENT 34 A review of Resident 34's face sheet showed they admitted to the facility on [DATE]. A review of Resident 34's comprehensive care plan, printed on 01/08/2025, showed Resident 34 used side rails to assist with bed mobility, and getting in and out of bed. A joint observation and interview on 01/7/2025 at 1:47 PM with Staff K, Registered Nurse (RN), showed Resident 34's bed had 1/4 side rails in the up position on both sides. Staff K stated that both side rails felt loose and need to be maintained. Staff K further stated that they would put in a work order to have Resident 34's side rails tightened. In an interview and joint observation on 01/08/2025 at 8:47 AM, Staff X, Maintenance Assistant, stated that they did not check on the side rails unless they were listed in the work order. A joint observation with Staff X showed Resident 34's bed had 1/4 side rails in the up position on both sides. Staff X moved the siderails from side to side, Staff K stated that both side rails were loose because they would loosen over time and that they would add a washer to the siderails to help tighten them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/08/2025 at 12:42 PM, Staff A stated that side rails should be maintained and should be working properly. Reference: WAC 388-97-1060(3)(g)(vi)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on observation, interview, and record review, the facility failed to provide respiratory care in accordance with accepted professional standards of practice for 2 of 3 residents (Residents 22 & 87), reviewed for respiratory care. The failure to follow physician orders for oxygen therapy, and properly store oxygen equipment placed the residents at risk for respiratory infections and related complications. Findings included . Review of the facility's policy titled, Oxygen Administration, revised in October 2010, showed, Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. RESIDENT 22 Review of the Quarterly Minimum Data Set (an assessment tool) dated 10/11/2024, showed Resident 22 was cognitively intact and that they received oxygen therapy. It further showed that they had diagnoses that included chronic obstructive pulmonary disease (a condition that blocks air flow and make it difficult to breathe). Review of Resident 22's January 2025 Medication Administration Record (MAR) printed on 01/05/2025, showed an order for oxygen at two to three liters (unit of measurement) per minute via nasal cannula (flexible tubing that sits inside the nose and delivers oxygen) continuously except when smoking every shift, dated 08/15/2022. Further review showed that Resident 22 received oxygen from 01/01/2025 through 01/05/2025. Observation on 01/03/2025 at 9:41 AM, showed Resident 22 was receiving four and a half liters of oxygen via nasal cannula. Observation on 01/05/2025 at 8:48 AM, showed Resident 22 was lying in bed asleep receiving five liters of oxygen via nasal cannula. In another observation at 12:44 PM, showed Resident 22 was sitting up in bed receiving five liters of oxygen via nasal cannula. When asked how many liters of oxygen they received, Resident 22 stated three liters. When asked if they touched the oxygen flow meter, Resident 22 stated, No and that the nurses do it. Observation on 01/06/2025 at 9:34 AM, showed Resident 22 was lying in bed asleep receiving five liters of oxygen via nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 01/06/2025 at 1:27 PM, Staff U, Registered Nurse (RN), stated that their process of oxygen use was to verify physician order, which type of delivery (mask or nasal cannula) and to adjust the oxygen to what was ordered. Staff U stated that they checked for correct liter flow at the beginning and during the shift if the resident got up. Joint record review of Resident 22's physician orders showed oxygen two to three liters per minute via nasal cannula continuously except when smoking every shift. Joint observation with Staff U showed Resident 22 was lying in bed receiving five liters of oxygen via nasal cannula. Staff U stated Resident 22's oxygen liter should have been between two to three liters per physician's order. When asked if they checked Resident 22's oxygen flow meter, Staff U stated, I have not checked it today. In an interview on 01/06/2025 at 3:23 PM, Staff T, Charge Nurse, stated their expectation for residents' receiving oxygen was for staff to ensure oxygen tubing was dated, oxygen tank was cleaned, and physician's orders were followed. Staff T further stated that Resident 22 should have received two to three liters of oxygen per physician orders and should not have been receiving five liters of oxygen. In an interview on 01/06/2025 at 4:21 PM, Staff B, Director of Nursing, stated that they expected Resident 22 to have received two to three liters of oxygen as ordered. 