STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505085	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crescent Health Care	505 North 40th Avenue Yakima, WA 98908

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31168 Based on observation, interview, and record review, the facility failed to provide care that maintained a resident's dignity for 1 of 2 sampled residents (Resident 12) reviewed for dignity. This failure placed the resident not able to maintain their bowel continence (using the commode) status and only received one shower a week. These failures caused embarrassment for bowel incontinent accidents and lack of shower/cleanliness before going to appointments and family visits. This placed the resident at risk for decreased quality of life. Findings included . <Resident 12> Review of the medical record showed Resident 12 was readmitted to the facility on [DATE] with a fracture of the right lower leg and no weight bearing to the right leg. Diagnoses include end stage kidney disease with kidney dialysis (process of cleaning waste from the blood artificially), heart disease and failure, left above the knee amputation, diabetes (disease that occurs when your blood sugar is too high), gangrene (death of tissue due to lack of blood flow) of right fingers and left finger. Review of the 10/21/2024 assessment showed the resident was alert and able to make needs known, required a mechanical lift with assistance of two staff to transfer the resident to and from their wheelchair, bathroom, shower, and bed. The resident was continent of bowel and had a suprapubic catheter (a device that is inserted into the bladder to drain urine). The resident was not on a scheduled bowel toileting program. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and concurrent interview on 12/03/2024 at 8:45 AM, the resident was up in their wheelchair in the front room area of the facility, looking out of the large picture window facing the parking lot. The resident's right leg was elevated on a wheelchair leg extension with a brace and dressing to the right lower leg and upper right foot. The resident was amputated to above the left knee. When asked about how the resident was doing and how things were going with their care, Resident 12 stated they were very unhappy about their care at the facility. Resident 12 stated staff used the Hoyer (mechanical lift) to get them up. Resident 12 stated they preferred to use my own underwear not a plastic brief. The resident stated staff do not come in when they use their call light to use the bathroom and they messed in their underwear. The resident stated they were to receive one shower a week which was not enough for them. Resident 12 stated they would prefer to shower before appointments and on Saturday mornings before their family visits. Resident 12 had asked staff to have an extra shower a week, but they stated to the resident they had no time. The resident stated even though their assigned shower day was Tuesdays there were no set times and sometimes was a different day. Review of the Nursing Assistant (NA) Bowel continence task charting for Resident 12 showed on 12/03/2024 three incontinent bowel episodes, 12/04/2024 one incontinent bowel episode, and on 12/05/2024 one incontinent bowel episode. The NA task for showers given for the end of November 2024 and beginning of December 2024 showed three showers given on 11/19/2024, 11/26/2024, and 12/05/2024. Review of the 10/10/2024 care plan for Resident 12 showed for toilet use a two person Hoyer to the commode, and to give a shower or sponge bath; do not rub skin, and there was no identified timed toileting schedule for Resident 12. During an interview on 12/05/2024 at 9:29 AM, Resident 12 stated they had to wait to have a bowel movement for the Hoyer so they could use the commode, and had an incontinent bowel episode. During an interview on 12/05/2024 at 8:50 AM, Staff M, NA, stated the residents usually get one bath a week. It's difficult to use the Hoyer quickly when it requires two staff to operate it. Resident 12 had some incontinent bowel incidents. Staff M stated there were no directions/interventions on the 10/10/2024 care plan for Resident 12's toileting schedule. Staff M stated the resident was able to use their call light for their needs to use the commode and to have a bowel movement. During an interview with Staff B, Director of Nursing Services, stated that there would need to be another assessment to determine the resident's needs for a toileting program and more showers during the week. Resident 12 needs to be able to remain continent of bowel and the staff will need to accommodate their needs. Reference WAC 388-97-0108 (1-4)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 48368 Based on interview and record review, the facility failed to ensure quarterly (every three months) personal fund statements were provided to residents and/or resident representative (RR) for 3 of 5 sampled residents (Resident 20, 23, and 27) reviewed for personal fund accounts. This failure placed residents at risk of not having an accurate accounting of their personal funds held in trust by the facility. Findings included . <Resident 20> Review of the medical record showed the resident was admitted to the facility with diagnoses to include Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination). The 10/01/2024 comprehensive assessment showed the resident required extensive assistance of two staff members for activities of daily living (ADL's basic care needs) and had severely impaired cognition. During an interview on 12/03/2024 at 9:33 AM, the RR stated they had not received any statements regarding Resident 20's personal funds. <Resident 23> Review of the medical record showed the resident was admitted to the facility with diagnoses to include cerebral palsy (damage to or abnormalities inside the brain that disrupt the brain's ability to control movement and maintain posture and balance). The 09/24/2024 comprehensive assessment showed the resident required extensive assistance of one staff member for ADL's and had an intact cognition. During an interview on 12/03/2024 at 9:00 AM, Resident 23 stated they did not receive any statements regarding their personal funds. <Resident 27> Review of the medical record showed the resident was admitted to the facility with diagnoses to include scoliosis (a condition where your spine, or back bone, curves sideways). The 10/16/2024 comprehensive assessment showed the resident required extensive assistance of two staff members with repositioning, transferring, and one to two staff members for all other ADLs, and had moderately impaired cognition. During an interview on 12/02/2024 at 2:03 PM, Resident 27's RR stated they had not received any personal fund statements, they assumed it all went for their care. (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/06/2024 at 10:56 AM Staff A, Administrator, stated their process was to send personal fund statements out quarterly. Staff A stated they were behind and had not sent any statements out in almost a year. Reference WAC 388-97-0340(3)(a)(b)(c)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 39652 Based on interview and record review the facility failed to have a system in place to promptly resolve grievances that were voiced in Resident Council (a formal meeting for facility residents to communicate preferences and concerns) for 1 of 4 residents (Resident 9) who expressed concerns about broken medical equipment that had been reported during the meeting and not resolved. Additionally, 4 of 4 residents (Residents 13, 4, 6 and 33) who regularly attended Resident Council were unaware of how to file a grievance (a formal complaint by a resident or resident representative [RR]) or who the facility Grievance Officer was. These failures placed residents at risk for overall dissatisfaction with their lives and unresolved concerns. Findings included . Record review of a facility policy titled Resident Grievance updated 09/2023 showed a grievance was defined as a complaint or concern that a resident had about care, services, or any other problem that may arise during their stay. The Grievance Officer is the Social Services Director. The Director of Nursing or the Administrator investigates (the grievance). The resident and/or responsible party will be notified of the results of the investigation which may be requested in writing. A copy of all grievances filed by a resident, as well as the solutions, will be filed in a confidential file in the Administrators office . <Resident 9> Review of the resident's medical record showed they admitted with diagnoses to include hospice services (specialized services for end of life care) and diabetes (how your body uses sugar for energy). The 09/11/2024 comprehensive assessment showed Resident 9's cognition was moderately impaired. An observation and a concurrent interview on 12/03/2024 at 9:53 AM, showed Resident 9's bathroom had a toilet riser (a portable toilet seat that adds height to an existing toilet) with handles to each side that was not secured/fastened to the toilet. The bathroom also had portable handrails to each side of the toilet, that were not secured to the floor or the wall and had a broken, right, handrail grip. Resident 9 stated they had communicated the broken bathroom equipment a month or two ago in a resident group meeting (Resident Council) but was told nothing could be done about the equipment. During an interview on 12/06/2024 at 10:00 AM, Staff V, Activities Director (AD), stated they recalled Resident 9 voicing a concern about their bathroom toilet being wobbly and stated they reported it to maintenance either by writing it in the maintenance book or verbally telling them. Staff V stated resident concerns voiced during Resident Council were reported on the notes that were taken during the meeting and then sent to each department head. Staff V stated then each department head would address the concerns. Staff V stated they did not initiate grievances for resident concerns brought up in Resident Council because they assumed the concerns were taken care of by the individual departments. Staff V stated they did not follow up with those concerns to ensure they had been followed through. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Resident Council meeting minutes from May 2024 to November 2024 showed no concerns had been documented for Resident 9 related to their broken bathroom equipment that was brought up in Resident Council. Review of the Maintenance book from 05/30/2024 through 12/05/2024 showed no written concerns for Resident 9's bathroom equipment. During an interview on 12/09/2024 at 9:26 AM, Staff I, Maintenance Director, stated they were not aware of Resident 9's bathroom equipment. Staff I stated they had not seen it in the maintenance book nor had they been told about them. During an interview on 12/09/2024 at 12:47 PM, Staff A, Administrator, stated resident concerns verbalized in Resident Council should be written in the minutes, then sent to each department head, and then addressed by the department head. Staff A stated the Maintenance director was responsible for completing environmental checks on the resident's equipment, but had just started 10/01/2024, and may not have been able to do those recently. On 12/04/2024 at 1:15 PM, Resident's 13, 4, 6 and 33 attended Resident Council meeting. Resident 13 stated they were the Resident Council President and the council met monthly. Resident 13 stated they did not know how to file a grievance or who the Grievance Officer was. Resident's 4, 6, and 33 stated they were also not sure how to file a grievance or who the facility Grievance Officer was. During an interview on 12/05/2024 at 1:40 PM, Staff V stated they assisted the residents to organize monthly Resident Council meetings and took minutes. Staff V further stated there was no formal process or documentation of concerns from Resident Council meetings. Staff V stated they gave a copy of the meeting minutes to the department heads to review and provide any follow up as indicated. Staff V stated they were unaware that the concerns may be considered grievances. During an interview on 12/05/2024 at 2:50 PM, Staff A, Administrator, stated the Grievance Officer was Staff H, Social Services Director. Staff A stated residents were given the Grievance policy and a blank grievance form in their admit packet. Staff A stated they did not fill out grievance forms from information brought up in Resident Council. Their process was to pass out the Resident Council minutes to department heads who were responsible to provide follow up on resident concerns the only documentation would be provided in the residents record. During an interview on 12/09/2024 at 1:40 PM, Staff H stated they were the Grievance Officer and were responsible to provide resolution for resident concerns. Staff H stated they attended Resident Council meeting, so they were aware of resident concerns brought up in the meetings. Staff H stated they did not initiate written grievances based on concerns brought up by the residents in the Resident Council meeting. The process was the AD sent the meeting minutes to the department heads and if they heard the concern was not resolved they would go and interview the resident which was not documented on a Grievance form to give to the resident or the RR, further stating sometimes I write something in the residents record. Reference WAC 388-97-0460

