STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505093	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Park Health Care & Rehab Center	4755 South 48th Tacoma, WA 98409

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on interview and record review the facility failed to have an antianxiety (a psychotropic medication that affect s a person's mental state) medication informed consent signed and in place prior to the resident receiving the medication for 1 of 5 sampled residents (Residents 60) reviewed for unnecessary medication use. Failure to obtain informed consents as required, placed the resident or their legal representatives at risk for lack of knowledge to make an informed decision regarding the use of the medication for the resident. Findings included . Review of a document titled, Psychotropic Medication Use, dated July 2022, showed residents, families and/or the representatives were to be involved in the medication management process. Psychotropic medication management included: indications for use, doses (including duplicate therapy), duration, adequate monitoring for efficacy and adverse consequences and preventing, identifying and responding to adverse consequences. Residents and/or representatives have the right to decline treatment with psychotropic medications and the staff and provider would review with the resident/representative the risks related to not taking the medication as well as appropriate alternatives. Review of the electronic health record (EHR) showed that Resident 60 was readmitted to the facility on [DATE] with diagnoses that included anxiety disorder and depression. The resident was able to make needs known. Review of Residents 60's psychotropic medication administration disclosure/informed consent dated 08/08/2024 showed it was signed by Resident 60. Review of Resident 60's August 2024 medication administration record (MAR) from 08/01/2024 - 08/23/2024 showed the resident was prescribed and provided hydroxyzine two tablets one time a day in the evening for anxiety with a start date of 08/05/2024 (provided three days prior to obtaining an informed consent). During an interview on 08/26/2024 at 11:24 AM, Staff D, Resident Care Manager/Licensed Practical Nurse, stated that Resident 60 was provided hydroxyzine on 08/05/2024, 08/06/2024, and 08/07/2024 prior to having an informed consent signed on 08/08/2024. Staff D stated this did not meet expectations. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/26/2024 at 11:36 AM, Staff B, Director of Nursing Services stated Resident 60's informed consent should have been obtained prior to the resident receiving an antianxiety medication. Reference WAC 388-97-0260

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on observation, interview and record review, the facility failed to ensure resident privacy was honored when providing topical medications for 2 of 4 sampled residents (Resident 62, and Resident 465) reviewed for medication administration, and failed to ensure a private location for personal phone calls and personal conversation for 1 of 2 sampled residents (Resident 25) reviewed for dignity. These failures placed residents at risk of not having personal space honored, feelings of institutionalization and a diminished quality of life Findings included . Resident 25 Review of the Electronic Health Record (EHR) showed Resident 25 was admitted to the facility on [DATE] with multiple diagnoses to include retention of urine, depression and heart failure. Resident 25 was able to make needs known. During an interview and observation on 08/22/2024 at 11:59 AM, Resident 25 stated there was no privacy in this room, roommate was yelling even when I am on the phone. Resident 25 stated that staff were laughing about it when they mention their concerns. For about 15 minutes of the interview, the roommate was observed and heard yelling out about eight times. Resident 465 Review of the EHR showed Resident 465 was admitted to the facility on [DATE], with multiple diagnoses to include chronic respiratory failure, malnutrition and anemia. Resident was able to make needs known. During an observation on 08/26/2024 at 9:38 AM, Resident 465 was sitting in bed with the door and privacy curtain open, the roommate had a visitor. Staff BB, Licensed Practical Nurse (LPN), applied 2 topical patches to Resident 465s right shoulder and lower back, during the application Staff BB opened the gown of Resident 465. Resident 62 Review of the EHR showed Resident 62 was admitted to the facility on [DATE], with multiple diagnoses to include depression, anxiety and adult failure to thrive. Resident 62 was able to make needs known. During an observation on 08/27/2024 at 8:00 AM, Resident 62 was sitting in bed, privacy curtain was closed; however, the window had open blinds and the lights were on. Staff CC, Registered Nurse (RN), asked the resident to apply pain patch to lower back. Resident 62 stood up from bed and lifted their gown exposing their naked body for patch application. There was no attempt to close the blinds or offer a more private area. During an interview on 08/28/2024 at 9:48AM, Staff B DNS, stated that was not acceptable practice. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97-0360(1)(b)(d)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on observation and interview, the facility failed to maintain a safe homelike environment for 2 of 4 halls (East B and [NAME] B) reviewed for environment. This failure placed residents at risk for lack of privacy, unsanitary conditions and diminished quality of life. Findings included . <Resident Blinds> Multiple observations between 08/23/2024 and 08/27/2024 between 8:00 AM and 4:00 PM showed the following resident rooms with broken or missing blind slats on the [NAME] B Hall. Rooms 61, 63, 65, 67, 69, 46, 55 and 50. Multiple observations between 08/23/2024 and 08/27/2024 between 8:00 AM and 4:00 PM showed the following resident rooms with broken or missing blind slats on the East B Hall. Rooms 19, 28, 31, 33, 34 and 37. During an interview on 08/23/2024 at 9:44 AM, Resident 29 stated they had complained about the missing blinds slats weeks ago since the window faced a parking lot. Resident 29 stated a family member put a large piece of dark reflective material on the window where the blinds were missing for privacy. During an interview on 08/27/2024 at 2:22 PM, Staff DD, Maintenance Director stated they did daily rounds to ensure the building was properly maintained. Staff DD stated they were aware of the broken blinds but were unable to repair/replace them due to previous budget restrictions. Staff DD stated the lack of privacy for residents did not meet expectation. <Resident Rooms> Observation on 08/23/2024 between 9:47 AM-10:00 AM showed rooms 55, 61, 62, 63, and 65 with dried matter/stains on the bedside tables. Observation on 08/22/2024 at 9:44 AM showed a dried white substance and stains on the top and bottom of Resident 7's bedside table. During an interview on 08/22/2024 at 9:44 AM, Resident 7 stated housekeeping came in daily but did not do a good job of cleaning. During an observation and interview on 08/23/2024 at 10:17 AM, Staff EE, Housekeeping/Laundry Manager stated the condition of Resident 7's floor and bedside table was unacceptable and did not meet expectation. 38344 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 10 Observation on 08/23/2024 at 9:28 AM of Resident 10's bathroom showed the tub had brown matter/stains on the inside of the tub and appeared soiled, the faucet handles for the tub was missing and instead had metal skinny pipes that stuck out of the tiled wall above the tub. Resident 10 readmitted to the facility on [DATE] with a diagnosis of paraplegia (the inability to voluntarily move the lower parts of the body/hips, legs, and feet) and was able to make needs known. During an interview on 08/28/2024 at 12:10 PM Staff EE, stated Resident 10's bathroom tub had a dead spider at the bottom of the tub. Staff EE stated they had tried to clean the tub before; however, the brown stains do not come off and the missing faucet handles was an issue for maintenance to fix. Staff EE stated they were informed that Resident 10 did not use the tub and that usually a board would be placed over a tub that was not being used and was not sure why it was not in place. Staff EE stated they had informed maintenance about the tub more than six months ago and this was not a safe and homelike environment. Resident 60 Resident 60 readmitted to the facility on [DATE] and was able to make needs known. Observation and interview on 08/23/2024 showed broken blinds (three slats broken off). Resident 60 stated they did not know why they did not have curtains over the window. During an interview on 08/28/2024 at 12:16 PM, Staff EE stated that Resident 60's blinds were broken and needed to be fixed/replaced. Staff EE stated housekeeping cleaned the blinds and should have informed maintenance but did not know if that had occurred. Staff EE stated this did not meet expectations. Suite 66 bathroom Observation on 08/23/2024 at 10:00 AM of Suite 66's bathroom (not located in a resident room) located near residents in rooms numbered 66, showed a paper towel dispenser attached to the wall by the door. When waving a hand over the censor to try to dispenser paper, it did not work. There was a plastic bag hanging from a paper towel dispenser with a paper roll hanging off the plastic bag. The paper towel roll was touching the wall. During an interview on 08/28/2024 at 12:04 PM, Staff EE stated the paper towel roll touching the wall hanging from a plastic bag over the paper towel dispenser did not meet expectations. Staff EE stated they had been aware of the broken dispenser and had informed the housekeeper to first change out the batteries to see if that would fix the paper dispenser and if that did not work, then inform maintenance. Staff EE stated they were not sure if housekeeping followed up with maintenance or not; however, it should have been fixed by now. During an interview on 08/28/2024 at 1:45 PM, Staff A, Administrator, was informed of issues noted in Resident 10's room, Resident 60's bathroom, and in Suite 66's bathroom. Staff A stated these findings did not meet expectations and needed to be addressed immediately. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference WAC 388-97-0880(1)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on interview and record review, the facility failed to initiate and thoroughly process a grievance for 2 of 22 sampled residents (Resident 7 and 67) reviewed for resident rights and missing personal property. This failure placed the residents at risk of unmet needs, personal loss and diminished quality of life. Findings included . Resident 7 Resident 7 admitted to the facility on [DATE] with diagnoses of right foot drop, left foot drop unspecified abnormalities of gait and mobility. The admission minimum data set assessment (MDS), dated [DATE], showed Resident 7 required extensive assistance with activities of daily living. During an interview on 08/22/2024 at 9:44 AM, Resident 7 stated they were only getting a few hours of sleep since getting a new roommate. Resident 7 stated their roommate frequently yelled at night which interrupted their sleep. Resident 7 stated they had complained to staff members however nothing had been done. During an interview on 08/27/2024 at 9:06 AM, Staff FF, Certified Nursing Assistant (CNA), stated Resident 7 had complained to them about the roommate staying up late, snoring and yelling about a fire. Staff FF stated they had not initiated a grievance. During an interview on 08/27/2024 at 9:10 AM, Staff P, Licensed Practical Nurse (LPN), stated Resident 7 complained once a week about the new roommate. Staff P stated they had never initiated a formal grievance; however, social services had been notified. During an interview on 08/27/2024 at 1:55 PM, Staff H, Social Work Designee (SWD), stated they had been made aware of Resident 7's concern that day. Staff H stated any staff member could initiate a grievance on behalf of a resident or assist the resident with completing a grievance. Staff H stated the expectation was that a grievance should have been initiated by staff and given to Social Services to investigate. 50945 Review of the policy titled Grievance/Concern, dated 08/25/2021, showed that the facility would investigate the grievance, and that the person who filed the grievance should be notified of the status or resolution of the grievance within 72 hours. Resident 67 Review of the electronic health record (EHR) showed Resident 67 was admitted on [DATE]. Review of the MDS, dated [DATE], showed Resident 67 was cognitively intact and able to make needs known. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/23/2024 at 8:58 AM, Resident 67 stated they had a pair of black pants that went missing about 5 months ago and they filed a grievance that was still unresolved. Review of the facility's grievance log on 02/28/2024, showed Resident 67 had a missing clothes grievance with no resolution. During an interview on 08/27/2024 at 8:43 AM, Staff C, Social Services Director, stated they have 72 hours to resolve a grievance, that Resident 67's grievance was still unresolved by the laundry department, and that this did not meet expectations. During an interview on 08/27/2024 at 11:58 AM, Resident 67 stated that no staff from laundry had come to talk to them and stated, This makes me feel like they do not care. During an interview on 08/27/2024 at 12:18 PM, Staff G, Laundry Services, stated they were unable to find the grievance and would ask social services to assist them. During an interview on 08/27/2024 at 4:12 PM, Staff A, Administrator, stated it did not meet expectations that the grievance was filed on 02/28/2024 and was not resolved until today. Reference WAC 388-97-0460

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148 Based on interview and record review, the facility failed to complete a thorough investigation to rule out abuse or neglect for 3 of 5 sampled residents (Resident 93 83 and 62) reviewed for abuse, accidents and/or incidents. The facility also failed to implement interventions after a fall to decrease the risk for falls for resident 93. These failures placed the residents at risk for injury related to repeated falls, unidentified abuse or neglect and continued exposure to abuse and/or neglect. Findings included . According to the Nursing Home Guidelines also known as the Purple Book, sixth edition, dated October 2015, All alleged incidents of abuse, neglect, abandonment, mistreatment, injuries of unknown source, personal and/or financial exploitation, or misappropriation of resident property must be thoroughly investigated . A thorough investigation is a systematic collection and review of evidence/information that describes and explains an event or a series of events. It seeks to determine if abuse, neglect, abandonment, personal and/or financial exploitation or misappropriation of resident property occurred, and how to prevent further occurrences. Resident 93 Review of the EHR showed Resident 93 re admitted to the facility on [DATE] with a diagnosis of pneumonia and had a history of falls in the last month. Resident 93 had completed treatment for a bladder infection (UTI) on 08/22/2024 and was alert, oriented and able to make needs known During an interview on 08/22/2024 at 11:58 AM, Resident 93 stated they had a fall about a month ago in the bathroom and had hit their head. Resident 93 stated they no longer had symptoms of a bladder infection. Review of the EHR showed Resident 93 had a fall on 07/30/2024 in the bathroom during which they had hit their head and a fall on 08/10/2024 next to the bed. Review of an incident investigation for the fall on 08/10/2024 did not include interviews of staff assigned to care for Resident 93 at the time of the fall to help determine the root cause of the fall. Further review showed interventions were added to the care plan for frequent checks and physical therapy. During an interview on 08/26/2024 at 10:32 AM, Staff X, Certified Nursing Assistant (CNA) stated resident 93 was on frequent checks. Review on 08/26/2024 of the EHR showed no documentation related to frequent checks. Review on 08/26/2024 of the order for physical therapy (PT) Evaluation & treatment as recommended related to fall on 8/10/2024 with a start date of 08/13/2024 showed it was still an active order. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/26/2024 at 11:23 AM, Staff L, Director of Rehabilitation, when asked to provide the therapy notes related to this evaluation stated they had not done an evaluation of Resident 93. Record review on 08/26/2024 at 11:43 AM, showed Resident 93 had two falls yesterday on 08/25/2024, had hit their head and was sent out to the hospital for evaluation. As of 09/02/2024 Resident 93 had not returned from the hospital. During an interview on 08/28/2024 at 10:05 AM, Staff B, DNS stated it was their expectation that staff working on the floor when a fall occurs should have been interviewed to determine the root cause of a fall. Staff B stated if there was an order for physical therapy evaluation it should have been completed regardless of the resident's diagnosis. During an interview on 08/28/2024 at 10:19 AM, Staff A, Administrator stated it was their expectation that during a fall investigation staff should be interviewed to determine the root cause and the interventions to prevent future falls be carried out such as Resident 93's frequent checks and physical therapy evaluation. 34567 Resident 83 Review of Resident 83's EHR showed the resident readmitted on [DATE] with diagnoses to include heart and lung disease, anxiety, depression and bipolar (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration and anxiety). The MDS further showed that the resident was able to make needs known. During an observation and interview on 08/22/2024 at 10:01 AM, Resident 83 sat on the side of their bed, a large semi-swollen, purplish, colored bruise was observed on the resident's forehead. When asked how they obtained the bruise on their forehead the resident stated that they fell yesterday and thought that they got their feet tangled up and landed on their head. Review of Resident 83's focus care plan dated 10/16/2023 showed the resident was at risk for falls related to multiple diagnoses including previous falls, back surgery, seizures, high blood pressure, alcohol withdrawal, depression, anxiety and bipolar disorder. Interventions included to monitor vital signs including orthostatic blood pressure (a procedure that measures blood pressure in various positions, laying, sitting and standing) as needed and report to the provider as indicated. Review of Resident 83's August 2024 medication administration record (MAR) showed the resident had several orders for the licensed staff to administer psychotropic medications (used in the treatment of mental health disorders), opioids (medication used for the treatment of moderate to severe pain) and a antispasmodic (a medication used in the treatment of muscle spasms). Resident 83's treatment administration record (TAR) showed no providers orders to monitor any adverse side effects of these medications that could include lightheadedness, dizziness or that could potentiate falls. In addition, the EHR showed Resident 83 lacked orthostatic postural blood pressure documentation as well as no provider's orders were found in the TAR for the staff to monitor. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 83's EHR on 08/22/2024 showed a licensed nurse (LN) had documented that that they had noticed the resident had a bump on their forehead that measured 3 x 3 centimeters (CM) in size. According to the resident, they thought that they might have had a fall; however, no one saw them on the ground or witnessed any fall. The LN further documented that the resident's family and provider was notified and recommended the treatment of ice to the resident's bump for 3 days. Review of Resident 83's EHR vital signs record showed no orthostatic blood pressure were obtained after the fall. Review of the facility's incident investigation log on 08/25/2024 showed Resident 83 was not included as having an incident investigation started for any unwitnessed falls on 08/21/2024. During an interview on 08/25/2024 at 8:16 AM, Staff B, DNS, stated that they were unaware of this resident's fall because nobody told them about the fall so it was never investigated but it should have been. During an interview on 08/27/2024 at 8:24 AM, Staff D, Resident Care Manager/Licensed Practical Nurse (RCM/LPN) stated that Staff B told them about Resident 83's fall yesterday and was looking into it. During an interview on 08/27/2024 at 8:45 AM, Staff E, LPN stated they notified Staff D, and Staff B of the residents fall and placed them on alert. 50945 Resident 62 Review of the EHR showed Resident 62 was admitted on [DATE] with diagnoses that included anxiety and depression. Review of the quarterly MDS assessment, dated 08/08/2024, showed Resident 62 was cognitively intact and able to make needs known. <Investigation One> During an interview on 08/22/2024 at 10:07 AM, Resident 62 alleged that they had been verbally assaulted by a staff member, had requested the staff leave their room twice, and that during the alleged incident the staff member had gotten spit in Resident 62's eye. Review of the incident investigation report showed a statement dated 08/19/2024 by the alleged perpetrator that they confronted Resident 62 in their room and 3 witnesses were present. Two of the staff witness statements did not include any statement on the alleged incident itself, only the events surrounding it. The third witness statement reported they heard the alleged perpetrator talking to Resident 62, no details were provided on where the witness was when they heard the conversation. No full statement by Resident 62 or documentation of an interview of Resident 62 was included in the abuse investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 62's incident report mentioned a full investigation was done, with interviews of the resident, the involved perpetrator, other residents, and other staff that were working during the time of the incident. Review of Resident 62's incident investigation showed that other residents and additional staff were not interviewed until after the investigation had come to the conclusion that the abuse and neglect was unsubstantiated. During an interview on 08/27/2024 at 09:04 AM, Staff C, Director of Social Services, stated they were involved in the investigation and that Resident 62 had never said to them that the alleged spitting incident was on purpose. During an interview on 08/27/2024 at 10:48 AM, Staff D, RCM/LPN, stated their expectation was for staff to not approach Resident 62 about personal matters or conflicts, and a non-biased second witness such as social work or management should have been involved in the incident. Staff D stated that it was an assumption by staff to think that Resident 62 was reporting the alleged eye spit as intentional. During an interview on 08/27/2024 at 11:04 AM, Staff B, DNS, stated they were in charge of the investigation. Staff B stated the file did not have a statement from Resident 62, there was no word-to-word documentation of what the resident had said, and that this should not have been missed. Staff B stated the questions being asked to additional staff members did not meet expectations, as it was not all inclusive of the allegations. Staff B stated that the investigation report, under the predisposing physiological factors (how the body functions that contributes to developing a problem) section, was missing the selection of medications. During an interview on 08/28/2024 at 11:56 AM, Staff A, Administrator, stated it did not meet expectations that other residents were not interviewed until 08/20/2024, the day after the investigation ended, and that other staff interviews were not done until 08/23/2024. Staff A stated it did not meet expectations that the investigation did not include a statement from Resident 62 of the incident. <Investigation Two> During an interview on 08/22/2024 at 10:07 AM, Resident 62 made an allegation of verbal abuse by a staff member. The facility was made aware on 08/22/2024 of the alleged incident. The alleged staff was reassigned but was not suspended pending investigation. Review of the incident file showed only one other resident was interviewed, on 08/22/2024, with the same question as the prior investigation. During an interview on 08/27/2024 at 11:04 AM, Staff B, DNS, stated their expectation for interviews of other staff by social work, is to be specific if there are allegations, and that the interviews with other staff did not meet expectations. During an interview on 08/28/2024 at 10:51 AM, Staff B, DNS, stated they did not suspend the alleged staff member. Staff B stated it did not meet expectations that only one resident was interviewed on 08/22/2024. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/28/2024 at 11:56 AM, Staff A, Administrator stated their expectation is that alleged staff should always be suspended immediately pending investigation, and this did not happen for Resident 62's investigation. Reference WAC 388-97-0640 (6)(a)(b)

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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** 49926 Based on interview and record review, the facility failed to provide written notification of the reason for transfer to the hospital to resident or responsible party for 1 of 2 sampled residents, (Resident 358) reviewed for hospitalization . This failure placed the resident at risk for not knowing rights regarding transfer and discharge from the facility, and diminished protection from been inappropriately discharged . Findings included . Review of the electronic health record (EHR) showed Resident 358 admitted to the facility on [DATE] with a diagnosis that included multiple sclerosis (a chronic autoimmune disease that damages the protective covering of nerve cells in the brain, spinal cord, and optic nerve), heart failure and diabetes. Resident 358 was able to make needs known. Review of Resident 358s EHR showed a hospitalization on [DATE], and readmission to the facility on [DATE]. There was no documentation about transfer notice. During an interview on 08/28/2024 at 8:20 AM, Staff D, Resident Care Manager /Licensed Practical Nurse (RCM/LPN) stated that there was no transfer notification documented. During an Interview on 08/28/2024 at 09:44 AM, Staff B, Director of Nursing Services, stated the expectation was to have transfer notice documented and scanned into the EHR. Reference WAC 388-91-0120(2) (a-d)