51090 RESIDENT 87 Resident 87 admitted to the facility on [DATE] with diagnoses that included generalized muscle weakness and chronic pain syndrome. Review of Resident 87's physician orders showed Resident 87 had an order for O2 [Oxygen] concentrator set to 2 [two] liters per minute every day and every evening shift for O2 supplement to enhance breathing, dated 08/08/2024. Review of Resident 87's January 2025 MAR showed an order for O2 concentrator set to 2 liters per minute every day and every evening shift for O2 supplement to enhance breathing, dated 08/08/2024. It further showed that the oxygen order was signed to have been administered every day, from 01/01/2025 through 01/07/2025. Review of Resident 87's documentation of oxygen saturation readings printed 01/07/2025 did not show oxygen saturation levels were read for Resident 87 since 10/26/2024. Observation and interview on 01/02/2025 at 8:58 AM, showed there was a magnet on Resident 87's room door that showed Oxygen in use. Further observation showed that Resident 87 had a portable oxygen concentrator in their room and that it was not in use. Resident 87 was asked when they received oxygen therapy and Resident 87 replied When they check my oxygen levels and it's low, that's when they put it on me. Observation on 01/05/2025 at 1:14 PM, showed Resident 87 was up in their wheelchair. It did not show that Resident 87 had their oxygen therapy in use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A joint record review and interview and on 01/07/2025 at 12:55 PM with Staff JJ, RN, showed Resident 87's January 2025 MAR had an order for O2 concentrator set to 2 liters per minute every day and every evening shift for O2 supplement to enhance breathing. It further showed that the oxygen order was signed to have been administered every day from 01/01/2025 through 01/07/2025. Staff JJ was asked if Resident 87 received their oxygen therapy every day and every evening and Staff JJ stated they did not think they needed to [administer Resident 87's oxygen therapy] routinely. Staff JJ stated, We would administer it if their oxygen saturation was below 90% [percent]. Joint record review of Resident 87's documentation of oxygen saturation readings did not show that oxygen saturation levels were read for Resident 87 since 10/26/2024. Staff JJ stated there was no documentation of oxygen saturation readings for Resident 87 since 10/26/2024. When asked if the physician's order instructed staff to hold oxygen administration for oxygen saturation readings less than 90%, Staff JJ replied, it did not, and that Resident 87's oxygen therapy physician's order was not as needed. Staff JJ was asked if they expected staff to follow Resident 87's physician order as it was written and Staff JJ answered, Yes. Staff JJ further stated, I should follow the order. A joint record review and interview on 01/07/2025 at 1:20 PM with Staff EE, Licensed Practical Nurse/Charge Nurse, showed Resident 87's physician order for O2 concentrator set to 2 liters per minute every day and every evening shift for O2 supplement to enhance breathing, dated 08/08/2024. Staff EE stated routinely scheduled orders would be reflected in the physician's order and that Resident 87's physician's order was scheduled for routine administration and not as needed. Staff EE stated, That's written there, every day and evening shift, it doesn't say PRN [as needed]. Staff EE further stated that they expected Resident 87's oxygen therapy to have been administered as ordered. A joint observation and interview with Staff EE and Staff JJ on 01/07/2025 showed Resident 87 in their room and that they did not have their oxygen therapy administered as ordered. Staff JJ stated they were about to put it on [Resident 87]. Observation of the nasal cannula showed it was placed across Resident 87's bedside table. Further observation showed it was placed on top of their personal belongings. Staff EE stated that Resident 87's nasal cannula should have been stored in a bag when not in use. Staff JJ was asked if Resident 87's nasal cannula was stored in a bag and Staff JJ replied, No, I'll change it. In an interview and joint record review on 01/08/2025 at 10:40 AM, Staff B stated they expected nasal cannulas to be bagged when they are not used and that nasal cannulas should not touch any surfaces. Joint record review of Resident 87's physician orders showed an order for oxygen therapy. Staff B stated Resident 87's physician order for oxygen therapy was routine and that they expected staff would follow the physician's order. Staff B further stated they expected nurses to clarify with the medical provider when they were unsure about a physician's order. Reference: (WAC) 388-97-1060(3)(j)(vi)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 47680 Based on interview and record review, the facility failed to complete the required annual performance evaluations for 5 of 5 staff (Staff M, N, O, P & Q), whose personnel files were reviewed for Certified Nursing Assistant (CNA) performance evaluations. The failure to complete a performance review of every nurse aide at least once every 12 months and provide regular in-service education based on the outcome of these reviews, placed residents at risk for receiving care from underqualified nursing staff and unmet care needs. Findings included . Review of the facility's policy titled, Performance Evaluations, revised in September 2020, showed, The job performance of each employee shall be reviewed and evaluated at least annually. Review of personnel file on 01/07/2025, showed Staff M, CNA, was hired on 12/02/2012. Further review showed that Staff M's most recent annual performance evaluation was completed on 07/15/2015. Review of personnel file on 01/07/2025 for Staff N, CNA, showed they were hired on 12/01/2012. Further review showed that Staff N's most recent annual performance evaluation was completed on 10/13/2015. Review of personnel file on 01/07/2025 for Staff O, CNA, showed that they were hired on 05/07/2020. The facility was not able to provide documentation that an annual performance evaluation was completed for Staff O. Review of personnel file on 01/07/2025 for Staff P, CNA, showed they were hired on 12/19/2019. Further review showed that STAFF P's most recent annual performance evaluation was completed on 03/15/2022. Review of personnel file on 01/07/2025 for Staff Q, CNA, showed