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview, and record review, the facility failed to comprehensively assess and monitor the need of physical restraints (posey (a brand of roll bolsters, an alternative to bed side rails to help protect alert patients from rolling out of the bed) for 2 of 4 residents (Residents 30 and 39) reviewed for physical restraints. In addition, the facility failed to obtain consents in the language the resident was able to read/understand, to document ongoing re-evaluation for the need of the restraint, and to ensure a least restrictive intervention were attempted prior to the use of the restraint. This failed practice placed residents at risk for a diminished quality of life, freedom of movement in their bed, and skin breakdown. Findings included . <Resident 30> Review of the resident's medical record showed they admitted with diagnoses to include a mood disorder (a group of mental conditions that affect a person's general emotional state) and heart failure. The 10/22/2024 comprehensive assessment showed Resident 30's cognition was severely impaired, had range of motion (ROM, the extent or limit to which a part of the body can be moved around a joint or a fixed point) to both legs, and required substantial to maximum assistance for bed mobility. During an observation on 12/03/2024 at 2:01 PM, showed Resident 30 being provided incontinence care. Resident 30 was lying in bed, on their back, with an air overlay mattress (an additional support surface designed to be placed directly on top of an existing surface) placed on top of the mattress. Between both mattresses there was a set of roll bolsters jammed up underneath the air overlay. The positioning of the roll bolsters caused the air overlay mattress to be curled up on the sides, towards the resident's body (waist and hip area), to immobilize them towards the middle of the bed. Review of the October 2024, November 2024, and December 2024 physician orders showed no orders for the roll bolsters. Review of Resident 30's 12/14/2023 and 10/07/2024 Rehab assessments, showed no assessment had been completed for the use of the roll bolsters. Additionally, the assessment did not show least restrictive devices were assessed or used prior to the roll bolsters being placed. There was no on-going reassessments to show the roll bolsters were appropriate for use. Review of 12/03/2024 care plan showed a focus for fall prevention with interventions on 04/10/2024 for roll bolsters to both sides of the bed for improved self positioning and use of soft pillows to both sides of the bed for improved self positioning. During an interview on 12/03/2024 at 2:01 PM, Staff M, Nursing Assistant (NA), stated Resident 30 insisted on getting up on the night shift and because there was not enough staff to get them up, it's safer to put those [roll bolsters] there so [Resident 30] don't get up and get hurt (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/06/2024 at 1:48 PM, Staff E, Restorative Director, stated Resident 30 needed the roll bolsters to maintain their alignment in bed while they were sitting up eating. Staff E stated they attempted to use soft pillows and rolled up blankets underneath the sheets and mattress, to keep the resident midline, but Resident 30 was rolling over the top of them so Staff E changed to the roll bolsters. Staff E stated they did not reassess interventions to see if they were still appropriate nor was there a medical diagnoses for using the roll bolsters. Additionally, Staff E stated they did not obtain physician orders or consents from the Resident or the Resident's Representative for the use of the roll bolsters. <Resident 39> Review of the residents medical record showed they were admitted with diagnoses including a stroke (blood supply is cut off from the brain), dementia (an ongoing brain disease that affects memory and judgement), and depression. The comprehensive assessment dated [DATE], showed the resident was severely cognitively impaired and required substantial assistance for bed mobility, dressing, and grooming. During multiple observations on 12/03/2024 at 3:10 PM, 12/04/2024 at 9:24 PM, 12/04/2024 at 2:10 PM, 12/05/2024 at 12:14 PM and 12/06/2024 at 3:30 PM showed resident 39 with bilateral roll bolsters attached to the sides of their bed which limited their freedom of movement and kept them positioned midline on their back. Record review of Resident 39's physician orders dated October 2024, November 2024, and December 2024, showed no order for the roll bolsters to identify medical rationale for their use as the roll bolsters limited their freedom of movement. Additional review of the record showed no assessment had been completed on the roll bolsters to justify and assess the necessity of their use. During an interview on 12/05/2024 at 2:15 PM, Staff D, Resident Care Manager, stated Resident 39 was very active in their bed movement and the roll bolsters were placed to prevent them from getting turned around in bed. During an interview on 12/09/2024 at 2:21 PM, Staff B, Director of Nursing Services, stated they were not familiar with roll bolsters and was told they were used to keep the residents' midline in bed. Staff B stated regardless of their knowledge of the equipment, they would expect an assessment, order, and consents, if needed to be used, and a re-assessment for continued use. Reference WAC: 388-97-0620 (1) 39652

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview, and record review, the facility failed to ensure a significant change assessment had been completed for 2 of 4 residents (Resident 9 and 30) reviewed for hospice and end of life care. This failed practice placed the residents at risk for unmet care needs due to their imminent decline and/or improvement in health. Findings included . Review of the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual (helps nursing home staff in gathering definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan), dated October 2024, showed it was a Centers for Medicare & Medicaid Services (CMS, a federal agency that administers health programs for seniors and people with disabilities) requirement to complete a significant change assessment (SCA) every time the hospice benefit had been selected and was also required if the resident came off of the hospice benefit. Additionally, the RAI manual showed a SCA should be completed when it was determined a resident had a major decline or improvement in their health status. Some areas of decline are as follows; when a resident has had a decline in two or more activities of daily living (ADLs, basic skills you need to perform daily life activities, such as bathing, dressing, and eating) and the presence of a mood disorder that was not previously reported. The manual showed SCAs were required to be completed within 14 days of the identification of the change. <Resident 9> Review of the resident's medical records showed they admitted to the facility on [DATE] with diagnoses to include hospice (a service that provides quality of life care for chronic conditions) and failure to thrive (the body was unable to absorb nutrients to maintain adequate nutrition). The 09/11/2024 comprehensive assessment showed Resident 9's cognition was moderately impaired and required staff supervision/touching assistance for eating meals and propelling their wheelchair (w/c). The assessment further showed no hospice care was being provided. During an interview on 12/03/2024 at 10:02 AM, Resident 9 was observed up in their w/c, clean, groomed, alert, and oriented. Resident 9 was being assisted with one staff person to the toilet. The resident stated they would like exercises to their legs but did not have the financing to be able to do that. Review of Resident 9's census status, showed they discharged from hospice services on 01/13/2024. Review of the MDS assessment schedule, showed a quarterly assessment had been completed on 12/12/2023 and again on 03/11/2024, no SCA had been completed. <Resident 30> (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's medical records showed they admitted with diagnoses to include kidney disease and heart failure. The record showed on 04/24/2024 Resident 30 had a new diagnosis of palliative care (focused on improving quality of life for people with serious illnesses). The 10/22/2024 comprehensive assessment showed the resident's cognition was severely impaired and was dependent on staff assistance for eating, transfers, and w/c mobility. Additional review of the quarterly 04/25/2024 assessment showed Resident 30 had a significant decline in several areas of ADLs when they went from partial to moderate staff assistance on their admission (12/26/2023) assessment, to substantial to maximum staff assistance on their 01/27/2024 re-admission assessment, and then fully dependent upon staff assistance on their 04/25/2024 assessment. The areas Resident 30 declined in were eating, bed mobility, transfers, and w/c mobility. Additionally, the 04/25/2024 assessment showed Resident 30 experienced hallucinations and received an antipsychotic medication. During an interview on 12/09/2024 at 11:11 AM, Staff C, Resident Care Manager (RCM), along with Staff D, RCM, stated they helped complete MDS assessments but did not complete all assessments. Staff C and Staff D stated they shared this task with Staff Y, MDS Coordinator. Staff C stated Staff Y completed MDS assessments remotely and did not know if they had completed a SCA for Resident 9 or Resident 30. Staff C stated Resident 9 had discharged from hospice services on 09/11/2023 and couldn't say if they were responsible for the MDS assessments at that time or not, it's hit and miss, when Staff Y doesn't do them [the assessments], we do [Staff C and Staff D] and when we don't, they do [Staff Y]. Staff C stated they missed that one for the SCA for Resident 30. During an interview on 12/09/2024 at 2:17 PM, Staff B, Director of Nursing Services, stated they were not knowledgeable on when a SCA should be done or how often. Staff B stated if a SCA assessment should have been completed when hospice was started or discharged , then they would expect the assessments to have been completed timely. Reference WAC: 388-97-1000 (3)(b)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on interview and record review the facility failed to ensure a Pre-Admission Screening and Resident Review (PASARR) Level I form (a screening tool used to determine if a resident requires further evaluation for serious mental illness or intellectual disability), was updated when the resident was newly diagnosed with mental health concerns for 1 of 5 residents (Resident 7) reviewed for PASARR accuracy. This failed practice placed the resident at risk for health and/or emotional decline related to the lack of a professional evaluation to determine if further mental health interventions were required. Findings included . <Resident 7> Review of the resident's medical records showed the resident admitted on [DATE] with diagnoses to include depression (a mood disorder that causes persistent feelings of sadness and loss of interest) and blindness. Review of Resident 7's July 2024 Medication Administration Record (MAR), showed an order on 07/17/2024 for Ativan (a brand of medication used to treat anxiety [a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome]) every four hours as needed (PRN). The order showed no stop date and showed it was being given for agitation/comfort care/palliative approach. The order showed it was discontinued on 08/29/2024 (43 days after being started). Review of the August 2024 MAR showed on 08/29/2024 a new order for Ativan to be given every four hours PRN with no stop date. During an interview on 12/09/2024 at 12:07 PM, showed the Contracted Pharmacist, stated during the psyche review meeting, they were told the resident was receiving the PRN Ativan because the resident experienced agitation from their delusions. Review of Resident 7's 01/19/2023 PASARR showed the assessment had not been updated to reflect new behavioral diagnoses of anxiety, agitation, or delusions when the resident was started on a new psychotropic (medications capable of affecting the mind, emotions, and behavior) medication to manage those behaviors. During an interview on 12/09/2024 at 12:47 PM, Staff C, Resident Case Manager (RCM), along with Staff D, RCM, stated they reviewed PASARRs on admission and did not know they were to update them if/when a resident was newly diagnosed with mental health concerns. Reference WAC: 388-97-1915 (4)

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	505085	A. Building B. Wing	12/09/2024

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Crescent Health Care	505 North 40th Avenue Yakima, WA 98908