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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** 49926 Based on record review and interview, the facility failed to provide written bed hold notice at the time of transfer to the hospital for 1 of 2 sampled residents, (Resident 358) reviewed for hospitalization . This failure placed the resident at risk for lacking knowledge regarding their right to hold their bed while in the hospital and diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 358 admitted to the facility on [DATE] with diagnoses that included multiple sclerosis (a chronic autoimmune disease that damages the protective covering of nerve cells in the brain, spinal cord, and optic nerve), heart failure and diabetes and was able to make needs known. Review of Resident 358's EHR showed a hospitalization on [DATE], and readmission to the facility on [DATE]. There was no documentation about bed hold notice. During an interview on 08/28/2024 at 8:20 AM, Staff D, Resident Care Manager/Licensed Practical Nurse (RCM/LPN) stated that there was no bed hold documented. During an Interview on 08/28/2024 at 9:44 AM, Staff B, Director of Nursing Services, stated the expectation was to have bed hold notice documented and scanned into the EHR. Reference WAC 388-91-0120(4)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on interview and record review, the facility failed to ensure the minimum data set assessment (MDS) accurately reflected the status for 3 of 22 sampled residents (Resident 7, 67, and 25) reviewed for accuracy of assessments. This failure placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . Resident 7 Resident 7 admitted to the facility on [DATE] with diagnoses of right foot drop, left foot drop unspecified abnormalities of gait and mobility. The admission MDS, dated [DATE], showed Resident 7 required extensive assistance with activities of daily living. Review of the quarterly MDS dated [DATE] showed the Functional Limitation in Range of Motion section marked no impairment for lower extremity. Review of Resident 7's form titled Physical Therapy PT Evaluation, dated and signed 03/27/2024, showed current reason for referral as, Patient referred by nursing. The ROM section listed RLE (right lower extremity) ROM = Impaired (with chronic ankle contracture [frozen joint]); LLE (left lower extremity) ROM = Impaired (with chronic ankle contracture). During an interview on 08/26/2024 at 3:34 PM, Staff J, MDS Nurse, stated they assessed Resident 7 for lower extremity impairment by having them lift both legs off the bed. Staff J stated they believed based off their assessment the MDS coding was correct. During an interview on 08/28/2024 at 9:13 AM, Staff B, Director of Nursing Services (DNS), stated the expectation was that the MDS was coded accurately. 49926 Resident 25 Review of the EHR showed Resident 25 was admitted to the facility on [DATE] with multiple diagnoses to include retention of urine, depression and heart failure. Resident 25 was able to make needs known. Review of the medication administration record for August 2024, showed Resident 25 received Seroquel (antipsychotic medication) every day at bedtime for Insomnia (persistent problems falling asleep or staying asleep). Review of the admission MDS dated [DATE] showed no use of antipsychotic medication. During an interview on 08/27/2024 at 10:59AM, Staff J, MDS nurse stated the MDS was coded incorrectly. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/28/2024 at 9:44 AM, Staff B, DNS, stated the expectation was for MDS assessments to be correctly coded. 50945 Resident 67 Review of the EHR showed that Resident 67 was admitted on [DATE] with diagnoses that included protein-calorie malnutrition (not enough protein and calories being consumed, weakening the body), anorexia (fear of gaining weight leading to poor nutrition), and gastroesophageal reflux disease (the backflow of stomach acid or bile). Review of the annual MDS assessment, dated 05/16/2024, showed Resident 67 was cognitively intact and able to make needs known. Resident 67 smoked cigarettes daily. <Dental> Further review of the annual MDS showed that Resident 67 did not have any dental issues or dental care areas selected. Review on 08/24/2024 of Resident 67's care plan, initiated on 06/01/2022, showed Resident 67 was at risk for dental care problems. Review of the document titled, Oral Health Evaluation dated 09/19/2023, showed Resident 67 had 1-3 decayed or broken teeth. Review of an uploaded communication to the provider, dated 02/19/2024, stated Resident 67 was having trouble chewing related to missing upper teeth. The bottom of the form requested the form be returned to the MDS department. This form was signed by Staff J, MDS nurse, on 3/8/2024. Review of Resident 67's dental referral, dated 02/27/2024, stated the referral was due to trouble chewing and missing teeth. Review of a MDS progress note on 05/15/2024 by Staff J, MDS nurse, stated that Resident 67 had healthy natural teeth. During an interview on 08/23/2024 at 9:22 AM, Resident 67 stated their dental problems made it challenging to eat due to the pain. During an interview on 08/26/2024 at 1:27 PM, Staff J, MDS Nurse, referred to their progress note on 05/15/2024 and stated their assessment showed no dental issues. During an interview on 08/27/2024 at 2:52 PM, Staff B, Director of Nursing Services (DNS), stated that due to the EHR documentation of broken/missing teeth, the MDS section for dental did not meet their expectations for accuracy. <Nutrition> (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review on 08/24/2024 of Resident 67's care plan, initiated on 06/01/2022, showed the resident was at risk for nutritional concerns. Review of the EHR showed Resident 67 had active orders (during the MDS assessment period) for a daily house supplement for weight stability and evening ice cream for additional calories. Review of the annual MDS showed that Resident 67 did not have a therapeutic diet or nutrition triggered areas selected. During an interview on 08/27/2024 at 4:00 PM, Staff B, DNS, stated the annual MDS was missing the therapeutic diet selection and that this did not meet their expectations. Reference WAC 388-97-1000 (1)(b)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on interview and record review the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR) assessments were accurately completed for four of five residents (Resident 83, 60, 93 and 20) reviewed for PASRRs and unnecessary medications. This failure placed the residents at risk for unidentified mental health care needs. Findings included . Review of a document titled, Preadmission Screening Resident Review (PASRR), dated 02/01/2023 showed all facility residents were to be screened for mental illness and mental retardation prior to admission. In addition, the facility's PASRR designee was responsible to access and ensure updates to the PASRR was done. Resident 83 Review of Resident 83's electronic health record (EHR) showed the resident readmitted on [DATE] with diagnoses to included heart and lung disease, anxiety, depression and bipolar (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). The resident was able to make needs known. Review of Resident 83's EHR showed a Level I PASRR was completed by a social worker at a local health care organization. The PASSR form was incomplete to include lack of signature of the individual who had completed the form as well as the missing completion date. In addition, Section I (Serious Mental Illness (SMI) / Intellectual Disability (ID) or Related Condition (RC) Determination) lacked documentation of Resident 83's mental health diagnoses. During an interview on 08/26/2024 at 11:42 AM, Staff H, Social Work Designee (SWD) stated Resident 83's Level I PASRR was inaccurate when they were last readmitted to the facility. In addition, the document should have been corrected to reflect the resident's mental health diagnoses. During an interview on 08/26/2024 at 11:45 AM, Staff A, Administrator (ADM) stated that their expectation was for the facility's social services staff to correct the PASSR form if it was inaccurate and ensure that the form was completed in a timely manner shortly after the resident's readmission back to the facility. 38344 Resident 60 Review of the EHR showed that Resident 60 was readmitted to the facility on [DATE] with diagnoses that included anxiety disorder and depression. The resident was able to make needs known. Review of Resident 60's Level I PASRR dated 02/16/2024 showed that the resident had SMI indicators marked on the form for depressive and anxiety disorders. The form showed that a Level II evaluation was not indicated. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/26/2024 at 10:53 AM, Staff A, Administrator, stated that based on the new regulations that came out, Resident 10 should have been upgraded to a Level II referral. Staff A stated Resident 10 needed to have another PASRR Level I completed, and a referral made for a Level II. 46148 Resident 93 Review of the EHR showed that Resident 93 was readmitted to the facility on [DATE] with a diagnosis of major depressive disorder. The resident was able to make needs known. Review of Resident 93's Level I PASRR dated 06/25/2024 showed that the resident had serious mental illness indicators marked on the form for mood disorders - depressive or bipolar. The form showed that a Level II evaluation was not indicated. During an interview on 08/27/2024 at 11:23 AM, Staff A, Administrator, stated that Resident 93 should have been upgraded to a Level II referral. 50945 Resident 20 Review of the EHR showed that Resident 20 was admitted on [DATE] with diagnoses that included paranoid personality disorder (mistrust and suspicion of others without reason), anxiety disorder and depression. Review of the annual MDS, dated [DATE], showed Resident 20 was able to make needs known. Review of the EHR on 08/26/2024 showed Resident 20 had one level 1 PASRR, dated 09/27/2019. Under SMI, the form said yes and had mood disorders selected. The form stated that a level two PASRR was not indicated. During an interview on 08/26/2024 at 2:54 PM, Staff H, SWD, stated that the level one PASRR was no longer accurate, and should be redone to meet current standards by requiring a level two PASRR. Reference WAC 388-97-1915 (1)(2)(a-c)