they were hired on 08/26/2014. The facility was not able to provide documentation that an annual performance evaluation was completed for Staff Q. In an interview on 01/08/2025 at 12:45 PM, Staff B, Director of Nursing, was asked how often they conducted performance evaluations for nursing staff, Staff B stated that they did not know but thinks it should be done yearly. In an interview on 01/08/2025 at 1:33 PM, Staff R, Senior [NAME] President of Operations, stated, Everyone should get an annual evaluation. Staff R was informed that Staff M, N, O, P, and Q did not have any current performance evaluations, Staff R stated, let me check and see, if they're not in the employee file then they're probably not up to date on those. On 01/08/2025 at 3:15 PM, Staff W, Human Resources, provided the following documentation: - Staff M's Employee Performance Appraisal Form dated 07/15/2015. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Staff N's Performance Appraisal Form dated 06/11/2015 and Employee Performance Appraisal Form dated 10/13/2015. -Staff P's Certified Nursing Assistant Evaluation dated 04/09/2020 and 03/15/2022. In an interview on 01/08/2025 at 3:37 PM, Staff W stated that the performance evaluations provided were the most current performance evaluations they had on file. In an interview and joint record review on 01/08/2025 at 4:18 PM, Staff A, Administrator, stated that they expected each department heads to complete evaluations for their staff. Staff A stated that for nursing it would be the Director of Nursing or Nursing Managers and that they should be doing the evaluations timely. Joint record review of the performance evaluations provided by Staff W showed that Staff O and Q did not have performance evaluations, and that Staff M, N, and P's performance evaluations were late. Staff A further stated that they expected staff performance evaluations to be completed timely. Reference: (WAC) 388-97-1680 (2)(b)(i)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50891 Based on observation, interview and record review, the facility failed to appropriately store drugs and/or biologics (diverse group of medicines made from natural sources) for 2 of 3 medication carts (Medication Carts 2 & 3), reviewed for medication storage. This failure placed the residents at risk for receiving compromised/ineffective medications and potential adverse outcome. Findings included . Review of the facility's policy titled, Medication Labeling and Storage, revised in February 2023, showed that the facility stored all medications and biologicals in locked compartments under proper temperature humidity and light controls. The policy showed the facility medications were stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle drawer, or other holding area to prevent the possibility of mixing medications of several residents. The policy further showed that multi-dose vials that had been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specified a shorter or longer date for the open vial. MEDICATION CART 2 A joint observation and interview on [DATE] at 2:47 PM with Staff G, Registered Nurse (RN), showed one opened vial of Humulin (insulin-injectable medication to treat high blood sugar) 100 units (a unit of measurement) for Resident 36 in the top drawer of the medication cart that was half empty, dated ,d+[DATE] [[DATE], 40 days from the date it was opened]. Further observation showed the bottom drawer of the cart had a box with different tubes of creams, ointments and powders for multiple residents. These medications were not properly stored or separated by resident, which included the following medications: - Two opened bottles of nystatin powder (used to treat fungal infections) and one opened tube of triamcinolone (topical ointment used to treat skin conditions) labeled for Resident 36. - One opened tube of bacitracin (a topical antibiotic that treats infections), house supply. - One opened bottle of nystatin powder for Resident 27. - One open bottle of Aspercream (brand name, a topical cream to treat pain), no label - One opened tube of nystatin cream for Resident 41. - One unopened tube of TheraHoney (brand name, a medical-grade wound dressing made from Manuka honey), unlabeled. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff G stated that they had planned to discard the vial of insulin and that some of the residents no longer use some of the medications included in the box of creams, powders, and ointments found on the bottom drawer. MEDICATION CART 3 A joint observation and interview on [DATE] at 2:28 PM with Staff HH, RN, showed the last drawer of medication cart 3 had a box with various creams, ointments and powders for different residents. These medications were not properly stored or separated by resident. These medications included: - One opened tube of a triple antibiotic ointment (topical treatment for minor skin issues), for house supply. - One opened tube of Halobetasol (topical cream used to treat minor skin irritations) and one opened bottle of nystatin for Resident 34. - One opened tube of bacitracin, house supply. - One opened tube of clotrimazole cream for Resident 88. - One opened bottle of nystatin for Resident 60. Staff HH stated that some of these treatments were discontinued and would discard them. In an interview on [DATE] at 10:38 AM, Staff B, Director of Nursing, stated that they expected discontinued medications to be sent back to the pharmacy and any medications that were expired and/or discontinued should be removed from the medication cart immediately. Staff B further stated that treatment