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on interview and record review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASARR, a process to determine if a potential nursing home resident had mental health/intellectual disability needs which required further assessment/treatment) assessment accurately reflected residents' mental health conditions for 2 of 5 residents (Resident 16 and 8) reviewed for unnecessary medications. This failure placed residents at risk for inappropriate nursing home placement and/or not receiving timely and necessary services to meet their mental health needs. Findings included . <Resident 16> Review of the resident's medical records showed they admitted on [DATE] with diagnoses to include a stroke (when the supply of blood to the brain is reduced or blocked completely, which prevents brain tissue from getting oxygen and nutrients) and depression (a mood disorder that causes persistent feelings of sadness and loss of interest). The 10/23/2024 comprehensive assessment showed Resident 16's cognition was severely impaired. The assessment also showed the resident had poor appetite and felt down and depressed. Review of Resident 16's 09/23/2024 PASARR assessment, showed the assessment was not completed by the hospital, but by Staff C, Resident Care Manager (RCM), upon admission to the facility. Resident 16 was identified to have a mood disorder with a yes answer for section A, question 1. The PASARR showed a level two evaluation was not indicated (even though one was required). <Resident 8> Review of Resident 8's medical record showed the resident admitted to the facility with diagnoses to include anxiety (a feeling of fear, dread, or uneasiness). The 10/29/2024 comprehensive assessment showed Resident 8 required the assistance of one to two staff members for activities of daily living and had a moderately impaired cognition. Review of a 07/18/2024 Level 1 PASRR section I: Serious Mental Illness/Intellectual Disability or related condition showed Resident 8 had an anxiety disorder. Further review showed No level 2 evaluation was indicated (even though one was required). During an interview on 12/09/2024 at 11:36 AM, Staff C and Staff D, RCM, stated they completed PASARRs on admission and did not know they were to be reviewed prior to the resident admitting to the facility. Staff D and Staff C stated they did not know the PASARR regulations had changed as of 07/01/2024 and were not offered/provided training. During an interview on 12/09/2024 at 12:47 PM, Staff A, Administrator, stated they were not aware of the changes to the PASARR had already been put into place and had not heard about any training on the new regulations. Reference WAC: 388-97-1915 (1)(2)(a-c) (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	48368

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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 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** 31168 Based on observation, interview and record review, the facility failed to ensure resident care plans (CPs) were reviewed, revised, and accurately reflected resident care needs for 2 of 5 sampled residents (Residents 38 and 39) whose CPs were reviewed for accuracy. These failures placed residents at risk for unmet care needs and psychosocial interventions to maintain current preferences. Findings included . <Resident 38> Review of the medical record showed the resident had been at the facility for over one year with diagnoses to include dementia (cognitive impairment) with behaviors, history of hip fractures with falls and anxiety. The 11/15/2024 comprehensive assessment showed the resident was cognitively impaired but able to determine their needs and express them clearly. Resident 38 used a wheelchair for mobility. The 11/15/2024 quarterly assessment showed the resident did not demonstrate any mood to resistive behaviors. Additionally, the quarterly assessment showed no impairment of vision or hearing. <Activities> Review of Resident 38's 09/27/2024 CP showed the resident attended no activities related to their disinterest in activities. The resident likes to watch the news (CNN). The CP had not been updated concerning the resident was not actively recovering from a hip fracture intervention from over a year ago (07/24/2023). Review of the 11/15/2024 Activities and Routine Preferences of the quarterly assessment showed the resident found it very important to have animal contact, choosing bedtime, and bathing preferences. During an interview on 12/02/2024 at 10:10 AM, Resident 38 stated they were isolated and there were no other residents to talk to because they were not able to carry on a conversation. The resident would also like to go outside and on outings. Resident 38 stated they would love to have someone to talk to that would understand them. Additionally, Resident 38 stated they liked to read the New York Times and the local newspaper. During an observation on 12/02/2024 at 10:15 AM, showed an old New York Times/magazines from 2023. When asked Resident 38 about the outdated magazines the resident stated they had not had any since a year ago and their hearing and vision had gotten worse. The resident stated reading books and newspapers was a favorite activity. <Vision and Hearing> During an interview on 12/02/2024 at 10:20 AM, Resident 38 stated they had more difficulty reading due to cataracts (a clouding of the lens of the eye). Review of the 10/14/2024 note from the ophthalmologist (eye doctor) showed the resident was scheduled for cataract surgery but refused to use the preoperative eye drops and declined the cataract surgery. The resident CP had not been revised to reflect resident's current condition with loss of eyesight. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Restorative Program> Review of Resident 38's 08/30/2023 CP, showed the resident was to walk with a front wheeled walker with assist of one staff for a transfer program with a goal dated 08/30/2023 that Resident 38 would have safe transfers and would not have any falls related to unsafe transfers. Resident 38 had a fall on 11/02/2023 and fractured their clavicle while transferring themselves, trying to get their walker. There was no update to the CP. The 11/15/2024 quarterly assessment showed a nursing restorative program for range of motion and transfers for seven days. Review of the last Restorative Assessment was 11/14/2023. There were no new updated restorative assessments, goals or identified interventions, to include type of exercises and repetition or the activity provided to complete the task. During an interview on 12/05/2024 at 10:00 AM, Staff C, Resident Case Manager, stated there was only one Restorative Aide and the Nursing Assistants (NA) were to include minutes of restorative care in the resident routine/regular care such as dressing and transferring them. <Resident 39> Review of the resident's medical record showed they were admitted with a history of a stroke (blood supply is cut off from the brain) and dementia. The comprehensive assessment dated [DATE] showed the resident was severely cognitively impaired and required substantial assistance for self care including grooming, bathing, eating, and mobility. Review of Resident 39's CP revised 02/06/2024, showed the resident was to be up in their wheelchair for every meal and staff were to provide verbal cues to enable the resident to feed themselves their meals. Additionally the goal was for the resident to feed themselves 50 % of their meals. During multiple observations on 12/03/2024 at 8:24 AM, 12/04/2024 at 11:57 AM, 12/05/2024 at 12:05 PM, and 12/06/2024 at 8:30 AM, showed Resident 39 sitting up in bed (not in their wheelchair) being fed 100% of their meals by staff. The resident did not participate or attempt to feed themselves. During an interview on 12/04/2024 at 11:40 AM, Staff T, NA stated Resident 39 required total assistance with their meals and stated the resident does not feed themselves anymore and staff provided the assistance for them. Additionally, Staff T stated the resident did not like to get into their wheelchair and remained in bed per their choice. During an interview on 12/05/2024 at 12:08 PM, Resident 39's representative stated they fed the resident when they came in to visit them at lunch because Resident 39 had not fed themselves in a long time and because of their ongoing dementia was no longer capable of feeding themselves. During an interview on 12/05/2024 at 10:30 AM, Staff B, Director of Nursing Services, agreed that the CPs do not reflect the current resident's care and needed to be reviewed to reflect current conditions and concerns. Reference WAC 388-97-1020(5)(b) 39652 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	44922

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39652 Based on observation, interview, and record review the facility failed to provide the necessary care and services to ensure Restorative Aide (RA) Nursing programs were consistently provided for 3 of 5 residents (Resident's 21, 39, and 9) reviewed for activities of daily living (ADLs, basic tasks people perform regularly to care for themselves). This failure placed residents at risk for avoidable decline in function and a diminished ability to reach their highest practicable level of well being. Findings included . Record review of a facility policy titled Rehabilitation Nursing Care revised 10/21 showed; The facility Rehabilitative Nursing Program was designed to assist each resident to achieve and maintain an optimal level of self care and independence. Through the resident care plan the goals of rehabilitation are reinforced. <Resident 21> Review of the residents medical record showed they were admitted to the facility with diagnoses including, dementia (a disease that effects brain function such as memory and judgement skills) and diabetes (a disease that results in too much sugar in the blood). The comprehensive assessment dated [DATE], showed Resident 21 had impaired cognition and required substantial assistance for ADL's including grooming and bed mobility. Review of Resident 21's RA programs showed two different programs a dressing/grooming program for staff to provide verbal cues to the resident to dress themselves. The second RA program was a bed mobility program which consisted of having the resident sit at the edge of the bed with their feet flat on the floor to maintain transfer ability. During multiple observations on 12/04/2024 at 10:46 AM, 12/04/2024 at 2:13 PM,12/05/2024 at 9:08 AM, 12/05/2024 at 12:59 PM, and 12/06/2024 at 2:40 PM, showed Resident 21 still in bed with the same clothes on and they had not been gotten up for their RA programs. During an interview on 12/04/2024 at 10:50 AM, Staff U, Registered Nurse (RN), stated Resident 21 generally did not get out of bed or participate in their RA programs. Staff U stated the last time the resident got up was on Thanksgiving when their family came in to visit. Staff U stated they had not seen Resident 21 participate in their RA programs as they easily fatigued and did not like to transfer to their wheelchair or sit at the side of the bed as it frightened them. During an interview on 12/05/2024 at 8:49 AM, Staff T, Nursing Assistant (NA), stated they did not complete any RA programs with Resident 21 such as grooming or range of motion as the Restorative Assistant was responsible to complete the RA programs however, was currently working on the floor as a regular NA. Staff T stated the resident required full assistance for most of their ADL's which included dressing and grooming. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/05/2024 at 12:06 PM, the Resident's Representative (RR) stated they had never seen Resident 21 participate in any RA programs. The RR stated they would support and assist the staff with the programs as they visited daily and would like to see Resident 21 be more independent and not stay in bed so much. <Resident 39> Review of the residents medical record showed they were admitted with diagnoses including history of a stroke (damage to the brain when blood flow is cut off), dysphagia (impaired ability to swallow), and dementia. Review of the comprehensive assessment dated [DATE] showed the resident was severely cognitively impaired and required substantial assistance from staff for ADL's and transfers. Record review of Resident 39's RA programs showed they had two programs an eating/swallowing program to provide set up and verbal cues to encourage the resident to maintain the ability to feed themselves. The second program was a transfer program which consisted of staff assistance to transfer between the bed and the wheelchair in order to get out of bed daily. During an observation and interview on 12/04/2024 at 11:40 AM, showed Resident 39 being fed their lunch by Staff T. Staff T stated the resident did not participate in an RA program to feed themselves we always feed them all of their meals. Additionally, Staff T stated the resident remained in bed and did not have an RA program for transfer training. During additional observations on 12/05/2024 at 11:50 AM, 12/06/2024 at 11:50 AM, and 12/06/2024 at 8:01 AM, showed Resident 39 in their room sitting up in bed receiving total assistance with their meals and they were not participating in a feeding program as directed by their care plan and RA program. During an interview on 12/05/2024 at 12:08 PM, Resident 39's (RR) stated they were not aware the resident had RA programs for eating and transfer training. Further stated we feed [Resident 39] now because [Resident 39] no longer feeds [themselves]. 44922 <Resident 9> Review of the resident's medical records showed they admitted to the facility with diagnoses to include Ankylosing Spondylitis (a type of arthritis [swelling and tenderness of one or more joint] in the spine, causing inflammation and gradual fusing of the vertebrae). The 09/11/2024 comprehensive assessment showed Resident 9's cognition was moderately impaired and received RA Nursing programs for bed mobility and dressing and/or grooming. An observation and concurrent interview on 12/03/2024 at 10:02 AM, showed Resident 9 sitting in their wheelchair, attempting to reach up to the top of the sink to fix their dentures. Resident 9 stated they were stiff and had asked to have exercises but was told they couldn't because Resident 9 had no financing source available. Resident 9 could not extend their right arm out past their right side. Resident 9 stated they had not received exercises from staff or the RA. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 9's 10/17/2024 Care Plan (CP), showed on 11/17/2024 a fall risk CP with an intervention for an RA program for transferring. Resident 9 was to stand, using a handrail, for 30 seconds, sit, then repeat again, until the resident was fatigued. This was to be done when transferring between surfaces or using the restroom. Review of the CP showed on 10/29/2024 a limited physical mobility CP with an intervention for an RA program for walking. Staff were to assist Resident 9 to walk in the hallway for 35-75 feet (a unit of measure) daily. During an interview on 12/03/2024 at 2:31 PM, Staff AA, Restorative Nursing Assistant, stated they were responsible for the RA programs but had been pulled to the floor related to low staffing awhile ago (one year ago) and were currently unable to consistently do the programs. An observation and concurrent interview on 12/04/2024 at 8:44 AM, showed Resident 9's call light was draped across their bed, with the push end of the call light placed on the side away from the resident. Resident 9 was sitting with their dentures in their hand and stated they could not reach the call light to request assistance because their arm would not extend out far enough to reach it, so was waiting for someone to walk by and ask for help. Resident 9 stated they did not receive exercises on 12/03/2024 or today, 12/04/2024, nor were they ever asked to stand and sit for 30 seconds when transferring. Resident 9 additionally stated they were never walked in the hallway. An observation and concurrent interview on 12/05/2024 at 9:01 AM, showed Staff M, Nursing Assistant (NA), assisting Resident 9 to the toilet. Staff M did not encourage/direct Resident 9 to stand for 30 seconds prior to transferring them to the toilet or back to the wheelchair. Staff M stated the NAs did not complete exercises with the residents. Staff M stated they had a RA that was responsible for the exercises. Staff M stated they used to have two RAs but now only had one. During an interview on 12/05/2024 at 1:27 PM, Staff S, NA, stated they documented on the task assignments (tasks assigned to nursing staff) when they would move a resident in bed and how they moved, and when they walked them to the bathroom and how much assistance they used, but did not have specific instructions. Staff S stated they did not document how much time was spent on those activities or how many steps a resident took because they were not told to do that, nor did they have a place to document that. Review of Resident 9's RA Nursing program documentation from 12/02/2024 through 12/08/2024, showed Resident participated in a transfer/standing program on all seven days, twice daily, for 10-20-minute durations. Additionally, the documentation showed Resident 9 participated in a walking program on 12/03/2024 (twice), 12/04/2024, and 12/07/2024. Also, the documentation showed the resident refused their program or the program did not apply (N/A) to the resident on 12/02/2024, 12/05/2024, 12/06/2024, and 12/08/2024. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and concurrent interview on 12/06/2024 at 9:19 AM, showed Resident 9 sitting in their wheelchair, their call light was draped across the bed, with the end of the call light placed to the furthest side of the bed away from the resident. Resident 9 stated they struggled with being able to grab their call light due to the stiffness in their arms. Resident 9, who was right hand dominant, could not extend their right arm out to reach the call light, turned their wheelchair around, and took their left hand and arm to extend out to the bed to grab the call light. Resident 9 had to take their fingers, grasp hold of the blankets on the bed, to walk their hand across to the cord, and grabbed the cord of the call light, and pulled the call light towards them. Resident 9 stated they did not receive any standing, transferring, or walking exercises nor had they refused any exercise programs. During an interview on 12/09/2024 at 8:41 AM, Resident 9 stated they had not received or refused exercises for standing, transferring, or walking during the past weekend, 12/07/2024 and 12/08/2024. Review of a 09/01/2023 Rehab Nursing Assessment, showed an assessment that was completed while Resident 9 was on hospice services (services provided for end-of-life comfort care), which Resident 9 discontinued those services on 01/13/2024. The assessment showed the resident required a hoyer (a type of mechanical lift that transfers a person from one surface to another) lift for transfers. The assessment also showed the resident had no arthritic deformities to the upper or lower extremities. No further Rehab Nursing Assessments had been completed to determine whether Resident 9 had experienced a decline in their ADL abilities or if the current programs were effective. During an interview on 12/06/2024 at 1:48 PM, Staff E, Restorative Director/Registered Nurse, stated there were two RAs that were responsible for the RA programs, but they had lost one of them and the other one was scheduled to work on the floor as a NA, so the responsibility of the programs was given to the NAs on the floor. Staff E stated they had attempted to hire for the position but had not been successful in finding anyone. Staff E stated their assessment of residents were completed by asking staff about the resident's abilities and that's how they determine their programs, such as if they had a fall. Staff E stated if a resident had a fall they would put them on an RA program. Staff E stated they did not have a process for prevention for Long Term Care residents unless they experienced a decline, or the staff communicated concerns. Staff E stated they did not consistently complete a Rehab Nursing Assessment. During an interview on 12/09/2024 at 2:34 PM, Staff B, Director of Nursing Services, stated they did have two RAs but currently was down to one, but that person was scheduled as a NA not as a RA. Staff B stated if the NAs completed the programs, they should have been in-serviced and trained for completing the programs. Staff B stated they were aware Staff E was behind in some of the assessments because they were required to work the floor passing medications and when they worked the floor, they would lose a day of Restorative work. Staff B stated if the RA programs were not being completed, as written, then they would not want the NAs documenting them as if they were. Reference WAC 388-97-1060(2)(b)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31168 Based on observation, interview, and record review, the facility failed to provide meaningful and engaging activities for 1 of 3 residents (Resident 38), that do not participate in activities. Resident 38 did not participate in activities designed for someone who could not see well and had difficulty hearing which was relevant to their mental state. This placed the resident at risk of decreased interactions with people, a decreased meaning to their life, and a decreased mental well-being. Findings included . <Resident 38> Review of the medical record showed the resident admitted to the facility on [DATE] with diagnoses to include cataracts (opacity of the lens of the eyes), dementia (cognitive impairment), and multiple falls with fracture. The 11/15/2024 quarterly assessment showed for Preferences for Daily and Routine activities showed reading books and newspaper was not important to the resident. Resident 38 could make their needs known and used a wheelchair to wheel themselves around the facility. Review of the 11/08/2024 Quarterly Activities Participation review showed the resident liked to watch the news channels, enjoys reading the New York Times and local newspapers, strolling the facility in their wheelchair, and talking to staff. During an interview on 12/02/2024 10:10 AM, Resident 38 stated they can't have a conversation with current people here and felt isolated. Resident 38 stated they couldn't read books or the New York Times (NYTs) newspaper. The resident stated they haven't received the NYTs for almost a year. The resident was very tearful about not having anyone to talk to and not being able to do things on their own. Resident 38 would like to go to another facility and stated they did not like the facility because there was nothing to do. The resident also stated they enjoyed football games but had nothing in common with the people who lived here because they are all unable to communicate and have a conversation with me. Resident 38 stated the nurses would talk with them and carry on a conversation, but it was limited. During multiple observations on 12/02/2024 at 10:10 AM, 11:00 AM, Noon, and/or afternoon scheduled activities, Resident 38 was in the hallway and their room and did not attend any group activities. During an interview with Resident 38 on 12/02/2024 at 1:30 PM, the resident was in bed in their room with the television on a news station, but they did not watch it, and stated it was hard to see and clearly hear the television. During an interview on 12/03/2024 at 11:00 AM, Resident 38 stated they were very political with their party of choice and had a degree in political science. During an observation and concurrent interview on 12/03/2024 at 11:05 AM a voting ballot was on the resident's dresser and showed the ballot was not marked or completed by Resident 38. Resident 38 stated they were sad they had not filled out the ballot because no staff had assisted them. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crescent Health Care	505 North 40th Avenue Yakima, WA 98908

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/04/2024 at 9:07 AM, Staff W, Activities Assistant, stated they started at the end of August 2024 and they helped with bingo, took residents to and from their rooms, and assisted with activities. Staff W stated Resident 38 did not like group activities because they could not see well but would come during group activities to get some coffee and then would leave. Staff W would do a one-on-one with Resident 38 when they had time and when they had enough staff. There were no planned activities for Resident 38 or planned activities for one-on-one visits. During an interview on 12/04/2024 at 9:39 AM, Staff V, Activities Director, stated they did the activities assessments to determine the programs for all resident groups, individual activities, and instruct their two staff on activities for residents. Staff V stated Resident 38 read the NYTs and the local paper and there was no set schedule for Resident 38's one-on-one, and it was not routine. Review of the December 2024 record of one-to-one activities documentation showed on 12/04/2024 Resident 38 asked an unidentified activity assistant to help them with their bedding and they assisted Resident 38 and then asked the resident if they needed anything else and Resident 38 responded no (that was documented as a one-on-one activity). On 12/05/2024, the documentation of an unidentified activity assistant attempted a one-on-one activity with a knock on Resident 38's door and asked the resident if they could come in. Resident 38 stated no. The response from the)unidentified activity staff showed since they (Resident 38) were okay, they would come back later. There was no other documentation. Review of the November and December 2024 Activities Tasks showed Programs for Emotional Domain Pet visits/music/radio/movies/TV and a documented active daily by activity staff from 11/18/2024 through 11/22/2024. There was no explanation as to which program was identified as the resident's activity nor was there a response to that activity. Another activity was outings with no documented response. During an interview on 12/05/2024 at 1:15 PM, Staff V was not sure how to address Resident 38's activity needs. Staff V stated they needed to complete follow through assessments so they would know what the resident's true meaningful activities were. Staff V stated that they probably needed to identify which activity the resident participates in and look at Resident 38's response. Reference WAC 388-97-0940(1)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31168 Based on observation, interview, and record review, the facility failed to ensure residents received care and services in accordance with professional standards of practice regarding ongoing skin assessments for 2 of 5 residents (Residents 37 and 8) reviewed for skin impairment. Additionally, the facility failed to follow physicians' orders to obtain specialized services timely for 2 of 5 Residents (Resident 9 and 20) reviewed for Range of motion (ROM). The facility's failure to provide the care and services required related to non-pressure skin issues and specialized services placed residents at risk for unidentified and/or avoidable decline, delay in treatment, pain/discomfort, and unmet care needs. Findings included . Review of the 01/2021 Urostomy Care procedure showed the purposes were to promote cleanliness and to protect the peristomal skin (skin around the stoma) where the urostomy (surgically constructed opening in the bladder/urinary tract allowing urine to flow through an opening outside the body) is opened through the abdomen. This protects the peristomal from irritation, breakdown, and infection. The policy included cleaning the surrounding skin around the stoma and application of skin sealant around the stoma and ensuring the pouch/appliance and drain spout was securely attached to prevent leakage. Documentation included the condition of the skin around the stoma and any abnormalities in the skin around the stoma. Skin Assessments <Resident 37> Review of the resident's medical record showed the resident readmitted to the facility on [DATE] after an infection to the right abdominal wall located by the right side of their urostomy site. The resident had spina bifida (a birth defect where there is an incomplete closing of the spine and membranes around the spinal cord which can cause problems with bladder and walking). Additionally, the resident had multiple health and physical diagnoses. The 10/06/2024 comprehensive assessment showed the resident was alert and able to make their needs known. Resident 37 required substantial assistance with dressing, transfers, toileting, and hygiene. A physician's order on 11/26/2024 showed to change urostomy bag for leakage, accumulation of sediment, discoloration of the bag, and dislodgment. The bag was to be monitored every day shift and changed every three days. Review of the 10/14/2024 care plan showed Resident 37 had a potential for impairment of skin integrity without specifying an area or interventions. The care plan did not identify any skin issues or assessments for the urostomy stoma or the skin surrounding the stoma located on Resident 37's right side of their abdomen. There also were no care plan for the other opening on the resident's right lower abdomen, below Resident 37's right abdominal fold, which was draining a clear fluid. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/03/2024 at 11:50 AM, Resident 37 stated the staff changed their urostomy bag when it leaked or came lose. The resident was unsure if the Licensed Nurses (LNs) checked the stoma or skin around the stoma. Resident 37 stated they also had a previous urostomy site that they had when they were [AGE] years old, but as they grew the urostomy site was changed to where it was currently, the upper right side of their abdomen. During an observation on 12/03/2024 at 12:00 PM, the resident had a one centimeter (cm, a standard of measurement) hole at the lower right side of their abdomen under an abdominal fold. Resident 37 stated they had this area that never closed all the way for years. The resident kept a washcloth at the lower area of the old urostomy site because it drained clear fluid. During an interview on 12/04/2024 at 10:00 AM, Staff EE, Nursing Assistant (NA) stated Resident 37's urostomy was leaking and they reported it to the nursing staff. Staff EE was aware that Resident 37 had an opening below the resident's abdomen on the right side, under their abdominal fold, with an opening that leaked fluid. During an interview on 12/04/2024 at 10:08 AM, Staff F, Licensed Practical Nurse (LPN), stated they had changed Resident 37's urostomy before but had never noticed another site or opening on the resident's abdomen that drained fluid. Staff F stated that were no orders or directions to assess Resident 37's skin or clean around the stoma, only to change the urostomy bag. During an interview and observation on 12/042024 at 10:18 AM, Staff D, LPN, stated Resident 37 had their urostomy bag changed every three days or sooner if it dislodged or came off. Staff D stated the resident did have an opening on their right lower abdomen that did drain clear fluid. During the urostomy bag change Staff D removed the urostomy bag and examined the site around the ostomy. The site at the top portion above the stoma was a small, scratched area. Staff D used skin barrier and adhered the appliance over the stoma where it was visible and then attached it to the urinary ostomy bag. Staff D had not informed the physician or documented the skin around the stoma or how the skin of the stoma looked. During an interview on 12/04/2024 at 11:00 AM, Staff B, Director of Nursing Services (DNS), stated that LNs were to document assessments of all skin issues concerning Resident 37's urostomy and stoma, and notify the physician. <Resident 8> Review of Resident 8's medical record showed the resident admitted to the facility with diagnoses to include Alzheimer's disease (a brain disorder that gradually destroys memory and thinking skills, and eventually the ability to perform basic tasks) and opened wounds to their head. The 10/29/2024 comprehensive assessment showed the resident required the assistance of one to two staff members for activities of daily living (ADLs, basic skills for personal care) and had a moderately impaired cognition. An observation on 12/04/2024 at 8:46 AM, showed Resident 8 sitting in their wheelchair with alopecia (hair loss) with multiple scabbed/crusted/pus-filled areas to their scalp. (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 a physician's order dated 09/09/2024, showed Erosive pustulosis (a chronic skin condition where small pus-filled bumps develop on the skin, causing sores) to their scalp and to document Resident 8's skin and wound weekly. Record review of the weekly 11/18/2024 skin observation tool used for weekly skin documentation, showed this was the only documentation of the Erosive pustulosis out of 12 weeks . During an interview on 12/04/2024 at 1:32 PM, Staff B stated they did not have a treatment nurse and the nurses on the floor were responsible for all skin and wound treatments and weekly skin documentation. Staff B stated the nurses were to follow the physician's orders and that was not done for Resident 8. Specialized Services <Resident 9> Review of the resident's medical record showed the resident admitted with diagnoses to include lower back pain and Ankylosing Spondylitis (a type of arthritis [swelling and tenderness of one or more joint] in the spine, causing inflammation and gradual fusing of the vertebrae). The 09/11/2024 comprehensive assessment showed Resident 9's cognition was moderately impaired and required substantial to maximum assistance from staff for ADLs. An observation and concurrent interview on 12/03/2024 at 10:02 AM, showed Resident 9 sitting in their wheelchair, self-propelling themselves in their room from the bed to the sink. Resident 9 stated they had wanted exercises so they could walk again, and that staff had told them they were going to work on my legs. Resident 9 stated they were told they did not have the financial funding for those services. Review of Resident 9's 05/19/2024 Incident investigation, showed Resident 9 had a witnessed fall in their bathroom. Resident 9 was found on their knees, bottom resting on their folded legs, in front of their toilet. Resident 9 stated their legs felt too weak to stand and could not place themselves back on the toilet, so they put themselves on the floor. The intervention for this fall was to obtain a referral for therapy services for leg strengthening due to deconditioning [changes in the body that occur during a period of inactivity]. Further review showed a 11/01/2024 incident investigation where Resident 9 had an assisted fall to the ground when their knees buckled [to give way; collapse] upon standing and were too weak to put themselves back on the toilet. Review of Resident 9's December 2024 physician orders showed on 05/22/2024 an order for the resident to be evaluated and treated by Physical Therapy (PT, focuses on treatment that helps you improve how your body performs physical movements) and Occupational Therapy (OT, focuses on enabling people to do things they want and need to do in their everyday lives) for deconditioning, weakness, and a recent fall that was related to poor standing tolerance. During an interview on 12/05/2024 at 11:35 AM, the Contracted Rehab Director (CRD), stated they received an email regarding an order for a PT/OT evaluation, but it was not completed. The CRD stated there was an electronic mail (E-mail) that showed family declined the services. (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 a 05/22/2024 E-mail, showed Staff E, Restorative Director, sent an e-mail to Staff C, Resident Care Manager (RCM), the Administrator, and the Business Office, requesting PT/OT services for Resident 9 due to a fall related to their leg weakness and deconditioning. Staff E wrote Resident 9 had been discontinued from hospice services (a specialized service that provides end of life comfort) and felt the resident would benefit from therapy services (hospice services were discontinued on 01/13/2024). The e-mail also showed a response from Staff C that read the family had made it clear that when Resident 9 was discontinued off hospice services, they did not want Resident 9 to have therapies. Staff C additionally wrote they would talk to the family. During an interview on 12/06/2024 at 10:18 AM, Staff C stated the family declined the referral for Resident 9 to have therapies because the resident was on hospice and in their head death was imminent [ready to take place: happening soon] for [Resident 9]. Staff C acknowledged they did not ask Resident 9 what their wishes were even though the resident was alert, oriented, and able to make their own decisions. Staff C stated Resident 9 should have been the one to make that decision. <Resident 20> Review of the medical record showed the resident was admitted to the facility with diagnoses to include Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination) and contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to restricted joint mobility) to the left hand. The 10/01/2024 comprehensive assessment showed the resident required extensive assistance of two staff members for ADL's. The resident was assessed to have severely impaired cognition, with impairment to upper and lower extremities. During an interview on 12/03/2024 at 9:35 AM, the Resident Representative stated Resident 20 was supposed to be having injections to their hands to help loosen their contractures so they could have therapy and they were unsure as to why Resident 20 was not receiving them any longer. Record review of an outside specialty hand clinic visit noted dated 03/06/2024 showed orders as follows:continue with Botox [an injection that blocks certain chemical signals from nerves that cause the muscle to contract] 300 units [a unit of measure] injections, 50 units to left hand; Right upper extremity Fingers/elbow 100 units . Schedule once power of attorney [POA, a written authorization to represent or act on another's behalf in private affairs] identified; Botox injections aborted as per lack of POA, emergency contact number and next of kin. Record review of a progress note dated 05/29/2024 showed the specialty hand clinic canceled Resident 20's 05/29/2024 Botox appointment related to not receiving the POA paperwork. Record review showed no further documentation or follow through regarding Resident 20's Botox appointments for their contractures to their hands until a physician's visit dated 10/17/2024 with orders as follows: Send POA documentation to specialty hand clinic as soon as possible so Botox injections to hand contractures can be scheduled (225 days after last Botox appointment with request for POA paperwork). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/05/2024 at 3:14 PM, Staff C stated it was their responsibility to ensure specialty appointments were made and Resident 20 was receiving their Botox injections. Staff C stated there should have been further follow-up from the 05/29/2024 canceled Botox appointment and they were unsure how that was missed. Reference: WAC 388-97-1060 (1), (3)(b) 44922 48368

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview, and record review the facility failed to consistently assess skin and/or wounds or implement interventions to ensure the prevention and the worsening of facility-acquired pressure injuries (PI) for 1 of 4 residents (Resident 30) reviewed for PIs. Resident 30 experienced harm when they developed three avoidable PIs (right heel, left heel, and left calf) that were not present upon admission, and a decreased quality of life due to the pain. Findings included . Review of the National PI Advisory Panel's (NPIAP, the leading expert in PIs/wounds) guidelines and definitions, dated September 2016, defined PI stages as follows: Stage 1 PI has intact skin with a localized area of non-blanchable erythema (redness). Stage 2 PI is a partial thickness skin loss with exposed dermis (the top inner layers of skin). Stage 3 PI is a full thickness loss of skin, in which adipose (fat) tissue is visible in the ulcer. Slough (dead tissue) and or eschar (dried blood and tissue) may be visible, granulation tissue and epibole (rolled or curled under edges) may include with undermining (a pocket of dead space under the visible wound edges) and tunneling (a passageway under the wounds surface which may be shallow or deep and impairs wound closure). Stage 4 PI is a full thickness loss of skin and tissue with exposed or directly palpable fascia (a layer of connective tissue), muscle, tendon, ligament, cartilage, or bone in the ulcer. Epibole undermining and tunneling often occur. Unstageable PI is a full thickness skin and tissue loss to which the extent of the tissue damage cannot be seen. <Resident 30> Review of Resident 30's medical record showed they admitted on [DATE] with diagnoses to include kidney and heart failure. The 10/22/2024 comprehensive assessment showed the resident's cognition was severely impaired, and substantial to maximum staff assistance with bed mobility and transfers. The assessment also showed the resident was at risk for developing PIs and had no PIs on admission. Review of the October 2024 Treatment Administration Record (TAR) showed an order on 03/17/2024 to monitor heels daily, ensure they are floating (a process that allows the legs to be elevated on pillows that keep the heels from touching the bed), and document weekly (no specified day of the week) for mushy [soft] heels; an order on 10/11/2024 to monitor an abrasion (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	(superficial cuts or scrapes to the skin that occur due to impact, pressure, or friction) to the left outer lateral calf daily; an order on 10/30/2024 for treatment to a pressure wound to the left outer lateral calf (unstaged) and to ensure offloading [positioning the body so that pressure does not rest on top of the wounded area], and the TAR showed no orders for the Stage 1 PI to the right heel. Review of the November 2024 TAR showed an order on 11/07/2024 for treatment to a left heel pressure wound (unstaged). An observation on 12/02/2024 at 9:45 AM, showed Resident 30 lying in bed, on their