STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505086	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark Care and Rehabilitation	710 North 39th Avenue Yakima, WA 98902

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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** 35676 39652 45117 Based on observation, interview, and record review, the facility failed to provide care in a manner that promoted resident respect and dignity for 3 of 3 residents (Residents 54, 10, and 5) reviewed for dignity. The failure to shower residents on a regular basis placed the residents at risk for distress, embarrassment, and an undignified existence. Findings included . Review of the facility admission agreement titled, Welcome to Landmark Care and Rehabilitation, dated 07/12/2021, showed the facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. <Resident 54> Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses to include Polymyalgia Rheumatica (an inflammatory disease causing inflammation, muscle pain, and stiffness around the shoulders and hips), osteoarthritis (a type of arthritis that occurs when tissue at the ends of the bones wears down) and Type 2 diabetes (a long term condition in which the body has trouble controlling blood sugar). Review of Resident 54's comprehensive assessment dated [DATE], showed the resident was cognitively intact. Review of the Kardex (care plan used to summarize resident care with directives) dated 05/21/2024 showed the resident required assistance with bathing and was scheduled for showers twice weekly on Wednesday and Saturday. During a concurrent observation and interview on 05/20/2024 at 9:30 AM, Resident 54 stated they had not received their shower on Saturday 05/18/2024 even though they had asked three to four times that day. The resident stated when they asked about getting a shower on Sunday 05/19/2024, they were informed that there was not enough staff. Resident 54 stated they had a skin condition which caused odor if they were not bathed enough. I can smell myself and it's even offensive to me and I am embarrassed. During the conversation Resident 54 it was noted there was a foul musty smell coming from the resident when in close proximity. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 10> Review of the medical record showed Resident 10 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a problem with the metabolism that causes brain dysfunction) and need for assistance with personal cares. The 04/24/2024 comprehensive assessment showed Resident 10 was dependent on one to two staff members for activities of daily living (ADLs), including showering. The assessment also showed Resident 10 was cognitively intact. During a concurrent observation and interview on 05/15/2024 at 8:39 AM, showed Resident 10 lying in a semi-reclined position in bed with their breakfast eggs spilled on their chest. Resident 10 was not wearing a shirt. The room smelled of body odor. Resident 10 stated they had missed their shower earlier that week and had not had one since last week. During a concurrent observation and interview on 05/17/2024 at 8:45 AM, showed Resident 10 lying in bed. Their hair was unkempt, and they had several days growth of facial hair. There was a pungent smell of body odor noted upon entering the room. Resident 10 stated I'm sorry, I am getting kind of rank (a slang word for something that is horrible, in bad taste, or actually smells unpleasant). They stated they usually had their showers on Monday's but did not have one since the Friday before last. Resident 10 stated they used to shave everyday but had not been shaved in a long time. Review of Resident 10's Kardex dated 05/21/2024, showed the resident was to receive showers on Wednesday's and Saturday's. The record showed they had received a shower on Wednesday 05/01/2024 and Saturday 05/11/2024. There was no documentation that Resident 10 received their showers on Saturday 05/04/2024, Wednesday 05/08/2024, Wednesday 05/15/2024, or Saturday 05/18/2024. <Resident 5> Review of the medical record showed Resident 5 was admitted to the facility on [DATE] with diagnoses including heart disease, liver disease and depression. The 03/24/2024 comprehensive assessment showed Resident 5 was cognitively intact and was dependent on one to two staff members for ADLs including showering. During a concurrent observation and interview on 05/20/2024 at 2:09 PM, showed Resident 5 sitting in their room in their wheelchair. Observation of the resident's fingernails and toenails showed both were long and jagged with an observable brown substance under the fingernails. Resident 5 stated they were supposed to get their nails cut and cleaned on their shower days but that had not been done in months, and their biggest concern was not getting their showers as assigned. Resident 5 stated they were supposed to get showers every Tuesday and Friday but lately they were lucky to get one a week. They stated, I'm fed up about it, I shouldn't have to beg to get a shower on my assigned days. I am a large person and I get sore under my skin folds if not cleaned and it burns like fire. Resident 5 further stated in addition to the pain, they easily get a yeast infection under their folds when they are not clean, and they knew they smelled bad. They stated, I can smell myself, that stinky yeast smell and it's so embarrassing I don't want to go around other people, so I just stay in my room most of the time. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 5's Kardex dated 05/20/2024, showed the resident was to receive showers on Tuesdays and Fridays for the month of May 2024. The record showed they had received a shower on Tuesday 05/07/2024 and Tuesday 05/14/2024. There was no documentation that Resident 5 received their showers on Friday 05/10/2024 or Friday 05/17/2024. Reference: WAC 388-97-0180(1-4)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to issue a Notice of Medicare Non-Coverage [(NOMNC) a notice that indicates when your care is set to end from a skilled nursing facility] as required for 3 of 3 residents (Resident 280, 281, and 67) reviewed for beneficiary notification. Additionally, the facility failed to provide a Skilled Nursing Facility (SNF) Advance Beneficiary Notice [(ABN) a notification that provides an estimated cost of continuing services which may no longer be covered by Medicare; beneficiaries may choose to continue services but may be financially liable] for 1 of 1 resident (Resident 67) reviewed for ABN requirements. These failures placed the residents at risk for the inability to make informed financial and care decisions related to their continued stay. Findings included . Review of a policy titled, Issuing a Notice of Medicare Non-Coverage (NOMNC) and Advance Beneficiary Notice of Non-Coverage (ABN), dated 10/29/2023, showed a NOMNC would be issued two calendar days before the Medicare covered services, and an ABN would be issued with the NOMNC. The NOMNC and ABN would be signed and dated by the resident and/or their representative; if the resident representative was not present, the representative would be notified by telephone, fax, or email. Social workers or designee would be responsible for issuing the NOMNC and ABN. <Resident 280> Review of the medical record showed Resident 280 was admitted to the facility on [DATE] with diagnoses including diabetes (a group of diseases that results in too much sugar in the blood) and repeated falls. The 02/01/2024 comprehensive assessment showed Resident 280 was independent with activities of daily living (ADLs). The assessment also showed the resident had an intact cognition. Review of the medical showed Resident 280's Medicare Part A skilled services began on 01/18/2024 and their last covered day was 02/02/2024. Resident 280 had not exhausted their Medicare Part A benefits and was discharged from the facility on 02/01/2024. A NOMNC was issued, signed, and dated by Resident 280 on 02/01/2014; less than the required two days' notice prior to the end of their Medicare Part A stay. <Resident 281> Review of the medical record showed Resident 281 was admitted to the facility on [DATE] with diagnoses including heart failure and pneumonia. The 02/22/2024 comprehensive assessment showed Resident 281 required moderate to maximum assistance of one staff member for ADLs. The assessment also showed Resident 281 had an intact cognition. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record showed Resident 281's Medicare Part A skilled services began on 02/15/2024 and their last covered day was 03/14/2024. Resident 281 had not exhausted their Medicare Part A benefits and was discharged from the facility on 03/14/2024. A NOMNC was issued to Resident 281 on 03/13/2024; providing the resident with less than the required two days' notice prior to the end of their Medicare Part A stay. <Resident 67> Review of the medical record showed Resident 67 was admitted to the facility on with diagnoses including heart failure and muscle weakness. The 04/30/2024 comprehensive assessment showed Resident 67 was independent with ADLs. Resident 67 had an intact cognition. Review of Resident 67's medical record showed their Medicare Part A skilled services began on 04/14/2024 and their last covered day was 04/29/2024. Resident 67 had not exhausted their Medicare Part A benefits and had discharged from the facility on 04/30/2024. A NOMNC was issued Resident 67 on 04/29/2024, signed by the resident, but not dated. They did not receive the required two-day notice for issuance of the NOMNC. Additionally, Resident 67 was issued an ABN that was incomplete; the form did not show the option the resident desired for continued care. The form was signed by the resident but not dated. During an interview on 05/15/2024 at 7:55 AM, Staff A, Administrator, stated social services was responsible for issuing ABN's and NOMNC's. Staff A stated they expected a team effort for issuing and ensuring the notifications were issued on time. Staff A stated there should be a system of checks and balances by staff to ensure they were issued on time. During an interview on 05/21/2024 at 4:03 PM, Staff B, Director of Nursing, stated the NOMNC was issued 72 hours prior to coming off of Medicare, and the ABN should go along with the NOMNC. During an interview on 05/22/2024 at 11:00 AM, Staff C, [NAME] President of Clinical Operations, stated social services were responsible for issuing ABNs and NOMNCs. They stated social services did not follow the process for issuance of the required forms. Reference: WAC 388-97-0300(1)(e)(5)(6)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to provide a written notice to the resident and their representative of the facility's intention and justification for the discharge of 4 of 4 residents (Resident 50, 4, Unidentified Resident 1, and Unidentified Resident 2) reviewed for facility-initiated discharges. Additionally, the facility failed to send a legible copy of the notice of transfer or discharge to the representative of the Office of the State Long Term Care (LTC) Ombudsman (a person that advocates for residents in nursing homes). This failed practice disallowed the resident and/or their representative an opportunity to fully understand the rationale and resident rights associated with the discharge. This failure also placed the resident at risk for diminished protection, lack of access to an advocate that could inform them of their options and rights, and to ensure the resident advocacy agency was aware of the facility practices and activities related to a transfer or discharge. Findings included . Review of the policy titled, Admission, transfer and Discharge - Notice Requirements Before Transfer/Discharge, dated 06/2023, showed before the facility transferred or discharged a resident, the facility would notify the resident and/or their representative of the transfer/discharge and the reasons for the move in writing. The reason for the transfer/discharge would be recorded in the resident's medical records. The facility would provide notification to the Office of the State LTC Ombudsman before or as close as possible to the actual time of the facility-initiated transfer/discharge. <Resident 50> Review of the medical record showed Resident 50 was admitted to the facility on [DATE] with diagnoses including respiratory failure and dependence on renal dialysis (the process of removing excess water and toxins from the blood in people whose kidneys can no longer perform these functions naturally). The 05/02/2024 comprehensive assessment showed Resident 50 required supervision/touch assistance of one staff member for activities of daily living. The assessment also showed Resident 50 had an intact cognition. Review of Resident 50's medical record showed the resident was transferred to the hospital on 05/08/2024 due to fluid overload (a condition in which the liquid portion of the blood is too high). There was no notice of transfer/discharge issued to the resident and/or their representative in the medical record. Further review showed no notice of transfer/discharge to the LTC Ombudsman. <Resident 4> (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record showed Resident 4 was admitted to the facility on [DATE] with diagnoses including heart failure, diabetes (a group of diseases that result in too much sugar in the blood), and end stage renal disease (the last stage of kidney disease where the kidneys can no longer support the body's needs). The 05/03/2024 comprehensive assessment showed Resident 4 required supervision/minimal assistance of one staff member for dressing and oral hygiene and was dependent on one to two staff members for toileting and showering needs. The assessment also showed Resident 4 was cognitively intact. Review of the medical record showed Resident 4 was transferred to the emergency department on 04/10/2024 at 9:00 AM due to shortness of breath and chest pain. There was no notice of transfer/discharge to either the resident and/or their representative or the LTC Ombudsman in the medical record. <Unidentified Resident 1> Review of a document titled, Nursing Home Transfer or Discharge Notice, showed an undated notification of transfer/discharge was provided to the LTC Ombudsman for a resident. The form listed the resident's first name only and had no date that the notice was given or the effective date of the transfer/discharge. <Unidentified Resident 2> Review of a document titled, Nursing Home Transfer or Discharge Notice, showed a resident's name that was illegible (impossible or hard to read because of poor handwriting). The date the notice was given was 02/07/2023 (the date of the fax completion was 02/07/2024). There was no effective date of the transfer/discharge. During an interview on 05/16/2024 at 4:36 PM, Staff F, Social Services Director, stated they were responsible for issuing and sending the notification to the LTC Ombudsman. Staff F stated they sent the form as soon as possible after the resident transferred/discharged . During an interview on 05/21/2024 at 4:05 PM, Staff B, Director of Nursing, stated social services was responsible for notifying the LTC Ombudsman. Staff B stated the process was not working; the forms were not timely, complete, or legible. Reference: WAC 388-97-0120(2)(a-d), 388-97-0140(1)(a)(b)(c)(i-iii)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to issue a written notice of bed hold (holding or reserving a resident's bed while the resident was absent from the facility) at the time of hospital transfer for 1 of 2 residents (Resident 50) reviewed for hospital transfers. This failure placed the resident at risk for lack of knowledge regarding their right to hold their bed and any monetary charges associated with the bed hold while in the hospital. Findings included . Review of the policy titled, Bed Hold Policy Notification 2024, updated 01/11/2024, showed residents were able to retain their bed when they were discharged to the hospital or on a therapeutic leave. The resident and/or their representative must sign and return the Bed Hold Policy Notification 2024 form to the business within 24 hours of receipt of the form if they chose to retain their bed. <Resident 50> Review of the medical record showed Resident 50 was admitted to the facility on [DATE], readmission on 04/17/2024, with diagnoses including respiratory failure and dependence on renal dialysis (the process of removing excess water and toxins from the blood in people whose kidneys can no longer perform these functions naturally). The 05/02/2024 comprehensive assessment showed Resident 50 required supervision/touch assistance of one staff member for activities of daily living. The assessment also showed Resident 50 had an intact cognition. Review of the medical record showed Resident 50 was transferred to the hospital on 05/08/2024. There was no notice of bed hold in the medical record. During an interview on 05/20/2024 at 4:17 PM, Staff F, Social Services Director, stated they were responsible for issuing bed hold notices to the residents or their representative. Staff F stated there should have been a notice of bed hold issued for this resident at the time of their transfer to the hospital. During an interview on 05/21/2024 at 4:11 PM, Staff B, Director of Nursing, stated that residents were usually transferred emergently, and bed hold should be done by the next day. During an interview on 05/22/2024 at 11:04 AM, Staff C, [NAME] President of Clinical Operations, stated that bed hold needed to be offered to the resident and/or their representative when they were transferred. Staff C stated the process for bed hold notification was not followed. Reference: WAC 388-97-0120(4)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to ensure the accuracy and completion of a Preadmission Screening and Resident Review (PASARR) for 2 of 7 residents (Residents 10 and 36) reviewed for PASARR Level 1. This failed practice placed the residents at risk for inappropriate placement and/or not receiving timely and necessary services to meet mental health care needs. Findings included . <Resident 10> Review of the medical record showed Resident 10 was admitted to the facility on [DATE] with diagnoses including dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), Post Traumatic Stress Disorder [(PTSD) an anxiety disorder that develops in some people who have experienced a shocking, scary, or dangerous event], and heart failure. The 05/24/2024 comprehensive assessment showed Resident 10 required substantial/maximal assistance of one staff member for activities of daily living; dependent on one to two staff members for toileting, showering, and dressing. The assessment also showed the resident was cognitively intact. Review of a document titled Level 1 Pre-Admission Screening and Resident Review (PASARR), dated 04/22/2024, showed Resident 10 was a current nursing facility resident. There was no documentation that an initial PASARR had been completed. The PASARR form did not include the diagnosis of PTSD. Additionally, the resident had a diagnosis of bipolar affective disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration) listed in their providers admission note that was not listed on their diagnosis list or PASARR. During an interview on 05/21/2024 at 4:11 PM, Staff B, Director of Nursing, stated the admissions nurse was responsible for obtaining the initial PASARR form. Staff B stated when a resident received a new diagnosis, the PASARR would need to be re-done. Staff B stated Resident 10 needed to have a new PASARR completed due to the addition of the bipolar affective disorder diagnosis. <Resident 36> Review of the medical record showed Resident 36 was admitted to the facility on [DATE] with diagnosis including anxiety (a feeling of worry, nervousness, or unease), insomnia (a sleep disorder that makes it hard to fall asleep, stay asleep, or get quality sleep), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The medical record showed that the resident had been receiving ciltaopram medication for the treatment of the depression. The resident's most recent comprehensive assessment dated [DATE], showed they required supervision with personal hygiene, transfers, and were severely cognitively impaired to make decisions regarding their daily care needs. Review of the residents Level 1 PASARR, dated 09/21/2023, showed no documentation of Resident 36's diagnoses of anxiety and depression. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/22/2024 at 10:15 AM, Staff B, Director of Nursing, stated PASARR's were reviewed by Social Services. Staff B stated their expectation was they were to be reviewed on admission, which included the residents' diagnoses, and with any new diagnosis or change. During an interview on 05/22/2024 at 11:05 AM, Staff C, [NAME] President of Clinical Operations, stated the PASARR process needed to be updated. Staff C stated nursing staff needed to review the provider notes to ensure all diagnoses were listed on the resident's diagnosis list and on the PASARR if applicable. Reference: WAC 388-97-1915(1)(2)(a-c) This is a repeated citation from Statement of Deficiencies dated 04/12/2023. 45642