creams should not be mixed and should be separated in the medication cart. Reference: (WAC) [DATE](2)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49619 Based on observation, interview, and record review, the facility failed to ensure residents received current food menus and/or alternative menus that meets their needs including daily fresh fruits and vegetables for 5 of 6 residents (Residents 14, 309, 89, 55 & 52), reviewed for dining services. This failure placed the residents at risk for not having their food choices honored, dissatisfaction with meals, unmet nutritional needs, and a diminished quality of life. Findings included . Review of the USDA Dietary Guidelines for Americans 2020-2025 [retrieved on 01/15/2025], stated nutritional needs should be from nutrient dense foods such as vegetables from all vegetable subgroups like dark green; red and orange; as well as whole fruits. The recommended intake for an adult (Age 19 - 59): Vegetables: 2 - 4 cups/day; Fruits: 1 1/2 - 2 1/2 cups/day; (Age 60 and up): Vegetables: 2 - 3 1/2 cups/day; Fruits: 1 1/2 - 2 cups/day. Review of the facility's policy titled, Menus, revised on 09/2017, showed that menu cycles would include nutrient analysis to ensure that all client nutritional needs were met in accordance with the most recent edition of the Food and Nutrition Board, Institute of Medicine, National Academies, and the Dietary Guidelines for Americans. The policy further showed that menus would be posted in resident/patient care areas. Review of the facility provided menus, printed on 01/04/2025, showed the following: Week Two Menu: - Sunday lunch, only meal with a fresh vegetable, and no fresh fruit was offered that day. - Monday, no fresh fruits/vegetables offered that day. - Wednesday dinner, only meal with fresh vegetables, no fresh fruit was offered that day. - Thursday, no fresh fruits/vegetables offered that day. - Friday dinner, only meal with fresh vegetable, and no fresh fruit was offered that day, - Saturday lunch, only meal with fresh vegetable, and no fresh fruit was offered that day. Week Three Menu: - Sunday, no fresh fruits/vegetables offered that day. - Monday, no fresh fruits/vegetables offered that day. - Tuesday dinner, only meal with a fresh vegetable, and no fresh fruit offered that day. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Wednesday lunch, only meal with fresh vegetables, no fresh fruit was offered that day. - Thursday lunch and dinner meal with fresh vegetables, and no fresh fruit offered that day. - Friday lunch, only meal with fresh vegetable, and no fresh fruit offered that day. - Saturday lunch, only meal with fresh vegetable, and no fresh fruit offered that day. Review of the undated Bistro Menu (always available menus) on 01/08/2025 at 8:15 AM, provided by Staff CC, Regional Dietary Manager, showed different food options, available for pre-order (place your order by 11 AM the day prior) that included breakfast options such as cream of wheat, eggs, toast and cold cereal and for lunch and dinner, cottage cheese and fruit plate, chef's salad, veggie burger and hamburger. RESIDENT 14 Review of the quarterly Minimum Data Set (MDS- an assessment tool) dated 12/17/2024, showed that Resident 14 was cognitively intact. On 01/03/2025 at 10:03 AM, Resident 14 stated they did not receive a food menu. On 01/04/2025 at 12:29 PM, Resident 14 stated that they did not receive food menus and that they don't have a choice. Resident 14 stated that staff just posted the menu out there, and that they had to get up into a wheelchair and look at the menu to see what they were having. Resident 14 further stated that they did not get fresh fruits or vegetables, that it was mostly canned and not fresh. Observations on 01/05/2025 at 8:11 AM and on 01/07/2025 at 8:09 AM, showed Resident 14 had no fresh fruit for breakfast. On 01/08/2025 at 12:00 PM, Resident 14 was shown the Bistro Menu, Resident 14 stated that they had not been made aware of a Bistro menu. RESIDENT 309 Review of the admission MDS dated [DATE], showed that Resident 309 was cognitively intact. Joint observation and interview on 01/07/2025 at 1:52 PM with Resident 309 showed an old menu from the first week of December 2024 on their bulletin board. Resident 309 stated that they did not get to choose what to eat. On 01/08/2025 at 11:26 AM, Resident 309 was shown the Bistro Menu, Resident 309 stated that they had not seen the Bistro menu, and that it was not available to them. RESIDENT 89 (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/03/2025 at 12:53 PM, Resident 89 stated that they did not always get a menu, and that there was no consistency. Resident 89 stated that staff needed to go over the menu with them, but they have not seen one in forever. Resident 89 further stated that the fruit was not fresh, and it was mostly canned. Observation on 01/07/2025 at 3:00 PM, showed no menu on Resident 89's side of the room. On 01/08/2025 at 11:27 AM, Resident 89 was shown the Bistro Menu, Resident 89 stated that the Bistro menu was not made available to them. RESIDENT 55 Review of the quarterly MDS dated [DATE] showed Resident 55 was cognitively intact. On 01/07/2025 at 1:25 PM, Resident 55 stated that they never received fresh fruits or vegetables, and it was either canned or frozen. On 01/08/2025 at 4:46 PM, Resident 55 was shown the Bistro Menu, Resident 55 stated that they had never seen a Bistro menu. On 01/08/2025 at 8:09 AM, Staff CC stated that the menus were corporate preloaded and used a preference-based system. Staff CC stated that this system would take residents' preferences and