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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** 34567 Based on interview and record review, the facility failed to develop a baseline care plan within 48 hours of admission for 2 of 22 sampled residents (Resident 460 and 68) reviewed for new admissions. Failure to ensure initial care plans were addressed for dementia and hospice care placed the residents at risk for unmet needs and a diminished quality of life. Findings included . <Dementia> Resident 460 Review of the Medicare 5-day minimum data set assessment (MDS) on 08/23/2024 showed Resident 460 admitted to the facility 08/17/2024 with multiple diagnoses to include heart disease, diabetes, Alzheimer's (a brain disorder that gradually destroys memory and thinking skills), and dementia. The electronic health record (EHR) showed the residents cognitive skills for decision making were moderately impaired. Review of the provider orders dated 08/17/2024 showed several orders for the treatment of dementia to include monitoring episodes of agitation due to dementia with behaviors every shift and to document non-drug interventions used. An additional order showed licensed staff were to administer Seroquel (an antipsychotic medication) at bedtime for dementia with behavioral changes. Review of Resident 460s current care plan on 08/27/2024 showed no focus area for dementia was created after resident was admitted to the facility. During interview on 08/28/2024 at 8:52 AM, Staff C, Director of Social Services (DSS) stated that developing a baseline care plan was a group effort but noted that they were a little behind on generating a base line care plan for this resident. Furthermore, the baseline care plan should have been created within 72 hours after the resident's admission. During interview on 08/28/2024 at 8:57 AM, Staff D, Resident Care Manager/Licensed Practical Nurse (RCM/LPN) stated that their expectations would be for Resident 460 to have had a baseline care plan created for their care and treatment for the resident's dementia. Staff D further stated that it was a group effort at times to create the baseline care plan and that the admitting nurse would usually develop one upon admission. 46148 Resident 68 Review of the EHR showed Resident 68 admitted to the facility on [DATE] with diagnoses of Dementia and adult failure to thrive and was receiving Hospice for end-of-life care. No plan of care for hospice services was found in the medical record. (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 08/27/2024 at 10:06 AM, Staff B, Director of Nursing Services stated it was their expectation that the facility collaborated and initiated a care plan on admission for hospice services, this did not happen for resident 68 and should have. Reference WAC 388-97-1020 (3)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on observation, interview and record review, the facility failed to ensure resident care plans were reviewed, revised to ensure needed interventions were in place, and accurately reflected residents' care needs and/or failed to provide care conferences in a timely manner for 5 out of 25 sampled residents (Resident 10, 78, 68, 25 and 62) reviewed. These failures placed residents at risk for unmet care needs and diminished quality of life. Findings included . Resident 10 Resident 10 readmitted to the facility on [DATE] with a diagnosis of paraplegia (the inability to voluntarily move the lower parts of the body/hips, legs, and feet) and was able to make needs known. Review of Resident 10's minimum data set assessment (MDS) dated [DATE] showed that the resident had traumatic spinal cord dysfunction (damage to the spinal cord that blocks communication between the brain and the body), Hammer Toe(s) (a foot condition in which the toe has an abnormal bend in the middle joint) on both feet, contracture (shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement) on both feet, muscle weakness and depression. Resident 10 was not on a restorative nursing program and was at risk for pressure ulcer injuries. Review of Resident 10's current care plan on 08/27/2024 showed no care plan for a restorative nursing program to maintain strength for the upper body parts and/or maintain available range of motion (ROM) to joints. There were no interventions to provide ROM exercises to the right wrist or both hips, legs, ankles, and feet to maintain available mobility, prevent worsening of contractures, and prevent new contractures. Observation and interview on 08/28/2024 at 11:29 AM, showed Resident 10 laid in bed and had a right wrist contracture. Resident 10 stated they did not wear any braces or splints on their feet or right wrist/hand but, would be interested in participating in a restorative program to have their legs exercised. Resident 10 did not know if their mobility had maintained or declined. During an interview on 08/28/2024 at 8:08 PM, Staff M, Physical Therapist, stated they were not sure if Resident 10 was on a restorative nursing program or not; however, the resident should have been receiving some type of passive range of motion (PROM, moving a joint for a person who is unable to move their own body part) to their right wrist and lower body parts, at least three times a week and/or as tolerated by the resident. During an interview on 08/24/2024 at 2:16 PM, Staff B, Director of Nursing Services (DNS), stated Resident 10's care plan needed more interventions to prevent ROM decline and they should have been on a restorative program, and this did not meet expectations. Resident 78 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 78 was readmitted to the facility on [DATE] with diagnoses that included heart failure and diabetes (a disease when the sugar in the blood it too high). The resident was able to make needs known. During an interview on 08/23/2024 at 9:55 AM, Resident 78 stated they had a rash under their right breast and staff were treating it with a cream. Review of the provider order dated 08/15/2024 showed that Resident 78 was prescribed miconazole external powder 2% topically under the right breast two time a day for the yeast rash for 14 days with a stop date of 08/29/2024. Review of Resident 78's focused care plan dated 08/15/2024 showed, Resident at risk for skin break down related to has actual skin breakdown Type: yeast Location abdominal [stomach area] rash (this care plan was inaccurate and did not mention Resident 78's rash under the right breast). The care plan goals showed, Healing Goal: The resident's wound /skin impairment will heal as evidenced by decrease in size, absence of erythema and drainage and/or presence of granulation X _____ days and showed, Maintenance Goal: Wound will remain free from signs and symptoms of infection X _____days (these goals were not measurable and were incomplete). During an interview on 08/28/2024 at 1:25 PM, Staff D, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated that care plans should include a focus problem, measurable goals, and interventions. Staff D stated that Resident 78's focused care plan for actual skin breakdown was inaccurate and was missing the appropriate location of the rash, did not have measurable goals, and needed to be revised. During an interview on 08/28/2024 at 2:10 PM, Staff B, DNS stated that Resident 78's care plan for actual skin impairment had an inaccurate location of the rash which should have been documented it was under the right breast, and there were no measurable goals, and this did not meet expectations. 46067 Resident 25 Review of the electronic health records (EHR) showed Resident 25 was admitted to the facility on [DATE] with multiple diagnoses to include retention of urine, depression and heart failure. Resident 25 was able to make needs known. Review of Resident 25's EHR showed no documentation a care conference was completed. During an interview on 08/27/2024 at 2:17 PM, Staff H, Social Work Designee (SWD) stated they were unable to locate documentation of a care conference. Resident 68 Review of the EHR showed Resident 68 admitted to the facility on [DATE] with diagnoses of dementia and adult failure to thrive and was receiving Hospice for end-of-life care. Review of Resident 68's EHR showed the last care conference attended was on 05/06/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/27/2024 at 2:17 PM, Staff H, SWD stated Resident 68 was currently overdue for their care conference. Staff H stated the expectation was that care conferences were held every three months and as needed. 