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35676 Based on interview and record review, the facility failed to develop and provide to the resident and/or resident representative, a baseline care plan within 48 hours of admission that documented resident specific initial goals, physician orders, and treatment plans for 2 of 2 newly admitted residents (Residents 20 and 59) reviewed for baseline careplans. This failure placed the residents at risk of not receiving continuity of care and resident centered care needs. Findings included . Per the F-655 Federal requirement effective date 11/28/2017: The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. <Resident 20> Review of the medical record showed Resident 20 was admitted to the facility on [DATE] with diagnoses including respiratory disease, congestive heart failure, (a chronic condition in which the heart doesn't pump blood as well as it should) and diabetes (a long-term condition in which the body has trouble controlling blood sugar levels). The comprehensive assessment dated [DATE], showed Resident 20 was cognitively intact and required extensive assistance of one to two staff members with activities of daily living (ADLs). Review of a care plan meeting titled, Post Admission 72-Hour Care Plan, dated 04/26/2024, showed the nursing needs were to monitor medication management and pain management, though no specific medications or treatments were listed. Dietary information listed Resident 20 as able to eat independently with a soft carbohydrate-controlled diet, though review of a nursing admission progress note dated 04/24/2024, showed Resident 20 required a moist, minced diet and assistance of a one-to-one staff member for meal supervision. The attendees listed in the care plan meeting were the Resident, the Resident Care Manager, (RCM), the Rehab Director, the Dietary Manager, and the Social Services Director. There was no information found to show that Resident 20 had received a copy of a baseline care plan within 48 hours of admission. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/14/2024 at 12:10 PM, Resident 20 stated there was a meeting a couple of days after they were admitted , and someone had discussed some information about the therapies they would get in the facility, but they could not recall that a copy of a care plan was given to them. <Resident 59> Review of the medical record showed Resident 59 was readmitted to the facility on [DATE] with diagnoses including malnutrition, dysphagia (difficulty swallowing), repeated falls, and chronic pain. The comprehensive assessment dated [DATE], showed Resident 59 required moderate assistance of one staff member for ADLs and had impaired cognition for daily decision making. Review of a care plan meeting titled, Post Admission 72-hour Care Plan dated 04/12/2024, showed the nursing needs were to monitor medication management and pain management though no specific medications or treatments were listed. Dietary information listed Resident 59 as able to eat independently with a soft carbohydrate-controlled diet and thin liquids. Review of a nursing admission progress note for Resident 59 dated 04/09/2024, showed the resident had a diagnosis of dysphagia and required supervision when eating a soft textured diet with thickened liquids related to a high risk of aspiration (the accidental breathing in of food and fluids into the lungs). The attendees listed in the care plan meeting on 04/12/2024 were the Resident, the Social Services Director, and a Physical Therapist. There was no information found to show that Resident 59 had received a copy of a baseline care plan within 48 hours of admission. During an interview with Resident 59 and their representative on 05/16/2024 at 1:35 PM, both stated they had not received a copy of a baseline care plan that listed the resident's medications, treatments, dietary needs, therapy, and discharge goals from a care conference held on 04/12/2024. During an interview on 05/21/2024 at 3:40 PM, Staff E, Licensed Practical Nurse/Assistant Director of Nursing, stated the social services department was responsible for initiating the baseline care plan and assuring that the resident and/or their representative received a copy of the plan after the interdisciplinary team had all added their input at the admission care plan meeting. Staff E stated there had been staffing changes in social services and nursing management in the past several months, so it was probable some systems had been missed in the baseline care plan process. Reference WAC 388-97-1020(3)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39652 Based on observation, interview and record review, the facility failed to develop and implement comprehensive resident-centered care plans consistent with the residents identified care needs for 2 of 6 residents (Resident's 4, and 60) reviewed for accuracy of care plans. This failure placed residents at risk for not receiving appropriate goods and services consistent with their identified care needs. Findings included . <Resident 4> Review of the medical record showed Resident 4 was admitted to the facility on [DATE] with diagnoses including heart failure, obstructive sleep apnea (a sleep disorder that keeps you from breathing normally while you sleep), diabetes (a group of diseases that result in too much sugar in the blood), and end stage renal disease (the last stage of kidney disease where the kidneys can no longer support the body's needs). The 05/03/2024 comprehensive assessment showed Resident 4 required supervision/minimal assistance of one staff member for dressing and oral hygiene and was dependent on one to two staff members for toileting and showering needs. The assessment also showed Resident 4 used a continuous positive airway pressure [(CPAP) a machine that uses mild air pressure to keep breathing airways open while sleeping] machine, intermittent oxygen therapy, and was cognitively intact. During a concurrent observation and interview on 05/14/2024 at 8:45 AM, showed Resident 4 in bed, in a semi-reclined position. Resident 4 stated their CPAP machine had been broken for a week. They stated it was hard to turn on and would occasionally shut off at night. Resident 4 stated it was their own personal CPAP machine and they had an upcoming appointment for a sleep study to evaluate their CPAP needs and a new machine. There was an oxygen concentrator with a nasal cannula (tubing used to deliver oxygen) next to the resident's bed. Resident 4 stated they used the oxygen as needed. Review of Resident 4's care plan dated 05/14/2024 had no focus area or interventions related to the use of oxygen or the CPAP machine. <Resident 60> Review of the medical record showed Resident 60 was admitted to the facility on [DATE] with diagnoses including surgical removal of left leg (below the knee) and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and chronic kidney disease (longstanding disease of the kidneys leading to kidney failure). The 03/20/2024 comprehensive assessment showed Resident 60 required maximum assistance of one staff member for activities of daily living: set up assistance of one staff member for eating, oral and personal hygiene. The assessment also showed Resident 60 had an intact cognition. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 05/13/2024 at 3:43 PM, Resident 60 was observed sitting in their wheelchair with their bedside table to their left. There was a plastic tumbler that contained 550 ml of water. Resident 60 stated they were not aware that they had a fluid restriction but had been on one at the hospital. They stated they drink as much as they want, that staff refill their plastic tumbler several times a day, more if they ask. They stated they get beverages with their meals and had not been told they had any type of fluid restriction. Review of the May 2024 Medication Administration Record showed Resident 60 had a 1500 milliliter [(ml) a unit of liquid measurement] daily fluid restriction; 1080 ml from dietary and 210 ml from nursing every day shift and 210 ml every evening shift. Review of Resident 60's care plan dated 04/01/2024 showed no focus area, goals, or interventions related to Resident 60's chronic kidney disease and fluid restriction. During an interview on 05/21/2024 at 4:16 PM, Staff B, Director of Nursing, stated comprehensive care plans were completed within 14 days of admission and reviewed quarterly. Staff B stated care plans were personalized for each resident and expected that the respiratory concerns and fluid restriction should have been on the care plans. During an interview on 05/2/2024 at 11:07 AM, Staff C, [NAME] President of Clinical Operations, stated that care plans should be comprehensive and updated as needed. Staff C stated the care plans were not comprehensive and should have included the CPAP, oxygen, and fluid restriction. Reference: WAC 388-97-1020(2)(c)(d) 45117 45642

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642 Based on interview and record review, the facility failed to ensure the ongoing review, coordination of care conferences, and revisions to care plans were implemented for 4 of 4 residents (Resident 28, 35, 54 and 55) reviewed for care planning. This failure placed the residents at risk for unmet care needs and decreased quality of life. Findings including . <Resident 28> Review of the resident's medical records showed they were admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a brain disorder that slowly destroys memory), anxiety (a feeling of worry, nervousness, or unease), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The comprehensive assessment dated [DATE] showed Resident 28 required maximal assistance for activities of daily living (ADLs) and had moderate cognitive impairment. Review of Resident 28's medical record showed the last quarterly care conference held was dated 04/20/2023, and showed the resident, their representative, social services, dietary and the Resident Care Manger (RCM) were in attendance. Further review of the medical records showed no further quarterly care conferences were completed since 04/20/2023. During an interview with Resident 28 on 05/13/2024 at 11:50 AM, they stated they could not recall when they last participated in a care conference. <Resident 35> Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including anxiety, depression, bipolar disorder(a chronic mood disorder that causes intense shifts in mood, energy levels and behavior), and post-traumatic stress disorder [(PTSD) a disorder that develops when a person has experienced or witnessed a scary, shocking, terrifying or dangerous event]. Review of the comprehensive assessment dated [DATE], showed the resident had moderate cognitive impairment and required maximal assistance of one staff member with ADL's. Review of Resident 35's medical record showed the last quarterly care conference held was dated 01/30/2024 and showed those in attendance were social services and dietary. Further review of the medical records showed no quarterly care conference was held within 90 days of the 01/30/2024 care conference. During an interview on 05/13/2024 at 2:45 PM, Resident 35 stated they were unable to recall when they had last attended a care conference or had been invited to attend a care conference. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/17/2024 at 12:39 PM, Staff F, Social Services Director (SSD), stated Resident 35's behavior therapist and representative had been involved in their care conference on 01/30/2024 and acknowledged there was no documentation of their attendance. During an interview on 05/21/2024 10:13 AM, Staff F, stated their process for assuring care conferences were completed timely was when a resident's comprehensive assessment was coming due, they would notify the resident and resident representative of the date and time of the care conference and would schedule a reminder call seven days prior to the conference. Staff F stated resident care conferences were scheduled for 72-hours after admission, quarterly, significant change, readmission, and for discharge if requested. During an interview on 05/21/2024 at 10:36 AM, Staff B, Director of Nursing, stated they attended resident care conferences if the nurses (RCM or floor nurse) were unable to attend. Staff B stated their expectations were that care conferences were to be done quarterly, for a significant change in status, 72-hours after admission and for a discharge conference. <Resident 54> Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses to include Polymyalgia Rheumatica (an inflammatory disease-causing swelling, muscle pain and stiffness around the shoulders and hips), osteoarthritis (a type of arthritis that occurs when tissue at the ends of the bones wears down) and Type 2 diabetes. Review of Resident 54's most recent comprehensive assessment dated [DATE] showed the resident was cognitively intact. During a concurrent interview, and observation on 05/08/2024 at 1:40 PM, showed Resident 54 up in their wheelchair in the north family room. A long clear tube was at the resident's feet attached to a bag which was covered in a secondary dark blue bag. The tube was noted to have yellow liquid draining downward into the bag which was consistent with urine. The resident stated, I had a urinary catheter(a flexible tube inserted into the bladder through the urethra to drain urine) recently placed. Review of a progress note dated 04/26/2024 showed the resident had seen a medical provider and a retention catheter had been ordered on 04/24/2024. Review of Resident 54's care plan with a revised date of 03/28/2024, showed no updates to the care plan related to the newly placed catheter such as required information including the size and frequency of changes. The care plan showed the resident was using the bathroom for bladder elimination. Review of the resident's Kardex (a care plan for nursing assistants that provides specific directions for resident activities of daily living needs) dated 05/02/2024 showed the resident used a bedside commode or toilet for bladder elimination. The Kardex had not been updated to reflect that the resident now had a retention catheter which required specific care and monitoring. <Resident 55> (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 55's medical records showed they were admitted to the facility on [DATE] with diagnoses including left side hemiplegia (the loss of the ability to move a part of the body), dysphagia (difficulty swallowing), cerebral infarction (damage to tissues in the brain due to the loss of oxygen to the area), muscle weakness, and a need or assistance with personal care. Review of Resident 55's most recent comprehensive assessment dated [DATE], showed the resident had moderate cognitive impairment. During a concurrent observation and interview on 05/14/2024 at 11:31 AM, Resident 55 had a brace to their left hand, the resident stated that they wore the brace all day. Further that they were unsure who placed the brace on their hand, family came in the evening and removed the brace to wash it. Review of the resident's care plan dated 04/22/2024 showed no updates to the care plan related to the resident's use of a left-hand brace including the checking of the skin underneath, a schedule of an on/off use of the brace, and who was to do the task. Review of the resident's Kardex dated 05/15/2024, showed the resident had an active range of motion task of the left upper extremity during cares to prevent new contractures. The Kardex had not been updated to reflect the resident's left-hand brace. During a concurrent observation and interview on 05/16/2024 at 1:51 PM, Staff E, Assistant Director of Nursing (ADON) had removed Resident 55's left hand brace, their skin was reddened and intact. Staff E stated that the brace was removed every night, and the nursing assistants replaced it in the mornings. Staff E acknowledged that the resident did not have a Physician order for the brace or that it was care planned. Reference WAC 388-97-1020 (2)(d)(f)(4)(b)(c)(i-ii)(5)(b)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35676 Based on observation, interview, and record review the facility failed to provide the necessary care and services to ensure residents dependent on staff received consistent showers for 5 of 11 residents (Residents 5, 28, 54, 55, and 10) reviewed for activities of daily living (ADLs). The failure to receive adequate showering and grooming care according to the residents' care plan placed the residents at risk for unmet care needs, impaired skin integrity, and embarrassment. Findings included . Review of a facility policy titled, Activities of Daily Living (ADLs), dated 06/2023, showed residents would be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs. In addition, the policy showed residents that were unable to carry out ADLs independently would receive the necessary services to maintain good nutrition, grooming, personal care, and oral hygiene. <Resident 5> Review of the medical record showed Resident 5 was admitted to the facility on [DATE] with diagnoses including heart disease, obesity, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest in daily activities). The 03/24/2024 comprehensive assessment showed Resident 5 was cognitively intact and was dependent on one to two staff members for ADLs, including bathing and grooming. In a concurrent observation and interview with Resident 5 on 05/20/2024 at 2:09 PM, the resident stated that they had not been getting their showers as they were supposed to for the past several months and had filled out grievance forms about it at least three times in recent months, including one last week for missing their showers. They stated the staff keep telling them they were short staffed and were doing their best, but stated they must be showered at least twice a week, or their skin broke down from yeast infections and they became very reddened and sore in their skin folds. Resident 5's fingernails and toenails were observed to be long and jagged, with a brown substance under the fingernails and they stated they were to be trimmed and cleaned on their shower days, but that had not been done for months. In addition, Resident 5 stated they thought they were to be cleaned every evening under their skin folds to prevent yeast infections and for odor control, but it rarely happened. Review of the facility's grievance logbook showed Resident 5 filled out a grievance form on 02/22/2024 and on 03/12/2024, stating they were not receiving their showers as assigned and were sore in their skin folds from not receiving their showers. Review of Resident 5's care plan showed they required maximal assistance of one staff member for bathing and was to have showers on Tuesdays and Fridays, and a sponge bath to clean under the abdominal and breast folds every evening before bed. In addition, the care plan showed to trim and file nails on the shower days. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the nursing assistant (NA) task flow sheets for May 2024 showed the NAs were signing that Resident 5's skin folds were being cleaned each evening before bed and showed they were last showered on 05/14/2024. In an interview on 05/21/2024 at 3:34 PM, Staff E, Assistant Director of Nursing (ADON), stated the bath team members were put back on the floor a few months ago because every time a NA on an assigned section called in, the bath team member was pulled to work as a NA anyway. Staff E stated the NAs now did their own showers for the residents on their section, which worked well if everyone showed up, but if they were short of staff on the floor, the showers were missed. We know it's a problem and are trying to figure out a system that works so residents don't miss their showers. <Resident 28> Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a brain disorder that slowly destroys memory), anxiety (a feeling of worry, nervousness, or unease), and depression. The most recent comprehensive assessment dated [DATE], showed Resident 28 was moderately impaired cognitively and required maximal assistance with bathing, dressing and personal hygiene. An observation on 05/16/2024 at 9:17 AM, showed Resident 28 in their wheelchair sitting at the nursing station, wearing blue pants and a striped shirt. The resident's hair was oily, and their nails were long, with dark matter noted underneath the nails. Review of Resident 28's NA task flow sheets for April 2024 and May 2024, showed the resident preferred to have showers on Wednesdays and Sundays. The Task sheet for April 2024 showed the resident went seven days without a shower and the May 2024 task sheets showed the resident went 13 days without a shower. During an interview on 05/17/2024 at 8:59 AM, Staff I, NA, stated we have on average 10 to 12 residents in a shift to provide all care for including showers. I'm going to be honest with you, yesterday we did not get showers done. The showers hardly get done as assigned, the proper care doesn't get done like it should, there just isn't enough time in one shift. <Resident 54> Review of the medical record showed they were admitted to the facility on [DATE] with diagnoses including Polymyalgia Rheumatica (an inflammatory disease which causing swelling, muscle pain and stiffness around the shoulders and hips), osteoarthritis (a type of arthritis that occurs when tissue at the ends of the bones wears down) and diabetes. Review of Resident 54's most recent comprehensive assessment dated [DATE], showed the resident was cognitively intact and required substantial assistance for showers. A concurrent observation and interview on 05/20/2024 at 10:00 AM, showed Resident 54 in their room, sitting up in their electric wheelchair. The resident stated they had not received their shower on Saturday 05/18/2024. Resident 54 stated I asked several times, to at least three or four aides, if I was going to get my shower and I was told there was not enough staff, so I had to wait until tomorrow. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 54 stated they stayed in bed on Sunday 05/19/2024, waiting for someone to get them up for a shower, as they had missed their shower on the previous day. The resident stated, I waited and waited and realized when no one got them up they were not going to get a shower that day either. I just stayed in bed the rest of the day. <Resident 55> Review of Resident 55's medical records showed they were admitted to the facility on [DATE] with diagnoses including difficulty in walking, muscle weakness, and a need for assistance with personal care. The most recent comprehensive assessment dated [DATE], showed the resident had moderate cognitive impairment, and had an ADL self-care performance deficit that required substantial/maximal assistance of one staff member with showering, upper and lower body dressing, and transfers. During an observation on 05/14/2024 at 1:46 PM, Resident 55 was lying in bed. The resident had food particles on their shirt and bedding from their lunch meal. The resident's face had long whiskers, and their nails were long with a dark substance underneath the nails. During an interview on 05/15/2024 at 9:03 AM, Resident 55 stated it had been eight days since they had a shower. The resident was in a white t-shirt and stated their spouse visited and changed it last night. Their whiskers continued to be long, though their nails were trimmed and clean. Resident 55 stated their spouse had trimmed their nails last night. In an interview on 05/16/2024 at 2:54 PM, Resident 55's Representative (RR), stated the resident's last shower was two weeks ago and stated they believed the problem was with the staffing, stating, if the facility had all hands-on deck the care would be getting done. During an interview on 05/16/2024 at 4:44 PM, the RR stated Resident 55's skin was breaking down from the lack of showering. The RR stated they come to the facility daily and the resident was usually wet, so they changed them, and they felt as if the staff waited for them to come in to change the resident. Review of Resident 55's NA task flow sheets showed the resident preferred to have showers on Mondays and Thursdays. The NA task sheet for March 2024 showed the resident went 24 days without a shower, the April 2024 task sheets showed the resident went six days, twice within the month, without a shower, and for May 2024 the task sheets showed the resident went 16 days without a shower. <Resident 10> Review of the medical record showed Resident 10 was admitted to the facility on [DATE] with diagnoses including dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), Post Traumatic Stress Disorder [(PTSD) an anxiety disorder that develops in some people who have experienced a shocking, scary, or dangerous event], and heart failure. The 05/24/2024 comprehensive assessment showed Resident 10 was cognitively intact and required substantial/maximal assistance of one to two staff member for toileting, showering, and dressing. An observation on 05/15/2024 at 8:39 AM, showed Resident 10 lying in bed in a semi-reclined position. They had scrambled egg debris on their shirt and bedding from their breakfast meal. The room smelled of sweat and body odor. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 05/17/2024 at 8:45 AM, showed Resident 10 lying in bed, no shirt on, long, patchy facial hair, and unkempt hair. They stated they hadn't had a shower since the Friday before last. Review of the NA task flow record dated April 2024, showed Resident 10's shower days were Wednesday's and Saturday's, with their last shower on April 27, 2024. The May 2024 NA task record showed Resident 10 refused their shower on May 1, 2024, and had received a shower on May 11, 2024, 14 days after their last shower. During an interview on 05/21/2024 at 4:23 PM, Staff B, Director of Nursing, stated they had recognized concerns related to residents getting their showers as scheduled and had changed the shower schedule. Staff B stated they believed they were improving in their ability to provide showers, but most definitely, the process needs more improvement. During an interview on 05/22/2024 at 11:13 AM, Staff C, [NAME] President of Clinical Operations, stated they were not aware of the issues with residents receiving showers. They stated the shower schedule should have been followed and any resident refusals need to be followed up on to ensure residents were receiving their showers. Reference: WAC 388-97-1060(2)(c) 39652 45117 45642

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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** 39652 Based on interview and record review, the facility failed to provide goods and services that met professional standards of care for 1 of 1 resident (Resident 41) reviewed for quality of care. Resident 41 had referrals for follow up with specialized physicians (a group of physicians who focus on specific illnesses or diseases) related to their complicated medical condition. The facility failed to follow through with the referrals which placed the resident at risk for a decline in their health status. Findings included . <Resident 41> Review of Resident 41's medical record showed they were admitted to the facility on [DATE] with diagnoses including Paget's disease (a disease that disrupts the replacement of old bone tissue with new bone tissue), Type 2 Diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy) and a Stage 4 sacral pressure injury (a deep wound at the tail bone that involves muscle, tendon and exposed bone). The resident had an additional diagnosis of chronic osteomyelitis (inflammation of bone caused by infection) in their sacral wound. Review of Resident 41's comprehensive assessment dated [DATE], showed the resident was cognitively intact and had a Stage 4 pressure injury on their sacral area. Review of the care plan dated 03/25/2024 showed the resident was at a high risk to develop additional skin breakdown. <Infectious Disease> Record review of the outside wound care consultant's (OWC) assessment notes dated 03/28/2024, showed a referral was made for an urgent Infectious Disease (ID a physician that has advanced training in treating infections) as soon as possible related to Resident 41's sacral wound osteomyelitis. Further review of the OWC's assessment notes, showed on 04/11/2024 another referral for follow up with ID was made as it had not been scheduled. Record review of an ID visit note dated 04/24/2024 (27 days after the urgent referral), showed Resident 41went to the ID appointment and did not have their sacral wound reviewed. The resident had not given details about their sacral wound infection or the deterioration of the wound, therefore it was not assessed by the ID physician. Review of OWC's assessment notes dated 04/25/2024, 05/02/2024, and 05/16/2024, showed additional requests for a new appointment with ID for follow up on the resident's sacral wound osteomyelitis. The referrals requested a staff attendant to accompany Resident 41 for accurate reporting of the condition of the sacral wound. <Rheumatology> (continued on next page)

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	505086	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark Care and Rehabilitation	710 North 39th Avenue Yakima, WA 98902

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional review of OWC's assessment note dated 04/25/2023, showed Resident 41 had requested to see a Rheumatologist (a physician who specializes in treating diseases that cause inflammation of the joints muscles and bone) related to a new diagnosis of Paget's disease . A referral was made by the provider for Resident 41 to see a Rheumatologist. Review of additional OWC's assessment notes dated 05/03/2024 and 05/16/2024, showed additional requests had been made for a Rheumatology consult as there had been no follow up from the original requests. <Urology> Review of an OWC's assessment note dated 05/02/2024, showed Resident 41 had developed a new wound on their penis. The wound was described as pressure from a urinary catheter (a small flexible tube which is placed in the bladder to drain urine) which had caused erosion and a split on the urethral opening (the opening where urine exits the body). The urinary catheter was immediately removed and a referral was made to have Resident 41 see a Urologist (a physician that treats disorders of the urinary system) as there was suspected urethral damage. Record review of an OWC's assessment note dated 05/16/2024, showed an additional request for an appointment with Urology as the referral from 05/02/2024 had not been followed up on. During an interview on 05/22/2024 at 10:12 AM, Staff H, Charge Nurse, was asked if resident 41's referrals had been obtained. Staff H checked the resident appointment calendar and Resident 41's medical record, and stated they could not find any referrals for Resident 41 to Rheumatology, Urology, or a re-scheduled ID appointment. Staff H stated the process for referrals was licensed nurses write an order and then forward the request to medical records who was responsible to schedule the appointments. During an interview on 05/22/2024 at 10:40 AM, Staff K, Health Information Manager, stated they had not received any orders from nursing to schedule Resident 41's referrals to Rheumatology, Urology, or to re-schedule an ID appointment with an attendant, therefore the appointments had not been made. Staff K stated the only way they knew that a resident needed a referral was when they received the written order from nursing. Reference WAC 388-97-1060(1)

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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** 35676 Based on observation, interview, and record review, the facility failed to provide the necessary treatment and services to prevent the occurrence of an avoidable pressure ulcer/pressure injury (PU/PI) and to implement wound treatments timely to avoid worsening of a PU/PI for 3 of 3 residents (Residents 20, 41, and 60), who had multiple co-morbidities with an increased risk for PU/PI, reviewed for PU/PI. Resident 20 experienced harm when they developed a Stage II PI (partial thickness skin loss with exposed top inner layers of skin) to their right buttock and an unstageable (a pressure injury that is a full thickness skin and tissue loss to which the extent of the tissue damage cannot be seen) wound to their left buttock, and expressed significant pain and discomfort. These failures placed the residents at risk for development or worsening of PU/PI, pain, infection, and a decreased quality of life. Findings included . Review of the National Pressure Injury Advisory Panel (leading expert in pressure injuries/wounds), September 2016, defined pressure injury stages as follows: Stage 1 Pressure Injury has intact skin with a localized area of non-blanchable erythema (redness). Stage 2 Pressure Injury is a partial thickness skin loss with exposed dermis (the top inner layers of skin). Stage 3 Pressure Injury 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 Pressure Injury 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 Pressure Injury is a full thickness skin and tissue loss to which the extent of the tissue damage cannot be seen. Review of an undated facility policy titled, Skin Integrity, showed the facility would provide care consistent with professional standards of practice to prevent pressure injuries, promote healing, and prevent infection. <Resident 20> (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the medical record showed Resident 20 admitted to the facility on [DATE] with diagnoses including respiratory disease, obesity, diabetes (a long-term condition in which the body has trouble controlling blood sugar level in the body), and hemiplegia (a condition that causes a severe loss of strength or paralysis on one side of the body). The most recent comprehensive assessment, dated 05/01/2024, showed Resident 20 required total assistance of two staff members for bed mobility, transfers, bathing, dressing and toileting, and was cognitively intact. Review of an admission nursing assessment dated [DATE], showed Resident 20 was admitted to the facility with no skin breakdown noted. Review of a nursing progress note dated 05/04/2024, showed a skin assessment was completed on Resident 20 and no skin issues were found. Review of a nursing progress note dated 05/07/2024 showed, shearing (skin abrasions) was noted on both the left and right buttock, each measuring two centimeters (cm, a unit of measure) round. The areas were cleansed and covered with a foam dressing. A new order had been received to change the dressings every other day (QOD) and as needed (PRN). Review of Resident 20's physician orders and Treatment Administration Records (TAR's) for the month of May 2024, showed on 05/09/2024 an order was received to change the dressings to the left and right buttocks pressure wounds QOD and PRN by cleansing the wounds and applying a thin layer of 50/50 Anasept/collagen powder (a specialized absorbent wound filler) to the wounds and then covering with a foam dressing. A concurrent observation and interview on 05/13/2024 at 11:10 AM, showed Resident 20 sitting in a wheelchair in their room. The resident stated their bottom hurt real bad from sores (pressure injuries) on it and asked to be put back to bed for relief from the pain. The resident stated they got the sores after they admitted to the facility and had not had any previous skin breakdown. Observation of the wounds during a dressing change on 05/16/2024 at 10:26 AM by Staff E, Assistant Director of Nursing (ADON), showed two distinct wounds on the right and left buttocks and a darkened area on Resident 20's coccyx (tailbone) area. The removed dressing showed a moderate amount of yellow colored drainage and the wound bed on the right buttock had partial thickness skin loss and was red in color. The wound on the left buttock was larger in size and had whitish colored slough covering the center of the wound with red partial thickness skin loss surrounding the center of the wound. Staff E took photos and measurements of the wounds for weekly wound assessment documentation and stated they would place the document for review in Resident 20's medical record when completed. During the same observation, Resident 20 stated the wounds were always very painful and especially during the dressing changes. The resident made moaning sounds indicating the areas were painful when touched during the dressing change process. During an interview with Staff E on 05/17/2024 at 2:37 PM, while reviewing the wound assessment record and pictures completed on 05/16/2024, showed a wound on the right buttock measured and defined as a 1.0 centimeter (cm, a unit of measure) by 1.0 cm Stage 2 open pressure injury, and a wound on the left buttock measured and defined as a 3.98 cm by 3.1 cm open unstageable area, as a portion of the wound was covered by yellow/whitish slough and the extent of tissue damage could not be observed. A closed deep colored area measuring 2.0 cm by 0.5 cm at the top of the coccyx was also noted on the wound assessment record. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 20's care plan showed a problem was opened on 05/08/2024, showing the resident had Stage 2 pressure injuries to both buttocks with the goal to be healed by the next review date. <Resident 41> Review of Resident 41's medical record showed they were readmitted to the facility on [DATE] with diagnoses that included type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and turning it into energy) and a Stage 4 pressure injury on their sacrum (located at the base of the spine) and osteomyelitis (an infection in the bone). Review of the most recent comprehensive assessment dated [DATE] showed Resident 41 was cognitively intact and required no assistance with decision making. During an observation and interview on 05/16/2024 at 9:16 AM, Resident 41 stated their air mattress (a specialized mattress that contains air cells or tubes which alternates to prevent pressure) was malfunctioning for a while and they could not get anyone to fix it. The resident pointed to the right side of the bed where a hard hyper inflated area was observed directly under their sacral wound and caused pain. Resident 41 stated that if the bed was not over inflated to 300 pounds it went flat and they would be sitting on the metal bed frame. It really needs to get fixed because the hardness pushes on my sore. Review of an outside wound care consultant (OWC) assessment note dated 04/25/2024 showed Resident 41's air mattress was malfunctioning and a referral to maintenance had been made to repair or replace the bed. Review of a OWC assessment note dated 05/05/2024 showed the OWC had again requested an air mattress replacement or removal of Resident 41's malfunctioning air mattress. The note stated the air mattress was putting inappropriate firmness under Resident 41's Stage 4 sacral pressure injury. During multiple observations on 05/14/2024 at 10:10 AM, 05/15/2024 at 2:10 PM, 05/16/2024 at 9:10 AM, 05/17/2024 at 3:30 PM, showed Resident 41 was using the same malfunctioning air mattress with the over inflated area putting pressure on their Stage 4 sacral wound set at 300 pounds to prevent it from going flat. An observation and interview on 05/19/2024 at 8:13 AM, showed Resident 41 laying on a non-air mattress (Sedona Medium Risk). The mattress did not include alternating air cells for pressure relief. Resident 41 stated I know it's not an air bed but at least it is not pushing on my sore. During an interview on 05/19/2024 at 9:00 AM, with a staff who requested to remain anonymous stated the malfunctioning air mattress had been reported for weeks, and nothing had been done about it until yesterday (05/18/2024). During an interview on 05/22/2024 at 11:12 AM, Staff B, Director of Nursing, stated they put Resident 41 on a non-air mattress on 05/18/2024. Staff B stated they were aware that the new mattress for Resident 41 was not an alternating air pressure relief mattress and would change the physicians order to discontinue the air mattress. The request for intervention of Resident 41's malfunctioning air mattress replacement took 23 days from the first noted documentation of the mattress malfunction on 04/25/2024. <Resident 60> (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the medical record showed Resident 60 was admitted to the facility on [DATE] with diagnoses including surgical removal of left leg (below the knee) and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). The 03/20/2024 comprehensive assessment showed Resident 60 required maximum assistance of one staff member for activities of daily living: set up assistance of one staff member for eating, oral, and personal hygiene. The assessment also showed Resident 60 had an intact cognition. Review of a nursing progress note dated 03/13/2024, showed Resident 60 was admitted with a deep tissue injury (a serious form of pressure injury that rapidly progresses to full thickness skin and soft tissue loss)/pressure injury to their right heel. Review of a progress note dated 04/18/2024 at 5:46 AM, by OWC, showed Resident 60's wound was improving with delayed wound closure. Non peeling eschar (dead tissue that forms over healthy skin, then over time, falls off) present. Keep clean and covered. Review of a progress note on 04/25/2024 at 5:30AM, showed OWC had assessed Resident 60's right heel wound and determined that surgical debridement (removal of damaged tissue from a wound) was necessary and had performed the debridement that day. The wound was then classified as a Stage 4 pressure injury. The OWC documented that the wound had a strong odor with purulent (thick fluid caused by infection) drainage. A wound swab was obtained to guide treatment options including antibiotics. Review of a PN on 05/02/2024 at 5:18 AM, showed the OWC had assessed Resident 60's right heel wound. The assessment showed the wound was deteriorating with severe exacerbation (an increase in the severity of the illness) and recommended labs and imaging to ensure no bone involvement was present. The OWC also documented that they and Resident 60's provider needed results of the wound swab to help guide treatment options including antibiotics. Additionally, the OWC had placed additional lab recommendations due to concerns of osteomyelitis, along with magnetic resonance imaging [(MRI) an imaging technique that is used in radiology to form pictures of the anatomy and physiological process inside the body] or x-ray. Review of the medical record showed the lab results for the wound swab were resulted on 04/26/2024 at 7:49 PM, and a report was generated on 04/27/2024 at 3:18 AM. Review of a nursing PN dated 05/08/2024 at 9:25 AM, showed Resident 60's right heel wound swab results were received and reviewed by the facility provider and antibiotics were prescribed, 11 days after the results were reported. Review of a progress note on 05/16/2024 at 5:18 AM, showed the OWC was unable to locate the wound swab results, inflammation labs, and imaging updates per their last progress note dated 05/02/2024. The OWC documented Please provide update on the following previous recommendations ., referencing the inflammation labs and imaging. During an interview on 05/20/2024 at 1:42 PM, Staff J, Resident Care Manger (RCM), stated they managed Resident 60's care. Staff J stated the results of the wound swab should have been in the record but could not find them. Staff J stated they were not aware of the 05/02/2024 recommendations from the OWC. They stated there was a nurse that had followed the wounds with the OWC during wound rounds, but since they left, they were not sure who followed those residents/wounds. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/20/2024 at 3:12 PM, the facility's Medical Director stated the facility should have followed up on the 05/02/2024 orders by the OWC. They stated they (the orders) were absolutely indicated for this resident. During an interview on 05/21/2024 at 4:29 PM, Staff B, Director of Nursing, stated they were unsure why the antibiotics were not ordered timely. Staff B stated they expected the nursing staff to contact the provider the same day the results were received to get a medication started. Staff B stated when the OWC made recommendations, the facility did not recognize them as orders. Staff B stated the nursing staff should have been reviewing the OWC's recommendations and forwarding them to the facility provider to create the orders. Staff B stated that process was not being followed. During an interview on 05/22/2024 at 11:15 AM, Staff C, [NAME] President of Clinical Operations, stated the OWC recommendations for additional labs and imaging should have been given to the facility provider for follow up. Reference: WAC 388-97-1060(3)(b) This is a repeat citation from Statement of Deficiencies dated 08/28/2023, 11/29/2023, and 03/12/2024. 39652 45117

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39652 on 5/14/2024, 0505/15/2024, Based on observation, interview, and record review, the facility failed to provide services to prevent a potential reduction in range of motion for 2 of 2 residents (Residents 55 and 25) reviewed for range of motion and/or use of splints. This failure placed the residents at risk for decreased mobility and loss of independence. Findings included . <Resident 55> Review of Resident 55's medical records showed they were admitted to the facility on [DATE] with diagnoses including left side hemiplegia (the loss of the ability to move in part of the body), muscle weakness, and a need or assistance with personal care. Review of Resident 55's comprehensive assessment dated [DATE], showed the resident had moderate cognitive impairment. During a concurrent observation and interview on 05/14/2024 at 11:31 AM, Resident 55 had a brace on their left hand, the resident stated that they wore the brace daily. Review of the resident's care plan dated 04/22/2024, showed no updates to the care plan related to the resident's use of a left-hand brace, including the checking of the skin underneath, a schedule of an on/off use of the brace, and who was to do the task. Review of the resident's Kardex (an information system that is used as a quick reference for nursing staff) dated 05/15/2024, showed the resident had an active range of motion task of the left upper extremity during cares to prevent new contractures. The Kardex had not been updated to reflect the resident's left-hand brace. During multiple observations on 05/14/2024 at 10:21 AM, 05/15/2024 at 9:03 AM, 05/16/2024 at 2:54 PM and 05/19/2024 at 8:26 AM, showed Resident 55 wearing a left-hand brace. During an interview on 05/16/2024 at 1:51 PM, Staff E, Assistant Director of Nursing (ADON), stated Resident 55's brace was removed every night, and the nursing assistants replaced it in the mornings. Staff E acknowledged that the resident did not have a Physician order for the brace or that it was in the resident's care plan. During an interview on 05/20/2024 at 2:25 PM, Staff L, Director of Rehab, stated Resident 55's restorative nursing program was opened 10/07/2023 and closed on 11/22/2023, and that they had met their goals. The resident's brace would have been the responsibility of nursing for donning (putting on) and doffing (taking off) it, typically the resident care manager (RCM). I can't speak to the brace, there is nothing in their initial evaluation about the brace. <Resident 25> (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 25's medical record showed they were admitted to the facility on [DATE] with diagnoses including diabetes type 2 (a disease in which the body is unable to process sugar and turn it into energy) and a stroke with a left-hand contracture (a permanent tightening of muscle, bone, and skin). Review of the comprehensive assessment dated [DATE], showed the resident was cognitively intact and had decreased range of motion to their left hand. During a concurrent interview and observation on 05/14/2024 at 10:21 AM, Resident 25 stated their left hand doesn't work very well. Observation of the resident's left hand showed their hand was closed in a fist. Resident 25 attempted to open their left hand with their right hand but it remained in a tight, fixed position and was unable to open. Resident 25 further stated I used to have a splint which helped keep my hand open, but those things are hard to keep track of. I haven't seen it in months. Review of Resident 25's care plan dated 03/30/2024, showed Resident 25 required daily placement of a left-hand roll (a device to keep the hand in position to prevent deformities) to be placed in the morning and removed at night. The intervention specified the thumb was to be placed on the indentation in the foam. Additionally, the fingers were to be straight, separate, and secured with a strap over the back of the hand. During an interview on 05/17/2024 at 9:20 AM, Staff U, Nursing Assistant (NA), stated they had not seen Resident 25's splint in a long time so they would roll up a washcloth and place in the palm of the resident's left hand to give them some relief of their contracture. During multiple observations on 05/14/2024 at 10:21 AM, 05/15/2024 at 8:48 AM, 05/16/2024 at 3:16 PM, 05/17/2024 at 8:18 AM, and 05/19/2024 at 8:01 AM, showed the resident did not have their splint on or any other intervention such as a rolled-up wash cloth on or in their left hand. During an interview on 05/20/2024 at 9:48 AM, Staff L, stated they had worked with Resident 25 related to their left-hand contracture. Staff L stated the resident had re-gained some mobility in their left hand and should have been wearing a splint with a finger spreader to help manage their contracture . Reference WAC-388-1097-1060(3)(d) 45642

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35676 Based on observation, interview, and record review, the facility failed to ensure adequate staff supervision during dining for 2 of 2 residents (Residents 20 and 59), and to provide a safe, functional environment for 5 of 5 shower rooms (South Hall shower room [ROOM NUMBER], shower room [ROOM NUMBER], North Hall shower room [ROOM NUMBER], shower room [ROOM NUMBER], and shower room [ROOM NUMBER]) reviewed for accidents. These failures placed the residents at risk of choking episodes, aspiration (when food or liquid enters the airways or lungs), access to toxic (a substance that can be poisonous or cause adverse health effects) chemicals, and dissatisfaction with their shower experiences. Findings included . <Dining Supervision> <Resident 20> Review of the medical record showed Resident 20 was admitted to the facility on [DATE] with diagnoses including pneumonia (a lung infection), dysphagia (difficulty swallowing), pleural effusion, (a buildup of fluid between the tissues that line the lungs and the chest), and diabetes (a long-term condition in which the body has trouble controlling blood sugar levels in the body). The comprehensive assessment dated [DATE] showed Resident 20 required extensive assistance of one to two caregivers with activities of daily living (ADL's) and was cognitively intact. Review of Resident 20's diet orders dated 04/24/2024, showed an advanced dysphagia (soft and bite size texture) carbohydrate-controlled diet with thin liquids. Review of an admission nursing progress note dated 04/24/2024 at 6:12 PM, showed Resident 20 had dysphagia, was on a moist, minced diet, and required one on one assistance to eat. On 05/13/2024 at 12:22 PM, Resident 20 was observed sitting at a table in the independent dining room by themselves. They were having difficulty swallowing their food and were coughing, gagging, and spitting out food onto their plate. Resident 20 stated in a soft distressed voice I can't eat this, it's too hard to chew and I can't breathe. By 12:39 PM, all staff and other residents had left the dining room leaving the resident alone with their food in front of them. On 05/14/2024 between 12:05 PM and 12:36 PM, Resident 20 was observed sitting at a table with two other residents in the independent dining room. The resident was having difficulty eating and was seen coughing, gagging, and spitting out pieces of chicken onto their plate. Resident 20 stated I can't eat, it's too hard to swallow and breathe. All the other residents and staff had left the dining room leaving Resident 20 sitting alone with their food in front of them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/15/2024 at 12:09 PM, Resident 20 was observed eating in the south hall assisted dining room with a nursing assistant (NA) helping them eat. Staff V, NA, stated the resident had just eaten 100% of a soft minced meat diet with minimal difficulty or coughing. Staff V stated they didn't know why Resident 20 was placed in the independent dining room as they needed supervision because they choked easily due to having a difficult time swallowing and had respiratory problems. During an interview on 05/13/2024 at 12:48 PM, Staff Q, Registered Nurse (RN), stated that no staff were needed to monitor the independent dining room because all of the residents assigned there could eat independently. Staff Q stated once the staff were done serving out the trays in the independent dining room, they moved on to help in another dining room or the hall trays where residents needed assistance with their meals. During an interview, on 05/15/2024 at 9:09 AM, Staff U, NA, stated no staff stay in the independent dining room and they were told not to go in there after the residents were served. I'm very concerned about the resident's safety with no one in there to monitor them in case they choke or need something. During a concurrent observation and interview on 05/19/2024 at 8:20 AM, Staff Z, NA, was observed sitting at a table with the residents eating in the independent dining room. Staff Z stated, I'm not supposed to stay in here and watch them eat but I'm afraid someone may have problems or choke and there won't be anyone to help them, so I just stay when I serve this dining room, even if it gets me in trouble. During an interview on 05/21/2024 at 4:14 PM, Staff E, Assistant Director of Nursing (ADON) stated it was a team decision about who was placed into which dining room. They stated to be placed in the independent dining room, a resident had to be on a regular diet, be independent in eating, and not require any staff supervision. They stated Resident 20 should never have been put into the independent dining room with a diagnosis of dysphagia and requiring assistance to eat. In addition, Staff E stated a lot of the staff don't think any of the resident's should be left unsupervised while they are eating. They are all vulnerable medically or they wouldn't be here. <Resident 59> Review of the medical record showed Resident 59 was admitted to the facility on [DATE] with diagnoses including dysphagia, pseudobulbar affect (a medical condition that causes uncontrollable and inappropriate crying and/or laughing that happens suddenly and frequently), and chronic pain. The comprehensive assessment dated [DATE] showed Resident 59 required extensive assistance of one to two caregivers for ADL's, was moderately impaired cognitively, and had difficulty making decisions concerning daily care needs. Review of Resident 59's diet order dated 04/09/2024, showed a diabetic carbohydrate-controlled diet, chopped texture, nectar (mildly thick) consistency with nectar thick fluids. Aspiration precautions, oral care before every meal, upright for meals in chair or wheelchair only during meal and 45 minutes after. Resident to take a small sip/small bite/alternate food and fluids, chin tuck with liquid. Eats with supervision only. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident 59's representative on 05/13/2024 at 11:32 AM, they stated the resident had been eating poorly since they came to the facility and had a lot of difficulty swallowing. The representative stated the resident went to the hospital a few weeks ago because they aspirated some food or fluid into their lungs causing pneumonia and needed to be put on antibiotics to clear the infection. An observation of Resident 59 on 05/17/2024 at 12:35 PM, showed them sitting in front of a tray of food at a tray table in their room by themselves, stating, I don't like this stuff. No one else was in the room supervising or assisting them with eating. An observation on 05/19/2024 at 8:36 AM, showed Resident 59 sitting in their room at a tray table eating breakfast alone. A concurrent interview with Staff U, NA, who was leaving the room after serving the meal, stated, The resident gets upset with us when we watch them eat so we just check on them once in a while and make sure they are doing ok. During an interview on 05/20/2024 at 2:20 PM, Staff AA, Speech Language Pathologist (SLP), stated they had worked with Resident 59 in the past on eating and drinking, as they were at a high risk for both choking and aspiration. Staff AA stated they had gone as far as they could working with Resident 59 as they frequently either did not want to or did not remember the steps they needed to take to eat and drink safely. Staff AA stated the resident should be supervised at all times while eating and drinking and encouraged to follow the steps for eating and drinking safely even though they would frequently refuse the assistance. <Shower Rooms> <South Hall Shower room [ROOM NUMBER]> Observation on 05/12/2024 at 8:30 AM, showed South Hall shower room [ROOM NUMBER] with an unlocked open door. On the sink adjacent to the shower stall was a container of Micro Kill wipes (a disinfectant wipe that is toxic if consumed) and a bottled of Bleach 360 cleaning solution (also toxic if consumed). The cleaning items were not secured from residents that had cognitive impairment. During the same observation on the other side of the room by the bathtub showed two unlocked closets. In the first closet were two opened bottles of vitamins, and a coffee maker. In the second closet were several purses, shoes, coats, cup of noodles and a box of cereal. <South Hall Shower room [ROOM NUMBER]> During an observation on 05/14/2024 at 9:28 AM, shower room [ROOM NUMBER] was open to the hallway. The sink behind the shower stall was observed to have Micro Kill wipes sitting on the counter. Observation of the shower stall showed two bottles of disinfectant sprays hanging on the shower bars. The first bottle was labeled as Micro Kill spray and Bleach 360 spray. All the disinfectant items were unsecured and within reach of cognitively impaired residents. <North Hall Shower room [ROOM NUMBER]> (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 05/13/2024 at 1:30 PM, showed the North Hall shower room [ROOM NUMBER] next to resident room [ROOM NUMBER], had an unlocked, open door. There were two unlocked cabinets under the sink, the cabinet to the right contained a bottle of Bleach 360 cleaning solution (toxic if consumed). The cleaning items were not secured from cognitively impaired residents. <North Hall Shower room [ROOM NUMBER]> An observation on 05/13/2024 at 2:15 PM, showed the North Hall bath/spa shower room [ROOM NUMBER] next to resident room [ROOM NUMBER], had a door that was open to the hallway. There was a bladed razor lying on the countertop. There was a partition wall in the shower room that separated the shower area from the spa tub area. The spa tub had headboards stored in the spa tub. There was an office area set up next to the spa tub that contained a small desk, a laptop computer, coffee thermos container, file cabinet, and paperwork. <North Hall Shower room [ROOM NUMBER]> An observation on 05/15/2024 at 12:58 PM, showed the North Hall shower room [ROOM NUMBER], next to resident room [ROOM NUMBER], had two unlocked cabinets under the sink. There was a spray bottle of Bleach 360 cleaning solution in each cabinet. During multiple observations of South Hall shower rooms [ROOM NUMBERS] showed the doors remained open to the hallway with the unsecured toxic cleaning items on 05/14/2024 at 10:57 AM, 05/15/2024 at 9:30 AM and 05/15/2024 at 2:11 PM. During a concurrent observation and interview on 05/16/2024 at 8:11 AM, Staff E was asked to observe South Hall shower rooms [ROOM NUMBERS]. Staff E stated the cleaning solutions should be behind a locked door so that cognitively impaired residents did not have access to them. Reference WAC 388-97-1060(3)(g), 388-97-3220(1) This is a repeated citation from Statement of Deficiencies dated 04/12/2023.