automatically swap out with the alternative option if they disliked something. Staff CC stated that residents received menus a week in advance, and that there was a Bistro menu where they could order things like a chef salad, or deli sandwiches, and that this menu was kept at the nurses' station. Staff CC stated that the activities staff was responsible for passing out the menus to the residents and that sometimes they would get menus back filled out. When asked about the percentage of population that turned in a filled menu, Staff CC stated that 5-10% of the facility's residents turned in a menu, and that, not very many turn it back in. Staff CC further stated that fresh fruits and vegetables were not always on the menu but were available if the resident requested and was told to them verbally during the initial preference meeting. When asked if they could prove that residents were made aware of this, Staff CC stated, You won it. On 01/08/2025 at 9:17 AM, Staff OO, Recreation Assistant, stated that they delivered a food menu to every single resident in the facility either Friday or Saturdays, as the menus started on Sunday. Staff OO stated that the dietary manager was responsible for giving them the menus to pass out to the residents, but that the dietary manager had resigned right before Christmas (12/25/2024) and had not handed them out for a few weeks, and believed they were available upon request from dietary. Staff OO stated that during this time the menus were not given to each resident individually, and that they probably should have been. On 01/08/2025 at 10:37 AM, Staff CC stated that they printed out a snack list and menu alternates from one of their other facilities and were going to pass it out to all the residents and post them at the nurses' station so everyone knows what is available. On 01/08/2025 at 11:59 AM, Staff PP, Dietitian, stated that fresh fruits were available every day, but not always served every day. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/08/2025 at 2:19 PM, Staff A, Administrator, stated that their expectation was for the residents to know what their choices were and what they were going to be eating, by receiving a menu. Staff A further stated that the facility should have fresh fruit daily. 46912 RESIDENT 52 Review of the quarterly MDS dated [DATE], showed that Resident 52 was cognitively intact. Review of Resident 52's nutrition care plan, revised on 01/02/2025, showed to Honor food preferences within meal plan. It showed that Resident 52 was allergic to shellfish, chili powder and red and green bell pepper. Review of the menu titled, Week-at-a-Glance, printed on 01/07/2025, showed that Resident 52 did not have an entree ordered for three meals in a three-week period. In an interview on 01/07/2025 at 2:46 PM, Resident 52 showed a picture they took of their dinner meal from 01/06/2025, which showed Brussel sprouts, a roll, and no entree. Resident 52 stated it was supposed to be fish, but I can't eat that. They didn't give me an alternative, they never do. In another interview on 01/08/2025 at 3:45 PM, Resident 52 was shown the Bistro Menu, Resident 52 stated that they had never seen the Bistro menu. Resident 52 stated that the facility used to have an alternative menu on the back of the menu that showed options if the main menu did not offer a resident's food preference. Resident 52 stated that this week the alternative to fish was stir fry that had peppers in it and I'm allergic to peppers. In an interview and joint record review on 01/08/2025 at 4:17 PM, Staff CC stated that if a resident did not want the entree or the alternative, they provided residents with their always available/bistro menu and it comes on the back of the menu. When asked when the last time the bistro menu was on the back of the main menu, Staff CC stated, probably around the time the [previous] Dietary Manager resigned. Staff CC stated they would be posting the bistro menu in residents' rooms so they would know the additional options. Joint record review of Resident 52's menu showed three days in a three-week period where Resident 52 did not have an entree. Staff CC stated that I went and spoke with [Resident 52] to fix that. So, moving forward [Resident 52] will have a cheeseburger or chef salad if they did not want the entree or the alternative. In an interview on 01/08/2025 at 5:22 PM, Staff A stated that they expected that residents should be able to choose from the always available menu, if they did not want the main dish or the alternative. Staff A stated that they did not expect a resident to not be provided an entree and it [the entree] should be given as appropriate for their preferences and dietary needs. Reference: (WAC) 388-97-1120 (2)(3)(a)

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 47680 Based on interview and record review, the facility failed to ensure the facility assessment (document describing resident population and needs to determine staff and other resources necessary to competently care for residents) was updated to include plans to maximize direct care staff recruitment and retention. This failure placed the residents at risk for unmet care needs. Findings included . Review of the facility's policy titled, Facility Assessment, dated in December 2023, showed, The facility assessment is conducted annually to determine and update our capacity to meet the needs of and competently care for our residents during day-to-day operations. Review of the facility's document titled, Facility Assessment Tool, updated on 08/14/2024, did not show how the facility plans to maximize direct care staff recruitment and retention. A joint record review and interview on 01/08/2025 at 2:47 PM with Staff A, Administrator, showed that the facility assessment tool did not include a plan to maximize direct care staff recruitment and retention. Staff A stated, Looks like it was missed. A joint record review and interview on 01/08/2025 at 3:11 PM with Staff C, Interim Administrator, showed that the facility assessment tool did not include a plan to maximize direct care staff recruitment and retention. Staff C stated that it was not addressed in the facility assessment tool and that it should have been included. No associated WAC