50945 Resident 62 Review of the EHR showed Resident 62 was admitted on [DATE] with diagnoses that included anxiety and depression. Review of the quarterly MDS, dated [DATE], showed Resident 62 was cognitively intact and able to make needs known. Review of the EHR on 08/16/2024 showed Resident 62 was receiving psychotherapy sessions and was followed by psychology. Record review showed Resident 62 had two reported incidents that the facility investigated on 08/16/2024 and 08/22/2024. During the first investigation, witness statements show that a staff member was made aware of comments by Resident 62, and that staff member confronted Resident 62. Review of the investigation on 08/22/2024 showed statements that Resident 62 overheard a conversation and believed it was about them. Prior to these incidents, the facility reported Resident 62 had a history of making allegations. During an interview on 08/27/2024 at 10:16 AM, Staff GG, Certified Nursing Assistant (CNA), stated Resident 62 had anxiety over missing or scheduling appointments. Staff GG stated that the Kardex (brief overview of residents/communicates cares) did not show anything about how to care for Resident 62's emotional state or mental health needs. During an interview on 08/27/2024, Staff E, Licensed Practical Nurse (LPN), stated Resident 62 had emotional distress over the loss of her son, and was perceived to have anxiety over new people/staff. During an interview on 08/27/2024 at 10:07 AM, Staff F, Registered Nurse (RN), stated Resident 62 was truthful, and sometimes needed anxiety medication in the evening, to help with anxiety around pain or going outside. Staff F stated they had been oriented by a staff member who informed them Resident 62 has anxiety around medication and appointments. Staff F stated they had noticed Resident 62 has some tension with certain CNAs. During an interview on 08/27/2024 at 09:04 AM, Staff C, Director of Social Services, stated that Resident 62 had a lull in behaviors and their best guess on why it was not care planned earlier was because of this lull. During this interview, Staff H, Social Work Designee, stated that Resident 62's anxiety caused them to fixate on things. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/27/2024 at 10:48 AM, Staff D, RCM/LPN, stated that it should be included in the care plan that a resident has anxiety with known triggers. Staff D, while looking over the care plan, stated that the care plan for Resident 62 only mentioned that the resident was having behaviors related to anxiety, but did not specify any triggers or anything that had worked for her in the past. Staff D stated their expectation was for social work to interview Resident 62, to determined triggers and plan for how to lessen/alleviate the triggers, to help Resident 62 work through the triggers and prevent escalation. Staff D stated there were no interventions in the Kardex that addressed how to care for Resident 62 regarding mental health concerns, and that this would contribute to the CNAs not knowing how to care for the resident appropriately. Staff D stated their expectation is to have the care plan and Kardex updated to include mental health needs. During an interview on 08/27/2024 at 11:04 AM, Staff B, DNS, stated Resident 62 is on anti-anxiety medication and sees mental health services every other week. Staff B stated the Kardex did not have any information to guide the CNAs on how to care for Resident 62's mental health, and that their expectation is the Kardex would show alternative interventions for anxiety for the CNAs to implement. Staff B, while looking over the care plan, stated that although Resident 62 is care planned for anxiety and depression, that their expectation, which was not met, is that there should also be known triggers included in the care plan. Reference WAC 388-97-1020(2)(c)(d)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on interview and record review, the facility failed to provide documentation in a manner that meets professional standards of quality for 1 of 22 sampled residents (Resident 67) reviewed. This failure placed residents at risk for decreased quality of care, biases towards residents, and a diminished quality of life. Findings included . The American Nurse Journal published an article on 08/07/2023 titled, Proper documentation protects patients and your license by [NAME], which stated documentation should be clinical and objective. Review of the electronic health record showed that Resident 67 was admitted on [DATE] with diagnoses of reduced mobility, chronic obstructive pulmonary disease (chronic lung disease making it difficult to breath), cognitive communication deficit (a problem with one or more communication abilities), chronic pain, anxiety and was able to make needs known. Review of a progress note dated 08/15/2024 showed Staff F, Registered Nurse (RN) described Resident 67 as annoying me. Further review showed a progress note dated 08/17/2024 where Staff F used the word difficult to describe interacting with Resident 67. During an interview on 08/26/2024 at 12:58 PM, Staff F, RN, stated that calling a resident annoying or describing them as difficult to interact with was not professional. During an interview on 08/26/2024 at 1:15 PM, Staff D, Resident Care Manager/Licensed Practical Nurse, stated that subjective documentation is opinion, and staff should be factual instead. During an interview on 08/26/2024 at 1:47 PM, Staff B, Director of Nursing Services, stated the subjective documentation used for Resident 67 was not professional and should not have been included in the progress notes. Reference WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on observation, interview and record review, the facility failed to ensure the necessary interventions were in place to prevent further skin condition issues for one of 3 sampled residents (Resident 35) when reviewed for skin care. Additionally, the facility failed to ensure wound care and ADLs (activities of daily living) were enacted for 2 of 3 sampled residents (458 and 68) when reviewed for hospice care. The facility also failed to consistently monitor and document bowel movements and implement the bowel program as needed for 3 of 5 sampled residents (Resident 93, 358 and 25) reviewed for bowel protocol. Furthermore, the facility lacked timely clinical interventions for 1 of 2 sampled residents (Resident 108) when reviewed for hospitalization . These failures placed the residents at risk for unmet needs, worsening condition, discomfort, and a decreased quality of life. Findings included . <Skin Conditions> Resident 35 Review of the quarterly minimum data set assessment (MDS) dated [DATE], showed that Resident 35 readmitted to the facility on [DATE] with multiple diagnoses to include, heart disease, diabetes, anxiety and depression. The MDS further showed Resident 35 was able to make their needs known and was dependent on staff for activities of daily living (ADLs). Review of Resident 35's focus care plan dated 03/31/2022 showed the resident was at risk for skin breakdown related to decreased mobility. The goal showed the resident would not show any further signs of skin breakdown. Interventions included application of a pressure redistribution surface to the resident's bed as per guidelines of a low air loss mattress (LAL, a type of bed support surface that helps prevent pressure wounds and keeps the skin dry and comfortable and which provides a constant flow of air that helps manage the skin's heat and humidity) During an observation and interview on 08/22/2024 at 11:10 AM, Resident 35 was observed to lay in a bed, no LAL mattress was observed on the resident's bed. Resident 35 stated that no one had provided them with any LAL mattress to use. Resident 35 stated they had a wound to their bottom and that the staff were treating it. Review of Resident 35's provider's order dated 07/23/2024 showed that a LAL mattress was to be used related to a new wound to the resident's coccyx (lower back) area and that LNs were to check the setting every shift. Review of a document titled, Body Check, dated 08/23/2024 showed that Resident 35 had an open area measuring 2x2 centimeters (cm) and that pressure relieving measures were in place. Review of Resident 35's treatment administration record (TAR) dated August 2024 showed multiple entries from LNs documenting a + which indicated a LAL mattress was being checked every shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/26/2024 at 10:44 AM, Staff P, Licensed Practical Nurse (LPN) stated the LAL mattress for Resident 35 does not appear to have been placed onto their bed but should have been. During an interview on 08/26/2024 at 10:54 AM, Staff D, Resident Care Manager/Licensed Practical Nurse (RCM/LPN) stated that Resident 35 had a chronic venous ulcer wound; however stated that it should get better if the interventions were in place i.e LAL mattress. In addition, Staff D, stated that LNs should not be signing off in Residents 35's electronic heath record (EHR), TAR, if the resident was not using it. 46148 <Hospice> Resident 68 Review of the EHR showed Resident 68 admitted to the facility on [DATE] with a diagnosis of Dementia and adult failure to thrive and was receiving Hospice for end-of-life care. Further review showed no Hospice care plan was initiated. During an interview and observation on 08/26/2024 at 9:01 AM, Resident 68 laid in bed and had a moderate amount of facial hair. Resident 68 stated the hospice aid provided bathing and shaving on Mondays and Thursdays but did not come last Thursday (08/22/2024). Resident 68 stated the facility aides here did not give them showers or baths or shave them and they would like to be clean shaven. During an interview on 08/26/2024 at 9:16 AM, Staff X, Certified Nursing Assistant (CNA) stated the CNA from hospice came and gave the showers to include shaving for resident 68, if they did not we would give them one. Staff X stated they were not aware if the Hospice CNA had given a shower on 08/22/2024. During an interview on 08/26/2024 at 12:35 PM, Staff B, Director of Nursing Services (DNS) stated hospice CNAs usually did shaving and nailcare with baths, if they miss, we pick it up. Staff B stated Resident 68 should have been shaven if they wanted shaved. During an interview on 08/27/2024 at 8:34 AM, Resident 68 stated hospice dropped me and did not come last week or yesterday. Resident 68 stated they had not received a bed bath or shower and shave in over a week. Review of the EHR on 08/27/2024 at 8:45 AM showed hospice communications forms uploaded to Resident 68s file on 08/22/2024 included all communications from 07/31/2024 through 08/21/2024. This included a discharge from hospice services note dated 08/21/2024. There was an order for Hospice services with a start date of 08/22/2024. During an interview on 08/27/2024 at 9:05 AM, Staff V, Licensed Practical Nurse / Infection Preventionist (LPN/IP) stated they were unaware that Resident 68 discharged from Hospice services. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/27/2024 at 10:06 AM, Staff B, DNS stated it was their expectation that the facility and hospice services communicate after each visit so any new orders can be addressed timely. Staff B also stated they should have the hospice care plan integrated into the facility care plan and physicians' orders in place for hospice. Resident 458 Review of the EHR showed Resident 458 admitted to the facility on [DATE] with diagnoses to include congestive heart failure, peripheral vascular disease and was receiving hospice services. Review of the EHR on 08/23/2024 showed no documentation related to hospice services since admission. During an interview and observation on 08/23/2024 at 9:27 AM, Resident 458 sat at the side of the bed. The resident stated they were in pain from a pressure wound on their bottom. There was a large bandage on their left lower leg and there was a strong unpleasant odor. Review of the residents EHR on 08/23/2024 at 4:22 PM showed no documentation or physicians orders related to the pressure wound to Resident 458's bottom. During an observation and interview on 08/26/2024 at 10:19 AM, Staff D, RCM/LPN removed a bandage from Resident 458's bottom and a large area was observed on the resident left ischium (sitting bone) which was completely covered with slough (thick white dead tissue). Staff D stated a hospice nurse changed the dressing twice a week and facility staff only change it as needed. During an interview and observation on 08/27/2024 at 10:49 AM, Collateral contact 1, Hospice Nurse, stated that they identified the new pressure wound to Resident 458's ischium on 08/14/2024 and had communicated it to the facility staff nurse the same day. CC1 stated they have a form they fill out after each visit and give to the assigned nurse that included any order changes and what services were provided during the visit. CC1 also stated that they had written orders to start a treatment for the strong unpleasant odor on Friday 08/23/2024 and handed it to the assigned nurse but it had not been started. During an interview on 08/27/2024 at 10:56 AM, Staff B, DNS stated that it was their expectation that there should have been clear communication with hospice services and the facility staff related to Resident 458's new pressure injury and new orders. <Bowel management> Resident 93 Review of the EHR showed Resident 93 admitted on [DATE] with a diagnosis of pneumonia. During an interview on 08/22/2024 at 12:04 PM, Resident 93 stated they had been having some constipation and loose stools off and on and had not received any medications for it. Review of Resident 93's bowel monitoring showed the resident did not have a documented bowel movement between the dates of 08/07/2024-08/15/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/26/2024 at 10:44 AM, Staff Z, Registered Nurse (RN) stated if Resident 93 went 72 hours without a bowel movement it should have flagged on the alert board, and the bowel protocol should have been initiated. Review of the EHR on 08/26/2024 at 10:55 AM showed no as needed medications for constipation were documented as administered to Resident 93 between the dates of 07/29/2024 and 08/26/2024. During an interview on 08/26/2024 at 12:31 PM, Staff B, DNS stated it was their expectation that the bowel protocol be implemented after 72 hours without a bowel movement and as needed medications for constipation be administered and documented in the EHR. 49926 Resident 358 Review of the EHR showed Resident 358 admitted to the facility on [DATE] with diagnoses that included multiple sclerosis (disease in which the immune system eats away at the protective covering of nerves), heart failure, diabetes and was able to make needs known. During an interview on 08/22/2024 at 10:40 AM, Resident 358 stated they have constipation, and have been trying to go for days. Review of Resident 358s EHR showed no bowel movements documented from 08/15/2024 to 08/22/2024. Review of the MAR showed an administration of milk of magnesia (laxative) on 08/21/2024 During an interview on 08/28/2024 at 8:09 AM, Staff O, Certified Nursing Assistant stated they document the bowel movements into the EHR and report to the nurse abnormalities. During an interview on 08/28/2024 at 8:20 AM, Staff D, RCM/LPN stated that the protocol was to start administration of the least aggressive bowel medications when there was no bowel movements documented. During an Interview on 08/28/2024 at 09:44 AM, Staff B, DNS stated that the expectation was for the nurses to follow the protocol, and this was not acceptable. Resident 25 Review of the EHR showed Resident 25 was admitted to the facility on [DATE] with multiple diagnoses to include retention of urine, depression and heart failure. Resident 25 was able to make needs known. During an interview on 08/22/2024 at 12:21 PM, Resident 25 stated they have constipation and diarrhea. Resident 25 stated that if they don't go for a long time, they would need nurse assistance and its horrible. Review of Resident 25 EHR, showed no bowel movements documented for the following days = 08/09/2024 - 08/13/2024 and 08/15/2024 - 08/18/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/28/2024 at 9:46 AM, Staff B, DNS stated the expectation was for nurses to follow the bowel protocol. <parameters> Resident 108 Review of the EHR showed Resident 108 was admitted to the facility on [DATE] with multiple diagnoses to include dementia (loss of memory and thinking ability) and stroke (brain damage) affecting left side of body. Resident 108 was unable to make needs known. Review of EHR dated 06/15/2024 at 9:42 AM showed Resident 108 had a low blood pressure of 91/48 with no documented notification to provider or resident representative. Review of EHR dated 06/16/2024 at 9:00 AM showed Resident 108 had a low blood pressure of 78/49, and a note dated 06/16/2024 at 10:16 AM showed resident was unresponsive for 2 days Resident has been unresponsive to sound and touch yesterday and today. Review of the facility policy titled, Change of Condition dated 08/25/2021, showed A Facility must immediately inform the resident, consult with the Resident's physician and/or NP, and notify, consistent with his/her authority, Resident Representative. During an Interview on 08/27/2024 at 2:17 PM Collateral Contact 2 (CC2) stated facility staff didn't notify them until 06/16/2024. CC2 stated that they would have requested for Resident 108 to go sooner to the hospital and receive treatment. During an Interview on 08/28/2024 at 8:20 AM, Staff D, Licensed Practical Nurse/Resident Care Manager (LPN/RCM) stated there should have been more clear documentation of what happened, and expectations are for nurses to notify as soon as practical, providers and residents' representative when there is a change of condition. During an interview on 08/28/2024 at 9:44 AM, Staff B, DNS stated that they had done an investigation about this case but was not able to find it. Reference WAC 388-97-1060(1)

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F 0686 Level of Harm - Minimal harm or potential for 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** 46148 Based on observation interview and record review, the facility failed to ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 2 of 3 sampled residents (Residents 458 and 358) when reviewed for pressure injuries. These failures placed the residents at risk for decreased comfort, infection, poor clinical outcomes and a decreased quality of life. Findings included . Resident 458 Review of the electronic health record (EHR) showed Resident 458 admitted to the facility on [DATE] with diagnoses to include congestive heart failure and was a high risk for pressure injuries. The resident was able to make needs known. During an interview on 08/22/2024 at 10:57 AM, Resident 458 stated they had wounds on their tailbone and their ischium (sitting bone). The one on the sitting bone was very painful. Review of physician's orders showed an order for staff to cleanse the pressure ulcer to the tailbone and apply alginate (highly absorbent fibers) and cover with a foam dressing every 3 days and as needed. There was no order found for the left ischium pressure wound. Review of the progress notes showed an entry by the interdisciplinary team dated 08/22/2024 which only documented a small pressure injury wound which measured 1 centimeter (cm) by 1 cm on the tailbone and stated it was managed by hospice. Review of the care plan on 08/26/2024 showed a care plan for the wound on the tailbone, it did not include the wound on the ischium. During an interview