back, with the head of the bed elevated. There were two purple, foam, heel protectors (used to cradle and cushion sensitive heel/ankle areas, helping protect against nerve damage, bed sores and skin breakdown) sitting on the seat of a chair in the corner of the room, at the end of the bed. Additionally, there was an air mattress overlay (an additional support surface designed to be placed directly on top of an existing surface) on the bed. An observation and concurrent interview on 12/03/2024 at 9:01 AM, showed Resident 30 lying in bed on their back, both purple heel protectors sitting on the chair in the corner of the room. Resident 30 had facial grimacing and was moaning ow, ow. Resident 30 pointed to their left lower leg when asked where their pain was and lifted their left leg slightly off the bed. An observation and concurrent interview on 12/03/2024 at 2:01 PM, showed Resident 30 lying in bed and purple heel protectors were located in the same place as previously observed at 9:01 AM. Staff M, Nursing Assistant (NA), and Staff N, NA, provided incontinence care to Resident 30. Staff M stated Resident 30 had a wound to their left calf and left heel. The left calf was covered with a white gauze bandage, there was a dressing patch over the left heel, and the ball of the top of the left foot, underneath the toes, was bright red. Also, the right heel had an area the size of a quarter that was slightly green, brown, and purple in color. Staff M stated they observed Resident 30 had an area to their left lower calf area that wasn't right and they had reported it to the nurse. Staff M stated they did not have a place to document abnormal findings and could not recall when it was reported, what nurse they reported it to, or what the area looked like at that time, only that the left lower calf area had worsened from when they originally reported it. Lastly, Staff M stated due to Resident 30 ' s wound to their left calf, they could no longer transfer to their wheelchair to get up and out of their bed as often as they used to. Review of nursing progress notes from 09/08/2024 through 12/08/2024 (90 days) showed no weekly documentation had been charted for the weekly heel assessments other than notes that showed the heels were floated. A crossed-out progress note on 10/10/2024 at 2:09 PM showed Staff M reported a red mark to Resident 30's left outer lateral calf, what appears to be an abrasion; and a note on 10/18/2024 at 2:43 PM that showed a Stage 1 PI to the right heel with no measurements, description, or treatment orders to monitor; and a note on 11/06/2024 that showed a pressure area to the left heel with no description or measurements. Review of the weekly skin observation assessments showed as follows: on 11/17/2024 (41 days after the previous skin assessment), a Stage 2 PI to the left heel two centimeters (cm, a unit of measure) by 2.5 cm and an Unstageable PI to the left outer calf that measured 4.5 cm by one cm. The 12/05/2024 (18 days after the previous assessment) skin observation assessment showed a PI to the left outer calf that measured five cm by three cm with areas of necrotic (dead) tissue and opened areas. The assessment did not show the left heel PI, or the right heel area observed by the Surveyor on 12/03/2024. There were no other weekly skin assessments for the left outer calf, left heel, or right heel. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the 10/28/2024 contracted medical provider's note, showed Resident 30 was assessed to have a Stage 1 PI to their left calf. The contracted provider's note on 11/08/2024 showed a Stage 2 PI to the left heel, and an opened, beefy red area. The note further showed the right heel was redness/boggy [soft] and to float the heels or obtain Podus boots (a type of boot/splint that is used to help keep pressure off the heel to prevent heel ulcers or relieve pressure if ulcers start) for offloading. The note showed the Stage 1 PI to the left outer calf was opened. The contracted medical provider's note on 12/06/2024 showed an unstageable pressure ulcer [injury] to the left calf. Additional observations on 12/04/2024 at 8:40 AM, showed Resident 30 lying in bed, slightly positioned to their right side and sleeping. The two purple heel protectors were on the chair in the corner of the room. An observation at 11:31 AM, showed Resident 30 in the same position and Staff O, NA, picked a pillow up off the floor at the end of the bed, picked up the two heel protectors and placed the pillow on the chair with the heel protectors placed on the pillow. Staff O then repositioned the resident's pillows under their head but did not assess their legs/feet to see where the pillow on the floor belonged, nor did they reposition the resident. An observation at 2:42 PM, showed Resident 30 lying in the same position observed at 8:40 am and 11:31 AM, heel protectors were in the chair, and the resident's legs were floated on a pillow, but the pillow was not thick enough for the heels to be floated, so they rested on the bed. An observation and concurrent interview on 12/05/2024 at 8:51 AM showed the resident lying in bed on their back. Resident 30 stated they liked bingo and would like to attend if their pain was tolerable. Resident 30 had a flat pillow underneath both calves and their heels rested on the bed. The purple heel protectors were sitting on the chair in the corner of the room. During an interview on 12/05/2024 at 1:31 PM, Staff S, NA, stated Resident 30 required staff assistance for bed mobility and could not do that on their own. Staff S stated when a resident had an intervention or equipment change, they would find that information in the care plan (CP). Staff S stated the purple heel protectors were for the resident's heels but didn't believe they were to use them anymore and they had not been taken out of the room yet. An observation and concurrent interview on 12/06/2024 at 11:32 AM, showed the Contracted Medical Director (CMD), along with Staff C, Resident Care Manager, and Staff G, Registered Nurse, changed and assessed Resident 30's wound to the left calf. Staff C removed the dressing, and the wound was less than 10 inches in length, from upper calf to the lower portion of the calf, located on the outer, posterior part of the calf. There were brown, hardened areas that ran about three quarters of the way down the wound, less than two centimeters wide, with the upper portion having an area the size of a baseball of brown hardened areas that showed some lifting off of the hardened brown areas with stringy skin attaching the hardened area to the wound. The edges around the wound were bright red (assessed as an unstageable pressure injury per the CMD). The resident had been pre-medicated prior to the dressing change but was still moaning out in pain during the dressing change. Staff C stated when asked if they were going to measure the wound, no, that was done yesterday during the dressing change. There was a dressing to the left heel that the CMD asked to be removed so they could assess it. There was an opened, 1.5 cm PI to the left heel. The CMD assessed the right heel, which showed a quarter sized, dark purple area to the upper portion of the heel. (continued on next page)

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	505085	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crescent Health Care	505 North 40th Avenue Yakima, WA 98908

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 30's 10/03/2024 CP showed a 12/03/2023 focus for Activities of Daily Living (ADLs, basic skills you need to perform daily life activities, such as bathing, dressing, and eating) deficit with an intervention to float the resident's heels while in bed; a 07/05/2024 fall prevention intervention to reposition Resident 30 in bed with care interactions; and an 11/06/2024 skin integrity focus for the left heel PI that showed a treatment intervention and for staff to use a draw sheet or lifting device to move the resident. The CP showed no focus for the left outer calf PI, the use of the air mattress overlay, or the purple heel protectors. During an interview on 12/06/2024 at 3:10 PM, Staff C stated skin and wound assessments were to be completed weekly using the skin observation assessment form. Staff C stated the last one they could find was from 11/17/2024. Staff C stated the purple heel protectors in Resident 30's room were to be used for Resident 30's heels and was not aware they were not being used. An observation on 12/09/2024 at 8:38 AM, showed Resident 30 lying in bed on their back, feet floated on a flat pillow so both heels were resting on the air mattress. One of the purple heel protectors was sitting in the chair and one on the floor underneath the chair, in the corner of the room. Additional review of the December 2024 TAR on 12/09/2024, showed no new orders for treatment or monitoring to the new PI to the right heel that was assessed on 12/06/2024. During a follow-up interview on 12/09/2024 at 11:11 AM, Staff C stated they missed updating the CP with the LLE PI and the heel protectors. Staff C stated they were not aware of a new PI to the right heel of Resident 30 and would assess and update the TAR. During an interview on 12/09/2024 at 2:34 PM, Staff B, Director of Nursing Services, stated Licensed Nurses (LNs) were required to complete weekly skin assessments on the skin observation assessment form and wound assessments should be done at the least weekly if not being done with every dressing change and was not aware those were not getting done. Staff B stated the Resident Care Managers were required to update the resident CPs at the time of changes in condition but since they worked the floor quite often, they were sure things were missed. Staff B stated NA staff were required to turn and reposition residents at the least, every two hours and if they had skin issues, it should be more often. Reference WAC: 388-97-1060 (3)(b)

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F 0688 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48368 Based on observation, interview and record review, the facility failed to ensure restorative therapy services including the consistent use of braces/splints were implemented timely to prevent avoidable reduction of range of motion (ROM) and mobility for 2 of 5 sampled residents (Residents 27 and 20) reviewed for restorative therapy. Resident 27 experienced harm when they developed right and left-hand contractures (a condition of shortening and hardening of muscles, tendons, or other tissue that leads to muscle stiffening and loss of range of motion of the effected body part). This failed practice placed other residents at risk for contractures, decreased mobility, and pain. Findings included . Record review of the facility policy titled, Rehabilitative Nursing Care, dated 01/2021, showed the facility had: .Nursing personnel who were trained in restorative nursing care. The facility will have an active program for restorative nursing which will be developed and coordinated through the resident's care plan. The facility's Restorative nursing care program is designed to assist each resident to achieve and maintain the highest practicable level of self-care and independence. The facility will carry out prescribed therapy exercises between visits of the therapist and will assist residents with their routine range of motion exercises . <Resident 27> Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses to include bilateral (both) hip osteoporosis (a disease that causes bones to become weak and brittle, making them more likely to break) and scoliosis (a condition where your spine, or back bone, curves sideways). The 10/16/2024 comprehensive assessment showed the resident required supervision or touching assistance with eating, extensive assistance of two persons with repositioning, transferring, and one-to-two-person extensive assistance with all other activities of daily living (ADL's). The resident was assessed to have moderately impaired cognition, with no ROM impairment to upper extremities. The assessment further showed that the resident did not have splint placement or skilled therapies during the assessment period. Record review from a 10/11/2020 hospital discharge history and physical, showed a physician ' s assessment that documented Resident 27 ' s musculoskeletal system (the bodies structural framework and system for moving, including bones and joints) as ROM full, muscles were not tender, there were no documented contractures. Record review of the facility's physician visit progress notes, dated 10/22/2020, 10/31/2023, 02/07/2024, 05/13/2024, and 08/15/2024 showed, Resident 27's musculoskeletal system was within normal limits (no contractures noted). Further review of the physician ' s visit progress note, dated 08/28/2024, showed Resident 27 complained of not being able to keep their right hand open and the musculoskeletal system showed a documented right-hand contracture. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Record review of the Physical Therapy (PT) discharge evaluation, dated 11/04/2022, showed that Resident 27 was to have a ROM restorative program. Further review of the record showed no documentation of ROM restorative programs or continued therapy were in place for Resident 27 ' s upper extremities. Record review of the Rehab Nursing Assessment's completed by Staff E, Rehab Director, dated 10/15/2020 (admitted), showed no documented contractures. Review of the next Rehab Nursing Assessment on 07/15/2023 (two years and nine months after admission) showed no documented contractures. Additionally, the Rehab Nursing Assessment, dated 10/22/2024 (55 days after the physician diagnosed Resident 27 with a right-hand contracture) showed Resident 27 had no contractures. Record review of a physician's visit progress note, dated 09/25/2024 (28 days after contractures were noted), showed a referral was ordered for PT, Occupational Therapy (OT), and Botox (injections that help treat contractures by relaxing the affected muscles) injections at an outside specialty hand clinic for a diagnosis of right-hand contracture. Additionally, a progress note, dated 11/05/2024 showed they were unable to take Resident 27 as a patient (42 days after the order for the Botox referral) a new appointment was made to another outside specialty hand clinic for 11/21/2024 (58 days after the order for the Botox referral). Record review of a nursing progress note, dated 10/22/2024 (56 days after contractures were diagnosed), showed Staff E, Rehab Director, documented they placed Resident 27 on a ROM Restorative program for movement of all extremities with a focus that Resident 27 would not develop contractures. Further review of the record showed no documentation of a ROM program put in place for Resident 27's upper extremities. Record review of a progress note, dated 11/22/2024, showed 1) passive ROM to hands; 2) place a dowel (a device used to help position severely contracted hands to gradually reduce contractures) to hands 3) if able to gain more motion will make custom splints, diagnosis given for significant flexion (a chronic condition that occurs when a joint is bent and cannot be straightened) contractures to hands. Record review of an OT Evaluation and Plan of Treatment, dated 12/03/2024 (70 days after the referral was ordered), showed Resident 27 had significant flexion contractures to both hands. During an interview on 12/02/2024 at 1:57 PM, Resident 27's Representative (RR) stated they had noticed the contractures to Resident 27's hands in August 2024 and they did not have contractures prior to this. The RR stated the facility did not do exercises with Resident 27's hands as far as they knew, and they were at the facility often. The RR stated they tried to do exercises with Resident 27's hands when they visited, to stretch them a little bit. The RR stated Resident 27 was unable to eat independently any longer and was not able to independently ambulate in their wheelchair as they use to. Record review of Resident 27's care plan dated, 09/01/2023 showed Resident 27 required set up and cueing for meals. Further review showed Resident 27 was able to self propel their wheelchair. Record review of the nursing assistant tasks documentation from 11/17/2024 to 12/08/2024 showed Resident 27 was totally dependent on staff for eating and wheelchair mobility. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During observations on 12/04/2024 at 8:49 AM, 12/04/2024 at 2:21 PM, 12/05/2024 at 8:48 PM, 12/06/2024 at 8:15 AM and 12/09/2024 at 9:15 AM, showed no dowel or equivalent to resident 27's hands. During an interview on 12/05/2024 at 8:48 AM, Resident 27 stated they were unable to hold utensils for eating any longer and it was almost impossible for them to do activities such as bingo and coloring. Resident 27 stated they would like to get their hands fixed so they could do their activities again. Staff Q, Occupational Therapist, entered Resident 27's room during this interview and stated this was the first time they had been asked to see Resident 27 and they felt if Resident 27 had therapy to their hands daily they could stretch their hands out. Staff Q stated they were aware Resident 27 was no longer able to eat independently and that was something they were going to look into. An observation on 12/05/2024 at 11:38 AM, showed Staff R, Activities Assistant, assisting Resident 27 with eating. Resident 27 attempted to grab the spoon off of the table with their right hand and was unable to do so. Staff R tried to place the spoon into Resident 27 ' s right hand and was unable to fit the spoon between the thumb and pointer finger related to the thumb and fingers being contracted inward. During an interview on 12/09/2024 at 1:31 PM Staff E, Rehab Director stated they had just found out about Resident 27 ' s contractures on Wednesday, 12/04/2024. Staff E stated they had not noticed anything ' different or wrong with Resident 27 during their last assessment on 10/16/2024 (contractures were diagnosed during a physician's visit on 08/28/2024). Staff E stated they were angry this got missed multiple different ways. Staff E stated Resident 27 should had been on a ROM Restorative program for their upper extremities to maintain their level of functioning and was not. <Resident 20> Review of the medical record showed the resident was admitted to the facility with diagnoses to include Parkinson ' s disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), and contracture to left hand. The 10/01/2024 comprehensive assessment showed the resident required extensive assistance of two staff members for ADL ' s. The resident was assessed to have severely impaired cognition, with impairment to upper and lower extremities. The assessment further showed that they had a restorative program for ROM with splint or brace assistance during the assessment period. Record review of the care plan, dated 05/14/2024, showed Resident 20 was on a nursing restorative program for passive ROM to include placing and removing the [NAME] guard splint (a device that can protect and help with issues including finger contractures and prevents further decline of contractures) to the left hand. During observations on 12/02/2024 at 3:49 PM. 12/03/2024 at 9:35 AM, 12/04/2024 at 8:51 AM 12/04/2024 at 2:10 PM, and 12/05/2024 at 9:02 AM, showed Resident 20 had no [NAME] guard splint to their right hand. During an interview on 12/05/2024 at 9:08 AM, Staff Z, Nursing Assistant, (NA) stated they were not aware of any restorative programs and were unable to explain what a restorative program was. Staff Z stated Resident 20 did not have any splints or devices that were to be placed in their left hand that they were aware of. Additionally, Staff Z stated they did not do any exercises for Resident 20. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/09/2024 at 1:54 PM, Staff E stated Resident 20 was to have their splint placed every morning and removed in the evening. Staff E stated it was a restorative program, and they were not aware the program was not being followed, and the process was broken. During an interview on 12/03/2024 at 2:31 PM, Staff AA, NA, stated they were the restorative NA and had been pulled to the floor related to low staffing a while ago (one year ago). Staff AA stated they tried and do a little bit of the programs as they were working but were not able to get to any residents that were not on their assigned hallway. During an interview on 12/03/2024 at 2:44 PM, Staff O, NA stated they completed the restorative programs for residents if they were not busy. Staff O stated they were unable to do any programs that day during their shift they were just too busy. During an interview on 12/03/2024 at 2:49 PM, Staff N, NA, stated they only completed the walking programs on their residents. Staff N stated they have not been trained how to do ROM programs, so they did not complete them. During an interview on 12/09/2024 at 12:13 PM, Staff A, Administrator, stated they would expect braces and splints to be placed as ordered and any resident showing a decline to be evaluated and treated by both the Restorative Nurse and Therapy in a timely manner. Reference: WAC 338-97-1060 (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. 44922 Based on observation, interview, and record review, the facility failed to ensure a resident's bathroom had safe and functional Durable Medical Equipment (DME, medically necessary equipment used by people with a medical condition, disability, or injury) for 1 of 3 sampled residents (Resident 9) reviewed for accident hazards. This failure placed the resident at risk for falls, injuries, and decreased independence. Findings included . <Resident 9> Review of the resident's medical record showed the resident admitted with diagnoses to include lower back pain and anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome). The 09/11/2024 comprehensive assessment showed Resident 9's cognition was moderately impaired and they had not experienced any falls since admission. An observation and concurrent interview on 12/03/2024 at 9:53 AM, showed Resident 9 sitting in their wheelchair, self-propelling in their room. Observation of Resident 9's bathroom, showed a toilet seat riser (a portable toilet seat that provides additional height to an existing toilet) with handles to each side, that was not secured to the toilet. Also, there was a set of portable handrails beside the toilet/toilet seat riser, that were not secured to the wall or the floor. When rising from the toilet, applying weight and pressure, the handrails would lift off the floor. Additionally, the right-side portable handrail was broken and when rising, and applying pressure and weight, would push outwards to the right. Resident 9 stated they had reported the bathroom equipment issues to staff during a group meeting but was told there was nothing that could be done. During an interview on 12/05/2024 at 8:56 AM, Staff M, Nursing Assistant, stated the process for reporting broken equipment would be to write them in the maintenance book that was kept at the Nurses station. Staff M stated they did not report the broken or unsecured bathroom equipment to maintenance or write it into the maintenance book. During an interview on 12/06/2024 at 10:00 AM, Staff V, Activities Director, stated they recalled Resident 9 reporting their wobbly toilet and thought they wrote the concern into the Maintenance book. Review of the Maintenance book from 05/30/2024 through 12/05/2024 showed no entries had been written in the book for Resident 9's bathroom equipment. During a follow-up interview on 12/09/2024 at 8:41 AM, Resident 9 stated they had fallen twice and felt they lost their balance whenever they rose from the toilet because there was no stability with the handrails. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During review of the 05/19/2024 and 11/01/2024 fall incident investigations, showed Resident 9 had experienced non-injury falls in the bathroom due to their deconditioning of their legs and weakness. During an interview on 12/09/2024 at 9:26 AM, Staff I, Maintenance Director, stated they had not had any reports, verbal or written, regarding Resident 9's bathroom equipment and would expect staff to report equipment issues to them or write them in the maintenance book. An interview and concurrent observation on 12/09/2024 at 10:48 AM, Staff E, Restorative Director, stated they were not aware Resident 9 had issues with their bathroom equipment. Staff E stated they had not assessed the bathroom themselves because the resident stated they fell due to being weak in their legs and nothing about the equipment itself. After observation of the bathroom toilet seat riser and the portable handrails, Staff E acknowledged they were not in the correct operational condition. Reference WAC: 388-97-1060 (3)(g)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31168 Based on observation, interview, and record review, the facility failed to ensure that a resident who was a trauma survivor received culturally competent, trauma-informed care in accordance with professional standards of practice for 3 of 4 residents (Residents 12, 27, and 38) reviewed for trauma informed care. The facility failed to identify triggers (a stimulus that causes a reaction, often an emotional or physical response) regarding history of Post-Traumatic Stress Disorder (PTSD, a mental health that is triggered by a terrifying event) and interventions. This failure placed the residents at risk for unidentified triggers and re-traumatization. Findings included . <Resident 12> Review of the medical record showed Resident 12 was readmitted to the facility with diagnoses to include end stage kidney disease with kidney dialysis (process of cleaning waste from the blood artificially), heart disease and failure, left above the knee amputation, and amputation of their penis due to gangrene (death of tissue due to lack of blood flow). Review of the [DATE] assessment showed the resident was alert and able to make their needs known. During an interview on [DATE] at 9:00 AM, Resident 12 was up in their wheelchair in the front room area of the facility, looking out of the large picture window facing the parking lot. When asked about how the resident was doing and how things were going with their care, Resident 12 stated they were very unhappy about their care at the facility. Resident 12 stated this past year had been hard on them with their spouse passing away, losing their left lower leg, and now possibly their right leg. The resident stated they had gangrene and an infection of their penis which was amputated, and now they had a suprapubic catheter. Resident 12 stated they felt they had lost their manhood. The [DATE] psychosocial history assessment completed by Staff H, Social Services Director (SSD), showed the Resident 12 was a widower. The assessment did not show Resident 12's most recent trauma. During an interview on [DATE] at 9:45 AM, Resident 12 was seated in their wheelchair in the front room of the facility with tears in their eyes and stated they were very sad about the loss of their spouse, the loss of their leg, and their manhood. The resident stated they had disturbing dreams of not improving, and they were worried about not being able to stand on their right leg/foot. Resident 12 stated they wanted their right leg to heal so they could walk again, but they were not sure if that would happen. Review of Resident 12's [DATE] care plan showed no care plan focus for Resident 12's trauma concerns, triggers from the resident's conditions from the loss of their wife and amputations, or associated interventions to manage their identified trauma. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 12:53 PM, Staff H stated they were aware Resident 12 was widowed but unaware the resident's loss of their wife was so recent. Staff H stated they were unaware that Resident 12's loss of their penis and illnesses, to include amputations, were a significant trauma to them. Staff H stated they did not assess Resident 12 further to determine how the resident's health conditions impacted their mental health well-being. <Resident 38> Review of the medical record showed the resident admitted to the facility on [DATE] with diagnoses to include cataracts (opacity of the lens of the eyes), dementia (cognitive impairment), and multiple falls with fracture. During an interview on [DATE] at 10:38 AM, Resident 38 stated they were disgusted and stated they did not like being at the facility and began to cry. Resident 38 stated they felt isolated from their Resident Representative (RR) and they felt that the RR did not want them. Additionally, Resident 38 stated they still were unable to forgive themselves regarding their younger child who died of alcoholism. Resident 38 stated it continued to bother them because they also had an issue with alcohol in the past. During an interview on [DATE] at 10:31 AM, Staff DD, Social Services Assistant, stated they were aware the resident had regrets about their child dying at a young age from alcoholism. Review of the [DATE] psychosocial history (completed by Social Services) did not reflect any of the issues discussed by Resident 38 or Staff DD. During an interview on [DATE] at 11:00 AM, Staff H stated there were no triggers or trauma-based care plan identified or initiated for Resident 38. 48368 <Resident 27> Review of Resident 27's medical record showed the resident admitted to the facility with diagnoses to include PTSD, anxiety (a feeling of fear, dread, or uneasiness), and depression (a prolonged feeling of sadness, hopelessness, or loss of interest in activities). The [DATE] comprehensive assessment showed Resident 27 required the assistance of two staff member for activities of daily living (ADLs, performing basic care needs) and was cognitively intact. During an interview on [DATE] at 1:51 PM, Resident 27's RR stated the resident had PTSD stemming from their parents not understanding their behaviors, so they yelled a lot, it was an ongoing thing. The RR stated Resident 34's triggers were yelling, and when anyone would yell out, Resident 27 would start yelling out with them. Record review of Resident 34's care plan, dated [DATE], showed no trauma informed based plan of care that included Resident 27's diagnosis of PTSD, triggers, behaviors, or interventions. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:01 PM, Staff H stated the process for trauma informed care was to fill out the PTSD form (which was not a trauma assessment) which included the resident's specific triggers and interventions. Staff H stated Resident 27's triggers and interventions should had been assessed and placed in the plan of care. Staff H stated Resident 27 did not have a trauma or PTSD assessment completed. Staff H further stated the trauma informed care process was not followed for Resident 27. During an interview on [DATE] at 3:50 PM, Staff B, Director of Nursing Services (DNS), stated that there was no assessment tool in the electronic health record for a trauma assessment. Staff B stated there were no trauma assessments completed for residents . WAC Reference: [DATE] (3)(e)

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	505085	A. Building B. Wing	12/09/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview, and record review, the facility failed to ensure residents were free of unnecessary psychotropic medications (any medication capable of affecting the mind, emotions, and behavior) for 2 of 5 residents (Residents 7 and 16) reviewed for unnecessary medications. The facility failed to consistently develop, monitor, and implement individualized targeted behaviors and ensure as needed (PRN) psychotropic medications were limited to 14-days or had a documented rationale for the extended use. Additionally, the facility failed to consistently obtain informed consent for the use of psychotropic medications. These failures placed residents at an increased risk for experiencing medication-related adverse side effects, and a decreased independence for making their own informed decisions. Findings included . <Resident 7> Review of the resident's medical records showed they admitted on [DATE] with diagnoses to include depression (a mood disorder that causes persistent feelings of sadness and loss of interest). The 10/15/2024 comprehensive assessment showed Resident's 7 cognition was severely impaired, displayed no behaviors, and received an anti-anxiety medication. An observation and concurrent interview on 12/03/2024 at 2:33 PM, showed Resident 7 lying in bed, unshaven, pleasantly talking and answering questions. Review of Resident 7's July 2024 Medication Administration Record (MAR), showed an order on 07/17/2024 for Ativan (a brand of medication used to treat anxiety [a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome]) every four hours as needed (PRN). The order showed no stop date and showed it was being given for agitation/comfort care/palliative approach. The order showed it was discontinued on 08/29/2024 (43 days after being started). Review of the August 2024 MAR showed on 08/29/2024 a new order for Ativan to be given every four hours PRN with no stop date. The Ativan was to be given for agitation/comfort care and 20 to 30 minutes prior to wound treatment to Resident 7's left forearm. Review of a 07/18/2024 Pharmacy review note, showed the pharmacist recommended a stop date be added to the new order for Ativan per the regulation. The note showed the Contracted Medical Director (CMD) agreed to the recommendation and the words added were documented with a date of 07/23/2024. Review of a 07/24/2024 Psychoactive Drug Review, showed a note to extend the Ativan for three more months without a documented rationale. The note was signed by the CMD. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 7's August 2024 MAR showed an order dated 07/31/2020 for behavior monitoring for agitation, name calling, and being argumentative. The order showed required documentation was to include the number of occurrences, the intervention attempted, and the outcome after the medication was given and to be documented twice daily. The order showed 18 shifts (62 possible) with behaviors, 13 of those shifts showed no interventions or outcome documented. Review of September 2024 MAR The MAR showed four shifts (60 shifts possible) of behaviors with two of those shifts showing no rational or outcome documented. Review of the October 2024 MAR, showed Resident 7 had behaviors on six shifts (62 shifts possible), five of those shifts had no documented intervention or outcome documented, the boxes showed N/A [does not apply]. <Resident 16> Review of the resident's medical record showed they admitted with diagnoses to include depression. The 10/23/2024 comprehensive assessment showed Resident 16's cognition was severely impaired and received an anti-depressant medication. An observation and concurrent interview on 12/02/2024 at 10:10 AM, Resident 16 was lying in bed, wearing a night gown, hair uncombed, and had a flat affect. Resident 16 was willing to answer a few questions before stating they were tired and wanted to rest. Review of Resident 16's October 2024 MAR showed an order on 09/24/2024 for Desvenlafaxine (a brand of anti-depressant medication) 50 milligrams (mg, a unit of measure) daily for depression, an order on 09/23/2024 for Remeron daily at bedtime for depression, and no orders for monitoring of targeted behaviors for depression. Review of the November 2024 MAR showed an order on 11/15/2024 to increase the Desvenlafaxine from 50 mg to 100 mg and an order on 11/12/2024 to monitor Resident 16 every shift for five days for depression/tearfulness and wanting to go home (five of the 15 shifts were not documented as completed). There were no other orders to monitor for targeted behaviors. Review of Resident 16's 12/01/2024 to 12/07/2024 MAR showed no behavior monitoring for targeted behaviors. Review of a 11/12/2024 nursing progress note at 8:36 PM, showed Resident 16 was sad about their condition and wanted to go home. The LN was able to comfort the resident and no tearfulness afterwards. Additional review of the nursing progress notes for 11/13/2024 to 11/17/2024, the five days of depression monitoring, showed as follows: on 11/13/2024 at 2:21 PM showed Resident 16 appears sad today, on 11/14/2024 at 7:40 PM, 11/15/2024 at 5:12 AM and 8:42 PM, 11/16/2024 at 11:03 AM and 8:37 PM, 11/17/2024 at 10:54 AM and 8:20 PM, showed no depression or tearfulness (even though the anti-depression medication was increased on 11/15/2024, prior to the end of the monitoring). Review of Resident 16's 09/24/2024 baseline care plan or their 09/24/2024 comprehensive care plan, showed there was no care plan formulated for Resident 16's depression or their use of psychotropic medications. Review of Resident 16's psychotropic medication consents showed there was no consent signed, or education given for the use of the Remeron medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/09/2024 at 11:22 AM, Staff C stated the resident did not have a signed consent for the use of the Remeron for this admission. Staff C stated they would normally monitor for targeted behaviors for depression and the anti-depressant was increased due to more sadness reported to Staff C by other staff. Staff C stated they did not recall all of the staff that reported increased sadness, and it was not documented. Staff C stated the Social Services Director reported the resident had increased unhappiness (even though review of the nursing documentation showed no evidence Resident 16 had experienced increase symptoms of depression). Review of Social Services notes from 09/23/2024 to 12/08/2024 showed no notes regarding Resident 16's increase in sadness, unhappiness, or depression. During an interview on 12/09/2024 at 2:03 PM, Staff B, Director of Nursing Services, stated a consent for psychotropic medications should have been completed and maintained in the resident's file. Staff B stated they would expect to see an increase in a psychotropic medication if there was an increase in behaviors that were being treated for. Staff B stated they would expect the documentation to prove the increase in behaviors and for there to be monitoring of the targeted behaviors. Reference WAC: 388-97-1060 (3)(k)(i)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 31168 Based on observation and interview, the facility failed to provide routine and repair maintenance services for a safe and sanitary environment in 1 of 1 kitchen. This failure placed residents at risk for infection by not having cleanable and maintained surfaces. Findings included . <Floor under the Oven/ Oven top dust> An observation on 12/02/2024 at 9:20 AM, showed the kitchen floor under the oven's right leg support, had an uncleanable, broken, and missing area of rubberized concrete which measured 6 inches by 4 inches. During an observation on 12/02/2024 at 9:23 AM, showed the top of the oven had several stainless steel appliances and inserts used for the steam table that were piled on top of the dusty oven. <Leaky Faucets> An observation on 12/02/2024 at 9:30 AM, showed the clean sink area had a leaking water faucet. Additional observations on 12/05/2024 at 11:10 AM and 12/15/2024 at 11:15 AM, showed the water leak had increased to the second faucet. During an interview with Staff FF, Dietary Manager, stated they had previously reported the issue a week before to Staff I, Maintenance Director, and they had stated they had ordered washers for the faucet. <Flour, powdered milk, and other dry good storage> An observation on 12/02/2024 at 9:45 AM, showed there were white plastic barrels with covers that were labeled powdered milk, flour, and other dried goods. The barrels were on rolling wheels and stored under the steam table. Due to the steam table's constant temperature of 180 degrees to 190 degrees Fahrenheit and the moisture created from the steam table, could affect the quality, texture, and shelf life of the stored products. During an interview on 12/02/2024 at 9:48 AM, Staff FF stated they had hardly any storage in the kitchen and they were unaware the moisture from the steam table, that was on constantly, could affect the dried goods stored under the steam table. < Black fuzzy dust on vents/ exposed insulation> (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 12/05/2024 at 11:10 AM, showed two dirty vents on the ceiling with black fuzzy dust, one on the dirty side of the kitchen and one on the clean side. The vent that was located on the dirty side of the kitchen showed a split in the ceiling on both sides. To the left side of the vent had a two-foot split with yellow insulation showing and to the right of the vent showed a foot and a half open seam with yellow insulation exposed. During an interview on 12/05/2024 at 12:00 PM, Staff FF stated they had not had a maintenance person for a while. Staff GG stated they now reported the kitchen issues to Staff I. During an interview on 12/06/2024 at 11:00 AM, Staff A, Administrator, stated they were unaware of the kitchen repair issues and needed to observe the kitchen. Staff A stated that the issues needed to be fixed. Reference WAC 388-97-3220(1)