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on observation, interview, and record review, the facility failed to ensure Contact Precautions (measures put in place to prevent spread of infection by direct or indirect contact with the resident or environment by staff wearing gown and gloves before entering a resident's room or environment) practices were followed for 4 of 4 residents (Residents 51, 27, 64 & 93), reviewed for infection control. In addition, the facility failed to ensure hand hygiene, proper glove use, and infection control practices were followed for 3 of 13 staff (Staff DD, Staff II & Staff V). These failures placed the residents, staff, and visitors at an increased risk for infection and related complications. Findings included . Review of the facility's policy titled, Isolation-Initiating Transmission-Based Precautions, revised in August 2019, showed that Transmission-Based Precautions may include Contact Precautions and when Transmission-Based Precautions are implemented, the Infection Preventionist .clearly identifies the type of precautions, the anticipated duration, and the personal protective equipment (PPE) that must be used. It also showed that there should be appropriate notification on the room entrance door that informs the staff of the type of .precautions. It further showed that there should be an appropriate linen barrel/hamper and waste container, with appropriate liner, are placed in or near the resident's room. CONTACT PRECAUTIONS RESIDENT 51 Review of Resident 51's physician orders showed an order to observe contact precautions related to a wound infection on Resident 51's left lower leg starting on 01/04/2025. Observation on 01/05/2025 at 8:21 AM, showed Staff M, Certified Nursing Assistant (CNA), entered Resident 51's room (Contact Precautions room) wearing Personal Protective Equipment (PPE-special equipment worn to protect from germs which included a disposable gown and gloves). It showed that there was no hazardous waste container inside Resident 51's room. It further showed Staff M took off their gown, left the room, and brought the gown down the hallway to the soiled utility room. On 01/05/2025 at 1:22 PM, Staff M stated that when entering a Contact Precautions room, they would wear a gown and gloves and when they took off their PPE, they should put it in a separate bin or put in a bag and take it to the soiled utility room. Staff M stated they couldn't [could not] find anywhere to put it [the soiled gown], so I took it took it to the soiled utility room and did not put it in a plastic bag. In an interview and joint observation on 01/05/2025 at 1:31 PM, Staff MM, Registered Nurse (RN), stated they would put PPE on every time they entered a Contact Precautions room and when they exited, they would put the gown and gloves in the can that's designated for it. We used to have a black garbage can. A joint observation showed nothing by the door to dispose of PPE in Resident 51's room. Staff MM stated, I'm going to look for a black garbage can. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/08/2025 at 9:59 AM, Staff T, Infection Preventionist, stated that they expected staff to remove PPE and place in a bin in the residents' rooms by the door. Staff T further stated if there was nowhere to dispose of the PPE then it should be placed in a bag when carried to the soiled utility room. In an interview on 01/08/2025 at 4:43 PM, Staff B, Director of Nursing, stated that they expected staff to take off their PPE prior to exiting a Contact Precautions room and place it in a designated container inside the room. 49619 RESIDENT 27 Review of Resident 27's order summary printed on 01/08/2025, showed an order for contact precautions due to a wound. Observation on 01/02/2025 at 8:05 AM, showed Staff HH, CNA entered Resident 27's contact precaution room without gowning up or applying gloves prior to delivering their breakfast tray. Observation on 01/02/2025 at 12:36 PM, showed the call light was on for Resident 27. Staff L, RN, entered the resident room without the appropriate PPE [gown and gloves] to answer the call light and turn it off. Staff L took a soiled water pitcher out of Resident 27's room and gave it to Staff K, RN. Staff K then took that water pitcher and walked down the hallway into the clean utility room to fill it with ice and brought it back into Resident 27's room without wearing the appropriate PPE prior to entering the room. RESIDENT 64 Review of Resident 64's physician orders showed an order dated for 12/27/2024 for contact precautions related to Multidrug-resistant organism (MDRO- bacteria that are resistant to multiple classes of antibiotics) and Extended-spectrum beta-lactamases (ESBL) E. Coli (a type of bacteria that is resistant to many antibiotics [medication to treat infection]) to wound. Observation on 01/02/2025 at 7:58 AM, showed Staff K entered Resident 64's contact precaution room and did not put on the appropriate PPE. Observation on 01/02/2025 at 8:03 AM, showed Staff HH, entered Resident 64's room without gowning up or applying gloves prior to delivering their breakfast tray. Observation on 01/02/2025 at 12:08 PM, showed Staff FF, Physical Therapist, Staff GG Occupational Therapist, and Staff K were in Resident 64's room without the appropriate PPE. Joint observation and interview on 01/02/2025 at 12:24 PM with Staff FF and Staff GG, showed contact precaution signage outside Resident 64's room that indicated to gown and glove prior to entering the room. Both Staff FF and Staff GG stated that based on the contact precaution sign they did not follow what it said and that they should have done hand hygiene and put on the appropriate PPE before entering. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/02/2025 at 12:41 PM, Staff K stated they had to wear PPE prior to entering a contact precaution room when they had direct physical contact with the resident, but if they were in the room quick or just passing out medication they did not. Joint observation and interview on 01/02/2025 at 12:48 PM, with Staff K, showed a contact precaution sign outside of Resident 27's room indicating staff and visitors to do hand hygiene, and wear a gown and gloves prior to entering the resident room. Staff K stated that they saw that the sign said to put on a gown prior to entering the room and that they did not do that when handing out medication. Staff K further stated that they took the water pitcher and filled it up with ice in the clean utility room and brought it back to Resident 27, and that they should not have done that as the pitcher was contaminated probably, instead they should have brought ice in a different pitcher into the room. Joint observation and interview on 01/02/2025 at 12:58 PM with Staff HH, showed a contact precaution sign outside of Resident 27's room that showed to gown and glove prior to entering the room. Staff HH stated that you had to wear PPE when going into a contact precaution room, but if you did not touch the resident or just stopped to deliver something you did not have to gown up. After reviewing the sign, Staff HH stated that the sign did not specify the above and that going forward they would gown up with everything. Joint observation and interview on 01/02/2025 at 1:10 PM with Staff L showed a contact precaution sign outside of Resident 27's room. Staff L stated that if the resident was on contact precaution they had to wear all the appropriate PPE prior to entering the resident room. Staff L stated that when they entered Resident 27's room to remove the water pitcher they did not gown or glove up because they thought the resident was on enhanced barrier precautions (precaution to protect residents from MDROs during high contact activity and not on contact precautions) and that they should have read and followed the sign outside the door. On 01/08/2025 at 9:39 AM, Staff T stated that anyone entering a contact precaution room should do hand hygiene and wear the appropriate PPE prior to entering. Staff T stated that Resident 27 was on contact precautions due to a wound, and Resident 64 due to ESBL. Staff T stated that Staff HH, FF, GG, L, and K, should have put on the appropriate PPE before entering the resident's rooms and taken it off prior to exit. Staff T further stated that Staff L should not have taken the soiled water pitcher out of a contact precaution room, and Staff K taken it down the hallway into the clean utility room to fill with ice and brought it back to Resident 27 as it placed a potential for spread of contamination. On 01/08/2025 at 2:37 PM, Staff B stated it was their expectation for staff to do hand hygiene and wear the appropriate PPE prior to entering a contact precaution room. Staff B further stated Staff K should not have taken the water pitcher from Resident 27's room and taken it into the clean utility room to fill it with ice. 51090 Resident 93 admitted to the facility on [DATE] with diagnoses that included paraplegia (a condition in which a person is unable to move or feel their lower part of the body because of an injury to the spine). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 93's contact precautions care plan revised on 12/25/2024 showed that Resident 93 was on contact precautions due to multiple wounds, had a history of MDRO infection, nephrostomy tube status (a small tube that is placed directly into the kidney to help drain urine when it can't flow normally due to a blockage) and foley catheter status (a flexible tube that is inserted into the bladder to help drain urine). Observation on 01/05/2025 at 9:17 AM, showed Staff KK, RN, entered room [ROOM NUMBER] while wearing gown and gloves, followed by Staff X, Maintenance Assistant, who did not wear gown and gloves. Further observation showed room [ROOM NUMBER] had signage for contact precautions posted and that an orange sticker [to indicate the resident is on contact precautions] was placed on Resident 93's name label. In an interview and joint record review on 01/05/2025 at 9:24 AM, after exiting room [ROOM NUMBER], Staff X was asked what their purpose was of entering room [ROOM NUMBER], Staff X stated they tried to put [bed] side rails for Resident 93. Staff X stated they touched Resident 93's privacy curtains and bed during their encounter with Resident 93. Joint record review of the contact precautions signage posted for room [ROOM NUMBER] showed that staff were instructed to don [put on] gloves and gown before entering the room. Staff X stated, Today I forgot, sorry. When asked if they should have followed contact precautions