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39652 45117 Based on observation, interview, and record review, the facility failed to provide adequate justification for the placement of a urinary catheter (a flexible tube inserted into the bladder through the urethra to allow urine to drain from the bladder for collection) for 1 of 1 resident (Resident 54) reviewed for placement of a urinary catheter. Additionally, the facility failed to ensure the appropriate care and use of a urinary catheter for 1 of 1 resident (Resident 3) by positioning the catheter drainage bag below the level of the bladder to prevent infection during a transfer with the mechanical lift. This failure placed the residents at risk for urinary tract infections (UTIs) and serious medical complications. Findings included . Review of the Centers for Disease Control and Prevention Guidelines titled, Prevention of Catheter-Associated Urinary Tract Infections 2009, dated 06/06/2019, showed the Proper Techniques for Urinary Catheter Maintenance, included the catheter drainage bag must be kept below the level of the bladder. Review of an undated facility policy titled, Catheter Care, Urinary, showed the drainage bag should be positioned lower than the bladder at all times to prevent urine from flowing back into the bladder. <Resident 54> Review of the medical record showed Resident 54 admitted to the facility on [DATE] with diagnoses including Polymyalgia Rheumatica (an inflammatory disease causing muscle pain and stiffness around the shoulders and hips), type 2 diabetes (a chronic disease in which the body has trouble controlling blood sugar and turning it into energy), and osteoarthritis (a type of arthritis that occurs when tissues at the ends of the bone wears down). Review of the most recent comprehensive assessment dated [DATE] showed Resident 54 was cognitively intact. Review of Resident 54's care plan dated 05/21/2024 showed the resident required two staff members to assist them with toileting needs and frequently used a bedside commode. During an observation on 05/13/2024 at 1:40 PM, Resident 41 was observed in their electric wheelchair in the library during a Resident Council meeting. A long plastic tube draining yellow liquid consistent with urine was in a covered bag at their feet. Resident 41 stated to the other residents participating in the meeting I got a new catheter because I asked for one. I was getting so tired of waiting too long for help to get me to the bathroom. Resident 41 further stated they had no more episodes of urinary incontinence and felt their new urinary catheter was convenient for the staff as they required two people for transfer assistance on and off the commode (a portable toilet use at the bedside). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a progress note dated 04/26/2024 showed a provider had requested that the resident have a urinary retention catheter placed. The note did not show a rationale, assessment, or specific diagnosis to support the placement of the urinary catheter. Record review of Resident 54's physician orders from 04/26/2024 to 05/20/2024 showed no documentation of an appropriate diagnosis to justify the use of a urinary retention catheter or specific orders for the size, frequency of changes, or follow up care and monitoring that met professional standards of care for use of a urinary retention catheter. During an interview on 05/21/2024 at 11:40 AM, Staff B, Director of Nursing (DON), stated they had reviewed Resident 54's orders and medical record and were not able to find justification for the placement of the urinary catheter. Staff B further stated they would contact the provider and request follow up for the urinary catheter placement. <Resident 3> Review of the medical record showed Resident 3 was admitted to the facility on [DATE] with diagnoses including muscle weakness, and palliative care (caregiving aimed at optimizing the quality of life and mitigating suffering among people with serious, complex, and often terminal illnesses). The 02/29/2024 comprehensive assessment showed Resident 3 required partial to maximum assistance of one to two caregivers for activities of daily living (ADLs), was dependent on two staff members for transfers with a mechanical lift, had a urinary catheter, and was cognitively intact. An observation on 05/13/2024 at 1:37 PM, showed Staff M, Nursing Assistant (NA) and Staff N, NA, transferring Resident 3 with a mechanical lift. Staff M and Staff N positioned a lift sling under the resident and connected the sling to the lift. Staff N, using the remote control for the lift began lifting Resident 3 in the sling and Staff M hung the catheter bag on the mechanical lift at the same height as Resident 3's head. Staff M and Staff N positioned Resident 3 over their wheelchair and lowered them into the wheelchair. Staff M then removed the catheter bag from the mechanical lift and placed it into the resident's lap. Staff M and Staff N disconnected the sling from the mechanical lift and both Staff M and Staff N hung the catheter bag under the resident's wheelchair. During an interview on 05/17/2024 at 9:22 AM, Staff M stated they knew the catheter bag was not supposed to be above the resident's bladder. They stated they did not know where to hang it. Staff M stated they knew the catheter bag should not have been placed in Resident 3's lap. During an interview on 05/21/2024 at 4:39 PM, Staff B, Director of Nursing, stated the catheter bag needed to remain below the level of the bladder. Staff B stated the correct process for transferring a resident on a mechanical lift with a urinary catheter was not followed. Reference: WAC 388-97-1060(3)(c)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35676 Based on observation, interview, and record review, the facility failed to provide respiratory care consistent with accepted standards of practice for 1 of 1 resident (Resident 2) reviewed for respiratory care and treatment. This deficient practice placed the resident at an increased risk of respiratory and tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe to help a person breathe.) status complications, including infection and injury. Findings included . Review of an undated facility policy titled, Laryngectomy/Tracheostomy Stoma Care stated the purpose of this procedure is to guide Laryngectomy/Tracheostomy care and the cleaning of reusable cannulas, which did not apply to Resident 2. <Resident 2> Review of the medical record showed Resident 2 was admitted to the facility on [DATE] with diagnoses including a total laryngectomy in 2016 (removal of the larynx, the part of the throat containing the vocal cords), tracheostomy care with a permanent laryngectomy stoma (a permanent stoma that is intended to remain open even without a cannula or tube in place), dysphagia, (difficulty swallowing) and diabetes (a long-term condition in which the body has trouble controlling blood sugar levels). During a concurrent observation and interview on 05/14/2024 at 1:17 PM, showed Resident 2 sitting in their room in a wheelchair. The resident was noted to have a tracheostomy stoma (hole in the neck) without any inner cannula or tube in place. Resident 2 would mouth yes and no words without sound and use hand gestures to answer questions and communicate. There was a crusty ring of a brown, thick substance surrounding the stoma. During the same observation, a suction machine (a medical device used to remove excess fluids, secretions, and/or foreign materials from a patient's airway) half full of a yellow-colored fluid, was noted on Resident 2's bedside table. Review of Resident 2's physician orders and medication administration records (MARs) dated 02/17/2024, showed care of the tracheostomy opening read as follows: Resident able to self-manage, area requires no wound care. Leave open to air. Staff should just monitor daily and chart and report changes. PRN (as needed) External Suctioning ONLY (external suctioning is a procedure that removes mucus and secretions from the outside of the tracheostomy). Any deep or internal suction (deep tracheal suctioning is a procedure that involves passing a catheter tube past the end of the tracheostomy and into the trachea or its branches and is usually only used in emergencies as it can damage the airway) by family/daughter only. Call POA (Power of Attorney) for assistance if resident is requesting suctioning. Further review of Resident 2's MARs for the months of 02/2024, 03/2024, 04/2023, and 05/2024 showed this order was signed on the MAR daily by the licensed nursing (LN) staff from 02/17/2024 through 05/14/2024. On 05/14/2024 the order was discontinued from the MAR without explanation in the nursing progress notes or physician visit notes. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 2's medical record showed the resident had a physician visit concerning their tracheostomy care on 05/08/2024 and returned to the facility with new orders to provide saline irrigated tracheal suctioning twice a day (saline is commonly instilled into a tracheostomy before suctioning to help loosen and clear mucus and secretions.) Review of Resident 2's MAR from 05/01/2024 through 05/15/2024, showed the physician order read as saline irrigated tracheal suctioning twice a day and was signed as completed by the LNs on day shift on 05/09/2024, 05/11/2024, 05/14/2024 and 05/15/2024, left blank on 05/10/2024 and 05/12/2024 and refused on 05/13/2024. On evening shift the MAR showed Resident 2 refused the procedure on 05/09/2024, 05/10/2024, 05/11/2024, 05/13/2024 and 05/14/2024 and was completed on 05/12/2024. Review of a nursing progress note for Resident 2 by Staff BB, Registered Nurse (RN), on 04/30/2024 at 4:26 PM, showed Late entry for 04/29/2024 1400-2300 (2:00PM -11:00PM). Deep tracheal suctioning x 2 done. Large green/gray mucous plugs (a buildup of thick secretions that blocks the airflow in the tracheostomy tube) returned, blocking the catheter at times. Copious (large quantity) amount expectorated (matter discharged from the throat or lungs). Review of a nursing progress note for Resident 2 by Staff P, RN, on 05/03/2024 at 4:25 PM, showed, at 1145 hrs (11:45PM), suctioned via trach and able to remove large mucus plug, green in color, thick. Some crusting around top of stoma, able to gently remove most of that. Review of Resident 2's care plan showed a problem for tracheostomy/stoma care was opened on 02/16/2024 with the goal being to have no abnormal drainage around the trach site through the review date. Care plan interventions included: *Monitor/document for restlessness, agitation, confusion, and increased or decreased heart rate. *Provide good oral care daily and PRN * Provide means of communication and procedural information. Reassure that help is available immediately. *Reassure Resident to decrease anxiety. There were no further individualized care planning problems or interventions regarding the resident's tracheostomy care or suctioning procedures for safety. During an interview on 05/15/24 at 4:00 PM, Staff BB stated they had deep suctioned Resident 2 on several occasions when they would get thick mucus plugs in their tracheostomy opening and couldn't breathe. Staff S stated there were no physician orders written for them to do the deep suctioning but felt competent with the skill in knowing how to perform the procedure from working in the intensive care unit (ICU) at a hospital for many years. Staff BB stated they felt it was an emergent situation when they did deep suction Resident 2 and notified the resident's physician that they had done so. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff BB stated they did not know if any of the other nurses had been trained on how to perform deep tracheal suctioning in the facility but stated they themselves had not received any training and no one had ever asked if they had been trained or had any certifications in tracheostomy care and suctioning. Staff BB stated from their knowledge as an emergency and ICU nurse, RN's required advanced training to deep suction and Licensed Practical Nurses (LPN's) were not allowed to do so. Staff BB further stated they had seen the order to call Resident 2's daughter on the MAR if they required deep suctioning and had seen one of the daughters' suction Resident 2 in the past but had never themselves called a family member to suction the resident. Staff BB stated they did not know why the order stated nursing staff were to do external suctioning only and to call the POA if deep suctioning was needed was discontinued on 05/14/2024. In addition, Staff BB stated they had seen the order dated 05/08/2024 to use saline to suction the resident twice daily and also felt comfortable performing this procedure, however the resident had consistently refused to have this done on their shift. Staff BB stated they did not know which nurses had documented they had performed the procedure or if they had any training on how to do the procedure correctly. During an interview on 05/16/2024 at 12:05 PM, Staff P, RN, stated they had deep suctioned Resident 2 when they were having difficulty breathing in the past and felt with the years of nursing experience they had, they were comfortable and confident on how to deep suction a resident. Staff P stated they had a discussion with Resident 2's physician about writing an order to deep suction Resident 2 when needed and thought they had written the order to do so but could not find the order in the resident's medical record. In addition, Staff P stated they did not know anything about the MAR saying to call the daughter to deep suction if Resident 2 needed it and for the nurses to only do external suctioning. Staff P stated they had never been formally trained in the facility on how to perform deep suctioning on a resident and did not know if any of the other nurses had been suctioning Resident 2, or if they had ever been trained on tracheostomy care and suctioning but stated they themselves had not. During an interview on 05/19/2024 at 11:30 AM, Staff Q, RN, stated they had suctioned Resident 2 in the past and felt competent to do so with their nurses training. They stated they had not had any formal training in the facility on tracheostomy care or on the different types of suctioning that Resident 2 may require per their physician orders. During an interview on 05/21/2024 at 4:00 PM, Staff E, Assistant Director of Nursing, stated they were in charge of training the staff if they had the knowledge of the procedure to do so. Staff E stated they had never suctioned Resident 2 or trained any staff on how to perform the procedure because as an LPN, it was not within their scope of practice to do so and one of the trained RNs in the facility would need to do so. Staff E stated to their knowledge the facility nurses had not had any training on tracheostomy care and/or suctioning and did not know which nurses in the facility had done suctioning on Resident 2. During an interview on 05/16/2024 at 1:45 PM, Staff R, LPN, stated they had seen the order to suction Resident 2 but had never done so because they had not been trained on how to do it and did not believe it was within their scope of practice to do so. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/22/2024 at 4:45 PM, Resident 2's Representative and POA stated they had cared for Resident 2 for many years at home prior to them coming to the facility and had been trained in tracheostomy care and deep suctioning. The POA stated they had no idea a physician's order had been written to call them if Resident 2 needed deep suctioning and for the facility nurses to only perform external suctioning as they were assured, when the resident was admitted , that the nurses were all trained and competent in suctioning and tracheostomy care. Resident 2's POA stated they had never been called to suction the resident but they had been in the facility numerus times when Resident 2 was in obvious respiratory distress from mucus plugs and had suctioned them at that time. They stated they had recently written a grievance form because they were upset about how frequently the resident was in respiratory distress when they visited and wanted to know why. The POA stated they were the one who made an appointment on 05/08/2024 for Resident 2 to see their tracheostomy physician as they were concerned about the lack of quality respiratory care the resident was receiving in the facility. During an interview on 05/21/2024 at 2:20 PM, Staff B, Director of Nursing, stated the facility did not have a physician order to deep suction Resident 2 and acknowledged that the procedures to deep suction and saline suction a patient required competency training in tracheostomy care and suctioning for RN's prior to performing the procedures. Reference WAC 388-97-1060 (3)(i)(vi)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to ensure dialysis services were consistent with professional standards of practice for 1 of 1 resident (Resident 4) reviewed for dialysis services. The failure to monitor Resident 4's condition before and after dialysis treatments, complete a comprehensive care plan, adhere to a fluid restriction, provide ongoing communication, and collaboration with the dialysis facility, ensure a current written agreement was in effect between the facility and the dialysis facility, and ensure policies and procedures were developed and implemented placed the resident at risk for complications and adverse medical conditions. Findings included . <Resident 4> Review of the medical record showed Resident 4 was admitted to the facility on [DATE] with diagnoses including heart failure, diabetes (a group of diseases that result in too much sugar in the blood), and end stage renal disease (the last stage of kidney disease where the kidneys can no longer support the body's needs). The 05/03/2024 comprehensive assessment showed Resident 4 required supervision/minimal assistance of one staff member for dressing and oral hygiene and was dependent on one to two staff members for toileting and showering needs. The assessment also showed Resident 4 was dependent on renal dialysis (the process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally) and was cognitively intact. <Monitoring> Review of a physician order dated 04/04/2024, showed Pre and Post Dialysis in Assessments (an analysis of the resident's medical condition before and after dialysis treatments) to be completed on Dialysis days. Tuesday, Thursday, Saturday. Nursing documentation on the April 2024 Medication Administration Record (MAR), showed seven of 10 pre dialysis assessments were not completed; five of 10 post dialysis assessments were not completed. Nursing documentation on the May 2024 MAR showed three of six pre dialysis assessments and two of six post dialysis assessments were not completed. During an interview on 05/17/2024 at 12:43 PM, Staff J, Resident Care Manager, stated they expected the floor nurses to complete a pre and post dialysis form in the computer with each dialysis visit. Staff J stated, it looks like it has not been done each time. During an interview on 05/21/2024 at 11:12 AM, Staff O, Registered Dietician, stated they typically asked for a before and after dialysis weight to monitor with each visit, but stated I am not going to say it happens every time. <Fluid Restriction> (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 05/14/2024 at 8:43 AM, Resident 4 was lying in a semi reclined position in bed with their breakfast tray on the over the bed table. The breakfast tray had a 120 milliliter [(ml) a unit of measure] glass of orange juice, a brown coffee mug (empty) and a 120 ml glass of milk (empty). Resident 4 stated the facility did not monitor their fluid intake. They stated they try to monitor their own intake and pointed to the 120 ml glass of orange juice. They stated I figure that glass (orange juice) is about 8 ounces (a unit of measure), and the coffee is probably 8 ounces . There was a 600 ml plastic water tumbler on the over the bed table. Resident 4 stated staff filled that (plastic tumbler) several times a day. Resident 4 stated they thought they were restricted to 32 ounces of fluid per day but were not sure if that was the correct amount. Review of a provider order dated 04/05/2024, showed Resident 4 had a fluid restriction of 32 ounces per day. Review of the April 2024 and May 2024 MARs showed no order for the fluid restriction and no monitoring of Resident 4's fluid intake. Review of the April 2024 nursing assistant (NA) task record showed the task Fluid consumption - monitor fluids - patient is on a fluid restriction. There was no documentation as to what the restriction amount was. Resident 4's fluid intake was inconsistently documented with missing documentation of their intake for at least one shift daily with exception of April 5th and April 6th, 2024. Review of the May 2024 NA task record showed Resident 4's fluid intake was consistently monitored on the evening shift; day shift and night shift were not consistently monitored. During an interview on 05/17/2024 at 12:43 PM, Staff J stated that they did not see a fluid restriction in Resident 4's record but would have expected a resident on dialysis to have a restriction. During an interview on 05/21/2024 at 11:12 AM, Staff O, stated they did not have contact with the dialysis center dietician. They stated they did not order fluid restrictions, they leave that up to the dialysis center dietician or the resident's provider. During an interview on 05/21/2024 at 11:23 AM, Collateral Contact 1 (CC1), dialysis center Registered Dietician, stated they did not have any communication with the facility dietician. CC1 stated Resident 4 absolutely should be on a fluid restriction. During an interview on 05/21/2024 at 11:30 AM, Collateral Contact 2 (CC2), dialysis center Registered Nurse, stated Resident 4 should have been on a fluid restriction of 32 ounces or less. <Comprehensive Care Plan> (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 4's care plan dated 05/14/2024, showed a dialysis care plan with interventions that included assessing for general edema, monitor and review dialysis notes from dialysis, monitor compliance to dietary and fluid restrictions, and monitor vital signs post dialysis. There was no intervention that showed how much fluid was permitted daily. Additionally, the care plan did not address how often to weigh Resident 4, how lab results would be monitored and who to notify regarding concerns with the labs, transportation to and from the dialysis center, goals of dialysis, where Resident 4's fistula (a connection made between an artery and a vein for dialysis access) was located, who their nephrologist (a medical doctor that specializes in kidney care and treating diseases of the kidney) was and how to contact them, and how the fistula site would be monitored. <Communication> During an interview on 05/14/2024 at 8:41 AM, Resident 4 stated the facility did not send any paperwork with them to their dialysis sessions. Resident 4 stated they used to take a paper with them each time but that hasn't happened for a while. Resident 4 stated the dialysis facility did not send any information or paperwork back to the facility after their dialysis sessions. During an interview on 05/16/2024 at 2:49 PM, the facility's Advanced Registered Nurse Practitioner stated lab work from the dialysis facility was not available in Resident 4's medical record. They stated, I struggle with that, and it makes it hard to manage the resident's care. During an interview on 05/21/2024 at 11:37 AM, Staff P, Registered Nurse (RN), stated they normally did Resident 4's pre dialysis assessment and print the form so the resident could take it with them to dialysis. The goal was to complete it each time, both pre and post dialysis. Staff P stated some mornings were rough and it did not always get done. They stated dialysis was supposed to send information back but had not seen any post dialysis documentation from the dialysis facility. During an interview on 05/17/2024 at 12:43 PM, Staff J, , stated they expected the floor nurses to complete a pre and post dialysis form in the computer with each dialysis visit. Staff J stated, it looks like it has not been done each time. Review of the medical record showed the dialysis facility provided patient summary report as communication on a weekly basis, not after each dialysis session. During a follow-up interview on 05/22/2024 at 11:24 AM, Resident 4 stated the other day was the first day they gave me a paper to take to dialysis . During an interview on 05/21/2024 at 4:57 PM, Staff B, Director of Nursing, stated the process for dialysis was not followed. They expected the nursing staff to complete the pre and post dialysis assessments with each dialysis visit. Staff B stated the care plan needed to include all appropriate interventions related to Resident 4's dialysis. <Written Agreement> (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the document titled, Nursing Home Dialysis Transfer Agreement, dated 2018, showed a written agreement that described how resident care was to be managed between the facility and the dialysis facility. The term of the agreement showed the term of this agreement shall commence on the last date of execution of this Agreement as indicated on the signature page (Effective Date) and shall continue for one (1) year, unless sooner terminated .this agreement shall be automatically renewed for successive one (1) year terms after the end of the initial term, unless sooner terminated .; provided, however the parties agree to review this agreement annually. The agreement was signed by the facility Administrator on January 8, 2019, and the dialysis facility Regional Operations Director on January 8, 2019. There was no documentation that the agreement had been reviewed annually. During an interview on 05/17/2024 at 1:01 PM, Staff C, [NAME] President of Clinical Operations, stated there was no documentation that the contract was signed or reviewed annually. <Policies and Procedures> During an interview on 05/21/2024 at 8:59 AM, Staff C stated there were no policies or procedures for dialysis services other than the written agreement. During an interview on 05/22/2024 at 11:52 AM, Staff B, stated they were aware of the issues with dialysis services and had not put a process in place to correct those issues. Reference: WAC 388-97-1900(1)(5)(6)(a-c)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on observation, interview, and record review, the facility failed to ensure that residents who were trauma survivors received trauma-informed care in accordance with professional standards of practice by not assessing, monitoring, or treating past experiences of Post Traumatic Stress Disorder [(PTSD) an anxiety disorder that develops in some people who have experienced a shocking, scary, or dangerous event] for 1 of 2 residents (Resident 10) reviewed for mood and behavior. This failure placed the resident at risk for unidentified triggers and re-traumatization. Findings included . Review of an undated policy titled, Trauma Informed Care Purpose, showed the trauma informed assessment would identify a history of trauma or interpersonal violence, when possible. <Resident 10> Review of the medical record showed Resident 10 was admitted to the facility on [DATE] with a diagnosis of PTSD. The 05/24/2024 comprehensive assessment showed Resident 10 required substantial/maximal assistance of one staff member for activities of daily living; dependent on one to two staff members for toileting, showering, and dressing. The assessment also showed the resident was cognitively intact and had the PTSD diagnosis. Review of a document titled Trauma Screening Questionnaire, dated 04/24/2024, showed the assessor had determined Resident 10 did not have a notable probability to experience trauma related symptoms that may influence care, despite their diagnosis of PTSD. During a concurrent observation and interview on 05/15/2024 at 8:30 AM, Resident 10 stated they had several traumas in their life including the suicide of a close family member and military service during the Vietnam War. As the resident spoke of the trauma in their life, they were visibly upset and sobbing. Resident 10 verbalized triggers (stimulus that prompts involuntary recall of a previous traumatic event) associated with their PTSD diagnosis. Review of Resident 10's care plan, dated 05/08/2024, showed no focus area or identified triggers associated with Resident 10's diagnosis of PTSD. During an interview on 05/16/2024 at 4:28 PM, Staff F, Social Services Director, stated all residents received a trauma screening questionnaire. Based on the information gathered, they determined triggers related to the trauma. Staff F stated they would formulate a care plan with interventions to cope with their triggers and concerns. They stated if the resident declined to answer the assessment questions, the process would be to do another screen at another time. Staff F stated the Social Services Assistant (SSA) had done Resident 10's screening. During an interview on 05/20/2024 at 2:23 PM, Staff G, SSA, stated they had been trained to trauma assessments. They stated Resident 10 did not express any concerns with their history. Staff G stated they did not reach out to family or ask any additional questions to determine triggers. Staff G stated they would do a repeat trauma assessment if they found out a resident had a history of trauma. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/21/2024 at 4:41 PM, Staff B, Director of Nursing, stated social services was responsible for completing the trauma assessment and creating the care plan. Staff B stated the staff were educated on trauma informed care and care planning appropriately for their triggers. They stated the correct process would have been for social services staff to do a second screening and reach out to family with further questioning to identify triggers and concerns related to the PTSD diagnosis. During an interview on 05/22/2024 at 11:19 AM, Staff C, [NAME] President of Clinical Services, stated social services staff never went any further with those negative responses on the assessment form. They stated the process would have been to reach out to family and continue with the process of identifying triggers and care planning appropriately. Staff C stated the staff did not follow the correct process. Reference: WAC 388-97-1060(3)(e)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39652 Based on observation, interview, and record review, the facility failed to ensure there were sufficient numbers of competent nursing staff to provide care and services for 14 of 14 residents (Residents 54, 10, 5, 28, 55, 25, 41, 20, 60, 59, 2, 3, 26, and 276) as evidenced by failures related to Resident Rights, Resident Mobility, Activities of Daily Living (ADLs), Quality of Care, Urinary Catheters, Pressure Injuries, Accident Prevention, Infection Control Practices, and Competent Staff. Additionally, reports in the facility grievance logbook, resident council meeting interviews, and staff interviews provided evidence of insufficient staff. These failures placed residents at risk of not having their needs met and potential negative outcomes to their physical and mental health. Findings included . <F-550 Resident Rights> The facility failed to provide an environment that enhanced and prompted a dignified lifestyle. <Resident 54> On 05/20/2024 at 9:30 AM Resident 54 stated they had not had a shower on Saturday 05/18/2024 even though they had asked multiple times and were told there is not enough staff. Resident 54 stated they had a skin condition which caused odor if they were not bathed enough. I can smell myself and it's even offensive to me and I am embarrassed. <Resident 10> A concurrent observation and interview on 05/17/2024 at 8:45 AM, showed Resident 10 lying in bed. Their hair was unkempt, and they had several days growth of facial hair. There was a pungent smell of body odor noted upon entering the room. Resident 10 stated I'm sorry, I am getting kind of rank (a slang word for something that is horrible, in bad taste, or actually smells unpleasant). They stated they usually had their showers on Monday's but did not have one since the Friday before last. Resident 10 stated they used to shave everyday but had not been shaved in a long time. <Resident 5> During a concurrent observation and interview on 05/20/2024 at 2:09 PM, Resident 5 stated they were supposed to get showers every Tuesday and Friday but lately they were lucky to get one a week. They stated they easily get a yeast infection under their folds when they are not clean, and they knew they smelled bad. Resident 5 stated I can smell myself, that stinky yeast smell and it's so embarrassing I don't want to go around other people, so I just stay in my room most of the time. <F-688 Prevent/Decrease in Range of Motion (ROM)/Mobility The facility failed to ensure staff provided care and services to maintain ROM and prevent contractures. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	<Resident 55> During a concurrent observation and interview on 05/14/2024 at 11:31 AM, Resident 55 had a brace on their left hand, the resident stated that they wore the brace daily. During multiple observations on 05/14/2024 at 10:21 AM, 05/15/2024 at 9:03 AM, 05/16/2024 at 2:54 PM and 05/19/2024 at 8:26 AM, showed Resident 55 wearing a left-hand brace. Review of the resident's care plan dated 04/22/2024, showed no care plan related to the resident's use of a left-hand brace, including the checking of the skin underneath, a schedule of an on/off use of the brace, and who was to do the task. During an interview on 05/16/2024 at 1:51 PM, Staff E, Assistant Director of Nursing (ADON), acknowledged that the resident did not have a Physician order for the brace or that it was in the resident's care plan. <Resident 25> Observation on 05/14/2024 at 10:21 AM, showed the resident sitting in their wheelchair. Their left hand was tight and closed and the resident was unable to open it. Review of the care plan showed the resident required a daily splint to the left hand. During multiple observations on 05/14/2024 at 10:21 AM, 05/15/2024 at 8:48 AM, 05/16/2024 at 3:16 PM, 05/17/2024 at 8:18 AM, and 05/19/2024 at 8:01 AM Resident 25 did not have their splint on. <F-677 ADL Care Provided for Dependent Residents> The facility failed to consistently provide assistance with bathing and grooming for dependent residents. <Resident 10> A concurrent observation and interview on 05/17/2024 at 8:45 AM, showed Resident 10 lying in bed, no shirt on, long, patchy facial hair, and unkempt hair. They stated they hadn't had a shower since the Friday before last. Review of the Nursing Assistant (NA) task flow record dated April 2024, showed Resident 10's shower days were Wednesday's and Saturday's, with their last shower on April 27, 2024. The May 2024 NA task record showed Resident 10 refused their shower on May 1, 2024, and had received a shower on May 11, 2024, 14 days after their last shower. During an interview on 05/21/2024 at 4:23 PM, Staff B, Director of Nursing, stated they had recognized concerns related to residents getting their showers as scheduled and had changed the shower schedule. Staff B stated they believed they were improving in their ability to provide showers, but most definitely, the process needs more improvement. <Resident 5> (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of Resident 5's fingernails and toenails on 05/20/2024 at 2:09 PM showed they were long and jagged with a brown substance under the fingernails. In an interview with Resident 5 on 05/20/2024 at 2:09 PM the resident stated they were not getting their showers as scheduled twice a week for the past several months and it was causing skin breakdown. Resident 5 stated staff told them it was because they were short of staff and were doing their best. Review of the facility's grievance logbook showed Resident 5 filled out a grievance form on 02/22/2024 and on 03/12/2024, stating they were not receiving their showers as assigned and were sore in their skin folds from not receiving their showers. Review of Resident 5's NA task record dated 05/20/2024, showed the resident was to receive showers on Tuesdays and Fridays for the month of May 2024. The record showed they had received a shower on Tuesday 05/07/2024 and Tuesday 05/14/2024. There was no documentation that Resident 5 received their showers on Friday 05/10/2024 or Friday 05/17/2024. <Resident 55> During an interview on 05/15/2024 at 9:03 AM, Resident 55 stated it had been eight days since they had a shower. Review of Resident 55's NA task flow sheets showed for March 2024 showed the resident went 24 days without a shower, the April 2024 task sheets showed the resident went six days, twice within the month, without a shower, and for May 2024 the task sheets showed the resident went 16 days without a shower. In an interview on 05/16/2024 at 2:54 PM, Resident 55's Representative (RR), stated the resident's last shower was two weeks ago and stated they believed the problem was with the staffing, stating, if the facility had all hands-on deck the care would be getting done. During an interview on 05/16/2024 at 4:44 PM, the RR stated Resident 55's skin was breaking down from the lack of showering. The RR stated they come to the facility daily and the resident was usually wet. <Resident 54> A concurrent observation and interview on 05/20/2024 at 10:00 AM, showed Resident 54 in their room, sitting up in their electric wheelchair. The resident stated they had not received their shower on Saturday 05/18/2024. Resident 54 stated I asked several times, at least three or four times, if I was going to get my shower and I was told there was not enough staff, so I had to wait until tomorrow. <F-684 Quality of Care> The facility failed to ensure facility staff scheduled follow up appointments to specialist physicians. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	< Resident 41> Record review of the outside wound care consultant's (OWC) assessment notes dated 03/28/2024, showed a referral was made for an urgent Infectious Disease (ID a physician that has advanced training in treating infections) as soon as possible related to Resident 41's sacral (region by the tail bone) wound osteomyelitis (infection in the bone). Further review of the OWC's assessment notes, showed on 04/11/2024 another referral for follow up with ID was made as it had not been scheduled. Record review of an ID visit note dated 04/24/2024 (27 days after the urgent referral), showed Resident 41 went to the ID appointment (unaccompanied) and did not have their sacral wound reviewed. The resident had not given details about their sacral wound infection or the deterioration of the wound, therefore it was not assessed by the ID physician. Review of OWC's assessment notes dated 04/25/2024, 05/02/2024, and 05/16/2024, showed additional requests for a new appointment with ID for follow up on the resident's sacral wound osteomyelitis. The referrals requested a staff attendant to accompany Resident 41 for accurate reporting of the condition of the sacral wound. <F-690 Urinary Catheters> The facility failed to ensure urinary catheters were justified with appropriate diagnoses and follow up care. <Resident 54> The resident had a urinary retention catheter placed without justification for use or specific orders. During and interview on 05/13/2024 at 1:40 PM, Resident 54 stated to other residents that the urinary catheter had been placed to helped with the long wait times they had experienced when needing to urinate. <F-686 Prevent/Heal Pressure Injuries> The facility failed to ensure pressure injuries did not develop or worsen in the facility. <Resident 20> Review of an admission nursing assessment dated [DATE], showed Resident 20 was admitted to the facility with no skin breakdown noted. Review of a nursing progress note dated 05/04/2024, showed a skin assessment was completed on Resident 20 and no skin issues were found. Review of a nursing progress note dated 05/07/2024 showed, shearing (skin abrasions) was noted on both the left and right buttock, each measuring two centimeters. In an interview with Resident 20 on 05/16/2024 at 10:26 AM, they stated the wounds were always very painful and especially during the dressing changes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with Staff E, Assistant Director of Nursing (ADON), on 05/17/2024 at 2:37 PM, while reviewing the wound assessment record and pictures completed on 05/16/2024, showed a wound on the right buttock measured and defined as a 1.0 centimeter (cm, a unit of measure) by 1.0 cm Stage 2 open pressure injury, and a wound on the left buttock measured and defined as a 3.98 cm by 3.1 cm open unstageable area, as a portion of the wound was covered by yellow/whitish slough (dead tissue that covers the base of a wound) and the extent of tissue damage could not be observed. <Resident 60> Review of a progress note on 05/16/2024 at 5:18 AM, showed the OWC was unable to locate wound swab results, inflammation labs, and imaging updates per their last progress note dated 05/02/2024. The OWC documented Please provide update on the following previous recommendations ., referencing the inflammation labs and imaging. During an interview on 05/20/2024 at 1:42 PM, Staff J, Resident Care Manger (RCM), stated they managed Resident 60's care. Staff J stated the results of the wound swab should have been in the record but could not find them. Staff J stated they were not aware of the 05/02/2024 recommendations from the OWC. They stated there was a nurse that had followed the wounds with the OWC during wound rounds, but since they left, they were not sure who followed those residents with wounds. <Resident 41> During an interview on 05/16/2024 at 9:16 AM, Resident 41 stated they had a Stage 4 pressure injury which required an air mattress. The mattress malfunctioned and was not replaced for several weeks which put them at risk for a worsening of their pressure injury. Resident 41 stated the malfunctioning mattress placed pressure on their Stage 4 sacral wound and caused pain. <F-689 Free of Accidents> The facility failed to provide adequate supervision to prevent accidents. <Resident 20> Review of an admission nursing progress note dated 04/24/2024 at 6:12 PM, showed Resident 20 had dysphagia (difficulty swallowing), was on a moist, minced diet, and required one on one assistance to eat. On 05/13/2024 at 12:22 PM, Resident 20 was observed sitting at a table in the independent dining room by themselves. They were having difficulty swallowing their food and were coughing, gagging, and spitting out food onto their plate. Resident 20 stated in a soft distressed voice I can't eat this, it's too hard to chew and I can't breathe. By 12:39 PM, all staff and other residents had left the dining room leaving the resident alone with their food in front of them. On 05/14/2024 between 12:05 PM and 12:36 PM, Resident 20 was observed sitting at a table with two other residents in the independent dining room. The resident was having difficulty eating and was seen coughing, gagging, and spitting out pieces of chicken onto their plate. Resident 20 stated I can't eat, it's too hard to swallow and breathe. All the other residents and staff had left the dining room leaving Resident 20 sitting alone with their food in front of them. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 05/13/2024 at 12:48 PM, Staff Q, Registered Nurse (RN), stated that no staff were needed to monitor the independent dining room because all of the residents assigned there could eat independently. During an interview, on 05/15/2024 at 9:09 AM, Staff U, NA, stated no staff stay in the independent dining room and they were told not to go in there after the residents were served. I'm very concerned about the resident's safety with no one in there to monitor them in case they choke or need something. During an interview on 05/21/2024 at 4:14 PM, Staff E, ADON, stated it was a team decision about who was placed into which dining room. They stated to be placed in the independent dining room, a resident had to be on a regular diet, be independent in eating, and not require any staff supervision. They stated Resident 20 should never have been put into the independent dining room with a diagnosis of dysphagia and requiring assistance to eat. In addition, Staff E stated a lot of the staff don't think any of the resident's should be left unsupervised while they are eating. They are all vulnerable medically or they wouldn't be here. <Resident 59> Review of Resident 59's diet order dated 04/09/2024, showed a diabetic carbohydrate-controlled diet, chopped texture, nectar (mildly thick) consistency with nectar thick fluids. Aspiration precautions, oral care before every meal, upright for meals in chair or wheelchair only during meal and 45 minutes after. Resident to take a small sip/small bite/alternate food and fluids, chin tuck with liquid. Eats with supervision only. An observation of Resident 59 on 05/17/2024 at 12:35 PM, showed them sitting in front of a tray of food at a tray table in their room by themselves, stating, I don't like this stuff. No one else was in the room supervising or assisting them with eating. An observation on 05/19/2024 at 8:36 AM, showed Resident 59 sitting in their room at a tray table eating breakfast alone. A concurrent interview with Staff U, NA, who was leaving the room after serving the meal, stated, The resident gets upset with us when we watch them eat so we just check on them once in a while and make sure they are doing ok. During an interview on 05/20/2024 at 2:20 PM, Staff AA, Speech Language Pathologist (SLP), they stated the resident should be supervised at all times while eating and drinking and encouraged to follow the steps for eating and drinking safely even though they would frequently refuse the assistance. <F-880 Infection Prevention and Control> The facility failed to ensure enhanced barrier precautions (EBP) were implemented. Observations on 05/19/2024 from 7:14 AM through 7:34 AM, showed no EBP signage outside of Resident's 2, 3, 20, 26, 41, 60, and 276's room, indicating the need for additional personal protective equipment (PPE) during high-contact resident care. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 05/21/2024 at 4:51 PM, Staff B, Director of Nursing, stated they were aware of the requirement to initiate EBPs for residents with open wounds and indwelling medical devices. Staff B stated they did not have a full-time infection preventionist in place and they were having trouble creating a policy and educating staff on the process. <Competent Staff> During an interview on 05/13/2024 at 2:59 PM, Resident 276 stated not all nurses at the facility were familiar with how administer medications through their Peripherally Inserted Central Catheter (PICC, a thin, soft tube that is inserted into a vein in the arm, leg, or neck for long-term administration of antibiotics, medications, nutrition, and blood draws) line. Record review of a document titled, Licensed Nurse Skills Inventory, dated 07/04/2023, showed Staff Q, Registered Nurse, completed a self-assessment of their nursing skills and had rated their competency for administration of Intravenous (IV) medications and care of an IV site as competent; performs on daily or weekly basis; proficient. The document was reviewed by Staff B, Director of Nursing, signed and dated on 07/04/2023. Record review of a document titled, Licensed Nurse Skills Inventory, dated 01/13/2023, showed Staff R, Licensed Practical Nurse, completed a self-assessment of their nursing skills for IV medication administration and care of IV site as competent; performs on daily or weekly basis; proficient. The document was reviewed, signed, and dated by Staff B on 01/13/2023. During an interview on 05/21/2024 at 4:45 PM, Staff B, Director of Nursing, stated I usually have the nurses walk me through the process to verify competencies. During an interview on 05/22/2024 at 11:22 AM, Staff C, [NAME] President of Clinical Operations, stated nursing staff should perform a return demonstration to verify competencies. <Resident Council Meeting> During a resident council meeting on 05/15/2024 at 1:34 PM, Resident 33 stated, there is just not enough staff and reported they did not consistently get showers and had to wait a long time for their call light to be answered. I dread having to use the bathroom. Resident 54 stated when they were put on the toilet, they take a whistle with them to blow because no one will come and assist me off the toilet unless I start blowing my whistle. In addition, Resident 54 stated they did not get their twice weekly showers as the staff were often shorthanded. Resident 9 stated when the staff was shorthanded they had to sit up in their chair all day until about 3:00 PM when someone can finally lay them down. <Grievance Logbook> Record review of the facility grievance logbook from 01/02/2024 to 05/10/2024 showed 27 grievances filed by residents and families related to not receiving showers. Additionally, there were 15 grievances filed by residents and families for not receiving timely assistance (including long call light wait times) to meet their basic care needs. The facility provided follow up to the grievances, however the issues continued to reoccur. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	<Staff Interviews> During a concurrent interview on 05/15/2024 at 9:09 AM with four full time nursing assistants (NAs) who wished to remain anonymous , Staff 1, Staff 2, Staff 3, and Staff 4. The all stated they often worked short-staffed and were unable to complete their showers consistently. Staff 2 stated it was difficult to answer all the call lights in a timely manner or consistently meet resident's basic care needs when working short-staffed. In addition, Staff 2 stated they reported complaints from the residents related to short staffing to facility management however, nothing gets done about it, so we tell them (the residents) to fill out a grievance form. During the same interview, Staff 3 stated the residents did not get their showers because we work short (staffed) so much. Additionally, Staff 3 stated it was very challenging. during mealtimes to assist all the residents that needed help and have to hurry through their meals. Staff 4 stated the facility had shower aides (NA's whose tasks were to focus on showers) until last November 2023 when they were taken away. Staff 3 stated there was not an appropriate follow up plan on how to incorporate the new shower duties into their already very busy day and showers were getting missed because of that. During an interview on 05/20/2024 at 11:14 AM, Staff B, Director of Nurses, stated they were aware of the concerns with showers and had been working on resolving the shower issue. Staff B stated they felt there was adequate staff to meet resident care needs. Reference WAC 388-97-1080 (1), -1090 (1)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on observation, interview, and record review, the facility failed to ensure licensed nurses had the specific competencies and skill sets, which included documented demonstration, necessary to safely and efficiently perform care for residents' needs in the area of Peripherally Inserted Central Catheter [(PICC) - a thin, soft tube that is inserted into a vein in the arm, leg, or neck for long-term administration of antibiotics, medications, nutrition, and blood draws] line for 2 of 2 nursing staff (Staff Q and R) reviewed for staff competencies. This failure placed residents at risk for adverse outcomes related to PICC lines and unmet care needs. Findings included . Review of the [NAME] Manual of Nursing Practice, 11th edition, Unit 1, Chapter 6, titled, Intravenous[(IV) a needle inserted directly into a vein to deliver liquids to the blood stream) Therapy; Standards of Care Guidelines, dated 2024, showed the resident should be monitored frequently for signs of infiltration (the accidental leakage of IV solution into the surrounding tissue instead of flowing into the vein) or sluggish flow, phlebitis (inflammation that causes a blood clot to form in a vein), infection, the condition of the catheter dressing, and frequency of dressing changes. Flush the vascular access device with normal saline and aspirate blood prior to each infusion to assess catheter function. Monitor for swelling and pain in the area of the catheter or insertion site. Washington State Board of Nursing (an entity that regulates the competency and quality of nurses to protect the health and safety of the public) defined nurse competency in reference to [NAME] Administrative Code 246-840-210(5) titled, Continuing Competency .the ongoing ability of a nurse to maintain, updated, and demonstrate sufficient knowledge, skills, judgement, and qualifications to practice safely and ethically . During an interview on 05/15/2024 at 3:27 PM, Staff Q, Registered Nurse, stated they were responsible for PICC line medication administration and care for one resident that shift. Staff Q stated they monitored the resident's PICC line for infection and displacement - if it (the PICC line) looks like it is coming out, I would note displacement. Staff Q did not verbalize monitoring the PICC line for function, signs of infiltration, phlebitis, or the dressing. Staff Q stated they had not received training for PICC line medication administration and care from the facility, just general nursing training. They stated they completed a self-assessment when they were hired but did not do a return demonstration of the skill. Record review of a document titled, Licensed Nurse Skills Inventory, dated 07/04/2023, showed Staff Q completed their self-assessment and had rated their competency for administration of Intravenous (IV) medications and care of an IV site as competent; performs on daily or weekly basis; proficient. The document was reviewed by Staff B, Director of Nursing, signed and dated on 07/04/2023. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/16/2024 at 8:03 AM, Staff R, Licensed Practical Nurse, stated they monitored the PICC line insertion site for inflammation or infection. Staff R stated they did not have PICC line training at the facility but if they had training, I would go to it. Staff R did not verbalize monitoring for displacement, infiltration, phlebitis, or the dressing. Staff R stated they had not done a return demonstration of the administration of medications and care of a PICC line. Record review of a document titled, Licensed Nurse Skills Inventory, dated 01/13/2023, showed Staff R rated their self-assessment competency for IV medication administration and care of IV site as competent; performs on daily or weekly basis; proficient. The document was reviewed, signed, and dated by Staff B on 01/13/2023. During an interview on 05/16/2024 at 2:37 PM, the facility's Advanced Registered Nurse Practitioner stated nursing staff should monitor the PICC line for both internal and external complications, including the function of the line, displacement, and the insertion site for signs/symptoms of infection. During an interview on 05/21/2024 at 4:45 PM, Staff B, Director of Nursing, stated I usually have the nurses walk me through the process to verify competencies. During an interview on 05/22/2024 at 11:22 AM, Staff C, [NAME] President of Clinical Operations, stated nursing staff should perform a return demonstration to verify competencies, but that would be up to the Director of Nursing's discretion. Reference: WAC 388-97-1080(10)(c)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on observation, interview, and record review, the facility failed to ensure mental and psychosocial health needs were identified and met for 1 of 1 resident (Resident 10) reviewed for behavioral health. Failure to identify and utilize person-centered interventions placed the resident at risk for unmet care needs. Findings included . <Resident 10> Review of the medical record showed Resident 10 was admitted to the facility on [DATE] with diagnoses including Post Traumatic Stress Disorder [(PTSD) an anxiety disorder that develops in some people who have experienced a shocking, scary, or dangerous event] and depression. The 05/24/2024 comprehensive assessment showed Resident 10 required substantial/maximal assistance of one staff member for activities of daily living; dependent on one to two staff members for toileting, showering, and dressing. The assessment also showed the resident was cognitively intact. Additional review of the comprehensive assessment showed Resident 10 expressed little interest/pleasure in doing things, felt down and depressed, had trouble sleeping, was having little energy, and had a poor appetite for more than half of the days of the previous two weeks. Resident 10 sometimes felt lonely or isolated from others. They had no behaviors, rejection of cares, or wandering in the facility. Review of Resident 10's care plan dated 05/08/2024, showed the resident had a diagnosis of depression and received an antidepressant (a drug used to help treat depression) medication. The care plan showed Resident 10 would be educated regarding the risks and benefits of the medication, monitored for side effects and effectiveness, and monitored for ongoing signs and symptoms of depression. During an interview on 05/21/2024 at 9:18 AM, Resident 10 stated they used to attend group therapy for war veterans and would like to restart therapy with a group. Resident 10 stated they had counseling services before living at the facility but no one at the facility had addressed my issues' or mentioned that services were available. Resident 10 stated please tell someone I would like to have services and support. During an interview on 05/16/2024 at 4:28 PM, Staff F, Social Services Director, stated that the facility offered behavioral health services that included a provider that came to the facility weekly to meet with residents. During a follow-up interview on 05/21/2024 at 10:04 AM, Staff F stated they were aware of the possible issues Resident 10 may have and had related to PTSD and had added the issues to their care plan. They stated they managed Resident 10's behaviors with medications and family reassurance. During an interview on 05/21/2024 at 4:49 PM, Staff B, Director of Nursing , stated the correct process for identifying residents that needed behavioral health services included looking at a behavior history and using a screening tool to identify concerns. Staff B stated with Resident 10's history of trauma, they should have been referred to behavioral health services. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/22/2024 at 11:26 AM, Staff C, [NAME] President of Clinical Operations, stated with Resident 10's known diagnoses, the process would have included staff asking the resident if they would like behavioral health services. Staff C stated facility staff should have made a community referral for services. Reference: WAC 388-97-1060(3)(e)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 39652 Based on observation, interview, and record review, the facility failed to ensure 2 of 4 residents (Resident's 7 and 26), reviewed for unnecessary medications, had adequate monitoring and assessment for the use of psychotropic medications (medications that alter brain activity of mental functioning and behavior). The facility did not ensure as needed psychotropic medications had stop dates as required or consistently perform assessments for abnormal voluntary movement (AIMS) testing with the use of antipsychotic medications [a class psychotropic medication that has a high risk for serious adverse side effects (ASE)]. Additionally, the facility failed to conduct quarterly Interdisciplinary Team [(IDT) a group of healthcare professionals that bring together knowledge from different health care disciplines to help people receive the care they need] reviews to ensure the psychotropic medications were appropriate or if a gradual dose reduction (GDR) could be attempted. These failures placed residents at risk for ASE's related to psychotropic medication use and a deterioration in their mental and physical health status. Findings included . Record review of an Alzheimer's Society August 2021 article titled, Antipsychotics and Other Drug Approaches in Dementia Care, showed .the decision to use an antipsychotic drug for dementia care should be taken very seriously, benefits may impact the person's health and quality of life .Antipsychotic drug use can also cause serious side effects including . * Drowsiness and confusion * Shaking, unsteadiness * Worse than usual dementia symptoms * Higher risk of infections such as chest or urinary * Higher risk of falls and fractures * Higher risk of stroke * Higher risk of death. <Resident 7> Review of Resident 7's medical record showed they were admitted to the facility on [DATE] with diagnoses including, type 2 diabetes (a chronic disease in which the body has trouble controlling blood sugar and converting it to energy), dementia (a disease which causes loss of memory and thinking skills) and depression. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 7's most recent comprehensive assessment dated [DATE] showed the resident had minimal cognitive impairment and required substantial assistance from staff members for activities of daily living (ADLs) to include dressing, grooming, transfers, and mobility. Review of Resident 7's physician orders from 01/01/2024 to 05/20/2024, showed Resident 7 had an order for an as needed (non-routine) antianxiety medication which was started on 12/23/2023 without a stop date. During an interview on 05/20/2024 at 11:10 AM, Staff B, Director of Nursing, stated they were aware that an as needed antianxiety medicationrequired a stop date. Staff B reviewed the residents record and confirmed there was no assessment or stop date for Resident 7's as needed antianxiety medication. Staff B stated they would need to contact the physician to correct it. <Resident 26> Review of Resident 26's medical record showed they were admitted to the facility on [DATE] with diagnoses including, dementia, type 2 diabetes, and general anxiety. Review of the most recent comprehensive assessment dated [DATE], showed the resident had severe cognitive impairment and required substantial assistance from staff for transfers, mobility, grooming, and personal hygiene. Review of Resident 26's 05/2024 physician orders showed the resident was taking an antipsychotic medication since their admission to the facility. Further review showed there was no AIMS assessment or IDT reviews completed related to the resident's antipsychotic medication use. During an interview on 05/22/2024 at 11:15 AM, Staff B stated the IDT met quarterly with the pharmacy to review psychotropic medications, however, Resident 26 had changed rooms and was missed for the reviews. Additionally, Staff B stated there was not a good system in place to ensure AIMS testing was completed for the use of antipsychotic medications, therefore it had also been missed. Reference WAC: 388-97-1060 (3)(k)(i) 45642

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642 Based on observation, interview, and record review the facility failed to ensure a resident's physician order of heparin (a substance that slows the formation of blood clots) was not implemented as observed during the medication administration observation, resulting in a significant medication error for 1 of 3 residents (Resident 276) was free from significant medication errors. This failure placed the resident at risk for adverse complications from the significant medication error and an unmet care needs. Findings including . Review of the policy titled, Administering Medications, dated June 2023, showed that all medications would be passed according to physician orders and medication guidelines. The licensed nurse were to follow general guidelines for safe and accurate medication administration. Review of the Nursing 2023 Drug Handbook, 43rd edition, page 29, showed heparin had the following adverse reactions; commonly caused bleeding and could cause hypersensitivity or hemorrhage. Contraindicated in patients with severe high blood pressure and diabetes. <Resident 276> Review of the resident's electronic medical record showed they were admitted to the facility on [DATE] with diagnoses including left knee infection, high blood pressure, and diabetes (a disease in which the body does not control glucose (a type of sugar) in the blood.) Resident 276's most recent comprehensive assessment, dated 05/17/2024, showed they required supervision/touching assistance of one staff member with activities of daily living and was cognitively intact. Review of Resident 276's physician's order dated 05/10/2024, showed: Cefazolin (a type of antibiotic medication) was to be given every eight hours by way of the residents Peripherally Inserted Central Catheter (PICC) line (a thin long tube that is inserted into a resident's arm, leg or neck that carries medication to the heart), for a septic (a serious condition in which the body responds improperly to an infection) left knee. to flush (the action of pushing a solution and/or a medication through a catheter line to clean it/keep it patent/open) the PICC line with five milliliters (ml, a units of measure) of normal saline (NS, a solution used as a solution to flush the PICC line), prior to administering the antibiotic medication. After the antibiotic was administered the nurse was to flush the PICC line again with 5ml of NS, and then flush with three ml of a Heparin solution. During an observation on 05/14/2024 at 9:22 AM, Staff R, License Practical Nurse (LPN), accessed and cleaned the PICC line ports with an alcohol pad, allowed the ports to dry, and began treatment. Staff R accessed the purple port of the PICC line and administered the five ml flush of NS, then administered a three ml flush of heparin, another five ml NS flush before starting the antibiotic medication on the infusion pump at 200 mls per hour. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/17/2024 at 12:22 PM, Staff R, LPN, stated their process was to review Resident 276 orders prior to administering the antibiotic medication and gather the supplies necessary to administer the medication. Staff R stated once the antibiotic medication was complete, they would use the same process of 5ml of ns, 3 ml of heparin and then 5ml of ns. After reviewing Resident 276's antibiotic and flush orders Staff R stated they did not follow the physician's orders correctly. During an interview on 05/19/2024 at 11:07 AM, Staff B, Director of Nursing, stated the expectation for medication administration was for the nurse to follow the physician orders and professional standards of practice. Reference WAC 388-97-1060 (3)(k)(iii)

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	505086	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark Care and Rehabilitation	710 North 39th Avenue Yakima, WA 98902

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on observation, interview, and record review, the facility failed to ensure enhanced barrier precautions [(EBPs) an approach to the use of personal protective equipment (PPE) to reduce transmission of Multidrug-Resistant Organisms (MDROs) between residents in skilled nursing facilities] were implemented for 7 of 7 Residents (2, 3, 20, 26, 41, 60, and 276) reviewed for infection control practices. The failure to identify, provide appropriate signage, and educate residents and staff on the need for EBPs placed all residents at risk for exposure, transmission of MDRO's, and serious medical complications. Findings included . According to the Centers for Medicare and Medicaid Services document titled Enhanced Barrier Precautions in Nursing Homes, dated 03/20/2024, showed EBPs were used along with standard precautions and expanded the use of PPE to donning (put on) of gown and gloves during high-contact resident care activities that provided opportunities for transmission of Centers for Disease Control and Prevention targeted MDROs to staff hands and clothing. EBPs were indicated for residents that were infected or colonized with an MDRO when Contact Precautions did not apply or when a resident had a wound and/or indwelling medical device even if the resident was not infected or colonized with an MDRO. <Resident 2> Review of the medical record showed Resident 2 was admitted to the facility on [DATE] with diagnoses including cancer and removal of larynx (the voice box), and a tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea from outside the neck). The 04/18/2024 comprehensive assessment showed Resident 2 required setup/supervision of one staff member for activities of daily living (ADLs). The assessment also showed the resident had an intact cognition. <Resident 3> Review of the medical record showed Resident 3 was admitted to the facility on [DATE] with a diagnosis of palliative care (specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness). The 02/21/2024 comprehensive assessment showed Resident 3 required substantial/maximal assistance for ADLs. The assessment also showed Resident 3 had an indwelling catheter (a tube inserted into the bladder to drain urine) and an intact cognition. <Resident 20> Review of the medical record showed Resident 20 was admitted to the facility on [DATE] with diagnoses including respiratory and heart failure. The 05/01/2024 comprehensive assessment showed Resident 20 required maximum assistance of one to two staff members for ADLs. The assessment also showed Resident 20 had an intact cognition. Review of a nursing progress note dated 05/08/2024 showed Resident 20 had open wounds on their buttocks and coccyx (a small triangular bone at the base of the spinal column). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 26> Review of the medical record showed Resident 26 was admitted to the facility on [DATE] with diagnoses including open wounds on their sacrum (coccyx). The 04/27/2024 comprehensive assessment showed Resident 26 required substantial/maximum assistance of one staff member for ADLs. The assessment also showed Resident 26 had a severely impaired cognition. <Resident 41> Review of the medical record showed Resident 41 was admitted to the facility on [DATE] with a diagnosis of a stage 4 pressure injury (a full thickness loss of skin and tissue with exposed connective tissue, muscle, tendon, ligament, cartilage, or bone) on their sacrum. The 03/25/2024 comprehensive assessment showed Resident 41 required substantial/ maximum assistance of one to two staff members for ADLS. The assessment also showed Resident 41 had an intact cognition. <Resident 60> Review of the medical record showed Resident 60 was admitted to the facility on [DATE] with diagnoses including diabetes (a condition where there is too much sugar in the blood) and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). The 03/20/2024 comprehensive assessment showed Resident 60 required maximum assistance of one staff member for ADLs. The assessment also showed Resident 60 had an intact cognition. Resident 60 had an open wound on their right heel. <Resident 276> Review of the medical record showed Resident 276 was admitted to the facility on [DATE] with diagnoses including bacterial infection of the left knee. Resident 276 had an intact cognition and required antibiotics through a Peripherally Inserted Central Catheter [(PICC) - a thin, soft tube that is inserted into a vein in the arm, leg, or neck for long-term administration of antibiotics, medications, nutrition, and blood draws]. Observations on 05/19/2024 from 7:14 AM through 7:34 AM, showed no EBP signage outside of Resident's 2, 3, 20, 26, 41, 60, and 276's room, indicating the need for additional PPE during high-contact resident care. During an interview on 05/13/2024 at 1:35 PM, Staff N, Nursing Assistant, stated there were no residents on their hall that required PPE for cares, unless Resident 60's wound was exposed. Staff N was assigned to Resident 3, 6, and 276. During an interview on 05/21/2024 at 4:51 PM, Staff B, Director of Nursing, stated they were aware of the requirement to initiate EBPs for residents with open wounds and indwelling medical devices. Staff B stated they did not have a full-time infection preventionist in place and they were having trouble creating a policy and educating staff on the process. During an interview on 05/22/2024 at 11:34 AM, Staff C, [NAME] President of Clinical Operations stated there should have been recognition for need to use EBPs for the indicated residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference: WAC 388-97-1320(2)(b) This is a repeated citation from Statement of Deficiencies dated 05/04/2023.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39652 Based on observation, interview and record review, the facility failed to maintain resident care equipment in a fully functional manner, for 3 of 3 mechanical lifts (Lift's 1, 2, and 3) reviewed for safety. This failure placed residents who were dependent for transfers at risk for injuries and potential harm. Findings included . <Lift 1> Observation on 05/17/2024 at 10:15 AM showed Lift 1 stored outside of the South Hall Dining Room. On the arm of the lift was a red emergency manual safety feature for lowering the mechanical lift arm in the event it malfunctioned. The emergency feature was loose, stripped and was no longer working. The motor box located at the base of the lift was broken with wires hanging down. It was also noted that the remote control did not match the make and model of the lift. <Lift 2> During an observation on 05/17/2024 at 10:30 AM showed Lift 2 stored on the South hall outside of room [ROOM NUMBER]. Lift 2 was observed to have the same red emergency feature for the manual lowering the lift was also loose, stripped and no longer working. The motor covering was open with exposed wires hanging down. The lever used to open and close the legs of the lift during transfers no longer worked to keep the legs secured when transporting residents between surfaces. <Lift 3> Observation on 05/17/2024 at 10:56 AM, showed lift 3 stored by the nurses station on the North hall. Lift 3's red emergency feature for manually lowering the lift was loose, stripped and not working as observed on Lift's 1 and 2. The motor covering was open with wires hanging down. During an observation on 05/17/2024 at 1:03 PM, Staff U, Nursing Assistant (NA) and Staff W, NA used Lift 1 to transfer Resident 61 (who required a mechanical lift to transfer) from their wheel chair to their bed). The NA staff hooked the sling under the resident to the arms of Lift 1. Resident 61 was six inches above their wheel chair and Lift 1 malfunctioned and stalled. Staff U pointed to the red emergency lowering device and indicated it did not work. After two minutes of Resident 61 suspended in the air Lift 1 started working again and Resident 61 was placed safely on their bed. During an interview on 05/17/2024 at 1:10 PM, Staff U stated Lift 1 had also malfunctioned in the am during a transfer with Resident 61. Staff U had reported the malfunction and Lift 1 was sent to maintenance to fix it. Lift 1 was returned to the floor after it had been repaired and they thought it was fixed and ready for use. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the manual for Invacare 600-1 lift (the brand of the mechanical lifts currently used by the facility) showed the primary way to manually lower the mechanical lift during a malfunction was to place a pen tip in a designated hole on the arm of the lift and push down. This action would cause the arm to lower so that a resident could be safely transferred to a stable surface in the event the lift malfunctioned. The manual noted the red emergency feature was the secondary option to lower the mechanical lift arm in an emergency. During concurrent interviews on 05/17/2024 at 1:20 PM, Staff Y, NA, Staff V, NA, Staff U and I NA, stated they were unaware of the primary way to lower the arm of the mechanical lift and were only aware of the red emergency feature which was visible on the lift. During an interview on 05/17/2024 at 1:25 PM, with a staff who requested to be un-named stated We have been reporting to management that these lifts are malfunctioning for several months and nothing has been done about it. During an interview on 05/17/2024 at 3:23 PM, Staff B, Director of Nursing, stated the lifts are not safe and that Lift 2 had been removed from the floor and replaced with a rental lift. Staff B further stated Lift 1 had been repaired and acknowledged that they had been unaware of the primary safety feature to lower the arm lift manually by placing a pen tip in the designated hole to lower the [NAME] lift in the event there was a malfunction. Reference WAC 388-97-2100