for Resident 93, Staff X stated Yeah. In an interview on 01/05/2025 at 9:28 AM, Staff II, Licensed Practical Nurse (LPN), stated they expected staff would have followed contact precautions for Resident 93 before entering the room. In an interview on 01/05/2025 at 9:30 AM, Staff KK stated they observed Staff X fixed the bed for Resident 93 and that they did not wear gown and gloves. Staff KK further stated that Staff X should have worn them and followed contact precautions for Resident 93. Observation on 01/05/2025 at 1:26 PM showed Staff LL, CNA, entered room [ROOM NUMBER] without donning gown and gloves and brought in a lunch tray. In an interview on 01/05/2025 at 1:59 PM, Staff LL stated they followed contact precautions for Resident 93 because they had an orange sticker on their name label and that they did not need to follow contact precautions for Resident 93's roommate. In an interview on 01/08/2025 at 12:43 PM, Staff T stated they expected all staff would follow contact precautions for a room regardless of the orange sticker on the name labels. Staff T stated contact precautions were to be followed by staff whenever they entered a room that was placed under contact precautions and that [staff] need to wear appropriate PPE. In an interview on 01/08/2025 at 1:07 PM, Staff B stated they followed the Centers for Disease Control and Prevention (CDC) guidelines on infection prevention control in nursing homes. Staff B further stated that all staff must wear PPE whenever they entered a room under contact precautions. 50891 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Handwashing/Hand Hygiene, dated 9/18/2023, showed all personnel should be trained on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. The policy showed that the use of gloves did not replace hand washing/hand hygiene, and that integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. The policy further showed that single-use disposable gloves should be used before aseptic procedures, when anticipating contact with blood or body fluids, and when in contact with a resident, or the equipment or environment of a resident, who is on contact precautions. Review of the facility's policy titled, Subcutaneous Injections [applied beneath the skin], revised in March 2011, showed its purpose of this procedure is to provide guidelines for the administration of medication by subcutaneous injection. The policy further showed procedure steps included performing hand hygiene, put on gloves, and placing the equipment on the bedside table or overbed table where it is easily reached. When administration is completed, gloves are discarded, and hand hygiene is performed. STAFF DD Observation and interview on 01/05/2025 at 8:31 AM, showed Staff DD, LPN, prepared Resident 75's medication. Staff DD dispensed a potassium chloride (a mineral supplement used to treat or prevent low blood levels of potassium) capsule and placed it aside in a separate medication cup. When Staff DD finished dispensing the rest of Resident 75's medications, Staff DD took the potassium chloride capsule and opened it with their ungloved hands and poured the capsule's contents into the medication cup with the crushed medications. Staff DD stated that they did not touch the inside of the capsule, only the outside. STAFF II Observation and interview on 01/05/2025 at 12:42 PM, showed Staff II, LPN, prepared an insulin (medication to treat/regulate blood sugar) pen for Resident 25 by placing a new insulin pen tip without swabbing the end of the insulin pen with an alcohol swab. Staff II stated that they did not sanitize the tip of the [insulin] pen because it was already clean. Still wearing the same pair of gloves used to prepare the insulin pen, Staff II was observed locking up the medication cart, walked down the hall, knocked on the door and opened it, administered the insulin, then removed their gloves. Staff II stated that after they prepared the insulin pen with their gloved hands, the insulin pen was still in their hand. Staff II further stated that if they placed the insulin pen down to change gloves, the insulin pen would get contaminated. In an interview on 01/05/2025 at 3:02 PM, Staff B stated that they expected staff to perform hand hygiene before preparing medications for residents. Staff B further stated that staff should be cleaning the end of the insulin pen before attaching a new needle. 47680 STAFF V (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 01/02/2025 at 1:23 PM, in the 500 Wing Hallway showed Staff V, CNA, was carrying a meal tray down the hallway when the cover on the meal tray fell on to the floor. Staff V picked up the cover off the floor, placed it back onto the meal tray and delivered it to room [ROOM NUMBER]-A. In an interview on 01/02/2025 at 1:45 PM, Staff V stated that when a cover fell on the floor it's dirty and that they would place it in the dirty meal cart. Staff V further stated that you're [you are] not supposed to pick it up. It's already dirty. In an interview on 01/08/2025 at 9:30 AM, Staff T stated that when a cover fell on the floor during meal tray delivery, they expected staff to return it to the kitchen or the dirty dishes because it's already contaminated, it touched the ground. Staff T further stated that Staff V should have returned it to the kitchen and got a new tray. In an interview on 01/08/2025 at 4:10 PM, Staff B stated that they expected Staff V to not put it back on the tray and that It's already dirty. Staff B further stated that they expected them to place it in the dirty meal tray cart. Reference: (WAC) 388-97-1320 (1)(a)(c)