and observation on 08/26/2024 at 09:13 AM, Resident 458 stated the wound on the ischium was worse. The resident was grimacing with movement and stated their bottom hurts. During an interview on 08/26/2024 at 03:36 PM, Staff N, Admission Nurse/Registered Nurse Stated that they had done the admission skin assessment on Resident 458 and the resident did not have a wound on their sitting bone. During an interview and observation on 08/26/2024 at 10:19 AM, Staff D, Resident Care Manager/Licensed Practical Nurse (RCM/LPN) removed a bandage from Resident 458's bottom and a large area was observed on the resident left ischium (sitting bone) which was completely covered with slough (thick white dead tissue). There was no dressing on the tailbone. Staff D stated a hospice nurse changed the dressing twice a week and facility staff only change it as needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/27/2024 at 10:49 AM, CC1, Hospice Nurse, stated that they identified the new pressure wound to Resident 458's ischium on 08/14/2024 and had communicated with the facility staff nurse the same day about it. During an interview on 08/27/2024 at 10:56 AM, Staff B, Director of Nursing Services (DNS) stated the nurse who was made aware of the new pressure injury wound on Resident 458 should have initiated an incident investigation and notified the provider for orders, Staff B stated Resident 458 not having treatment orders or wound monitoring in place and not having an incident investigation completed did not meet expectations. 49926 Resident 358 Review of the electronic health record (EHR) showed Resident 358 admitted to the facility on [DATE] with diagnoses that included multiple sclerosis (a chronic autoimmune disease that damages the protective covering of nerve cells in the brain, spinal cord, and optic nerve), heart failure and diabetes. The resident was able to make needs known. During an observation and interview on 08/22/2024 at 10:38 AM, Resident 358 was in bed on their back and their feet were on the mattress. Resident 358 was grimacing in pain and stated they were experiencing burning in their feet and lower back. Review of the EHR showed a progress note dated 08/21/2024 describing a bed sore to the sacrum (low back/tail bone) and repositioning every two hours. Review of the EHR showed, Resident 358 had a body check documented on 08/23/2024 that showed skin injury to the left heel and sacrum. Body check documentation on 08/25/2024 showed a right buttock healing sore and a new open area on the left buttock. Review on 08/25/2024 of Resident 358's care plan, showed a Focus area at risk for skin breakdown and redness to coccyx area, with no updates of actual skin condition . Multiple observations of Resident 358 from 08/22/2024 - 08/28/2024, showed resident in bed, laying on their back with heels touching the mattress. Observation of Resident 358 on 08/26/2024 at 8:43 AM showed a wedge cushion was on the floor, instead of under Resident 358's feet to provide pressure relief. During an interview on 08/28/2024 at 8:26 AM, Staff AA, Certified Nursing Assistant (CNA), stated Resident 358's heels were touching the mattress as the wedge cushion was positioned under the knees, not under the lower feet to elevate the heels During an interview on 08/28/2024 at 9:44 AM, Staff B, DNS stated the expectation is for staff to follow the care plan and ensure the skin prevention plan is followed. Reference WAC 388-91-1060(3)(b)

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	505093	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on observation, interview and record review, the facility failed to ensure residents consistently received restorative care (movement of joints to maintain range of motion) to maintain or prevent declines in mobility and services to improve mobility for 3 of 5 sampled residents (Residents 7, 10 & 85) reviewed for range of motion (ROM)/mobility. Resident 7 experienced harm when they had an avoidable decline in range of motion where their splints could not be applied without risking skin breakdown due to ankle contractures. Resident 10 experienced harm when they had an avoidable decline in bilateral ROM when passive ROM was not implemented. This failure placed the residents at increased risk of decreased motion, contractures, decreased mobility and a diminished quality of life. Findings included . Review of a document titled, Resident Mobility and Range of Motion, undated, showed Residents would not experience an avoidable reduction in range of motion (ROM). Residents with limited range of motion will receive treatment and services to increase and/or prevent further decrease in ROM. Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. Resident 7 Resident 7 admitted to the facility on [DATE] with diagnoses of right foot drop, left foot drop unspecified, abnormalities of gait and mobility. The admission minimum data set assessment (MDS), an assessment tool, dated 09/21/2022, showed Resident 7 required extensive assistance with activities of daily living. Review of Resident 7's form titled Physical Therapy PT Evaluation, dated 11/15/2022, showed current reason for referral as Patient recently referred to physical therapy after receiving B dynamic Ankle Foot Orthotics (AFOs) for ankle contractures and needing to establish a wearing schedule. The evaluation showed Resident 7 had right ankle active range of motion (AROM) Dorsiflexion (flexing up) = -50 (-70) and left ankle AROM Dorsiflexion = -50 (-64). Short Term Goals were documented as follows: 1. Patient will establish wearing schedule of B dynamic AFOs for up to 2-3 hours a day in order to prevent worsening of B ankle contractures with a target date 11/29/2022. 2. Patient will be able to improve right ankle ROM to -50 degrees in order to allow for improved mobility and ankle ROM target date 11/29/2022. 3. Patient will be able to improve left ankle ROM to -44 degrees in order to allow for improved mobility and ankle ROM target date 11/29/2022. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Review of the form Physical Therapy PT Discharge Summary, signed 12/22/2022, showed Patient has demonstrated good progress in therapy. Patient has made small but steady improvements in ROM. Patient is now tolerating up to 2 hours a day of wearing dynamic AFOs. Documentation showed Resident 7's right ankle AROM improved to -60 and left ankle AROM improved to -54. The Discharge Recommendations and Status section showed, Discharge Recommendation= RNP (Restorative Nursing Program) and Prognosis to Maintain CLOF (current level of functioning) = Excellent with consistent staff support. Review of Resident 7's form titled Physical Therapy PT Evaluation, dated and signed 03/27/2024, showed current reason for referral as, Patient referred by nursing. The ROM section listed RLE (right lower extremity) ROM = Impaired (with chronic ankle contracture); LLE (left lower extremity) ROM = Impaired (with chronic ankle contracture). No new measurements were documented. The Assessment Summary showed, Patient is functioning at prior level which is SBA (standby assist) for transfers with the slide board. Patient does not need PT services at this time. Patient is however, concerned that nursing has not been donning (putting on) the Podus (brace for lower extremity disorders associated with trauma or immobility) on bilateral LE [lower extremities]. Patient's concern communicated to DOR (Director of Rehabilitation) and placed on communication board for nursing to address. Review of Resident 7's Care plan and Kardex on 08/22/2024, showed an intervention of Restorative Program Splint/brace assistance #1: See care plan/Kardex for program description. Review of the Resident 7's Restorative Program Splint/brace assistance flow sheets for July 2024 and August 2024, showed 27 days documented as Not Applicable. On 07/24/2024 and 07/26/2024 the EHR noted Resident 7 tolerated splint/brace assistance good for 15 minutes. Additionally, it was documented on 08/07/2024 that Resident 7 tolerated splint/brace assistance good for 10 minutes. Observation on 08/22/2024 at 9:44 AM, showed a pair of Ankle Foot Orthotics, Podus boots, under a table in Resident 7's room. During an interview on 08/22/2024 at 11:14 AM, Resident 7 stated they couldn't remember the last time they wore the Podus boots because nursing staff weren't putting them on. Resident 7 stated they believed they were losing feeling in their left foot and had told therapy staff in the past about the concern with nursing staff not applying them. Resident 7 stated they were not receiving any restorative services and had not done physical therapy since the beginning of the year. During an interview on 08/26/2024 at 9:02 AM, Staff Y, Certified Nursing Assistant (CNA), stated the Restorative Aides were the ones who did restorative with residents not CNA's. Staff Y stated if needed they could assist a resident with putting on brace or splint with the nurse's permission. During an interview on 08/26/2024 at 9:04 AM, Staff P, Licensed Practical Nurse (LPN), stated nurses are responsible for putting braces/splints on residents. Staff P stated they were unaware Resident 7 had AFO's. Staff P stated it was not on the resident's Treatment Administration Record. Review of Resident 7's form titled, Physical Therapy PT Evaluation, dated and signed 08/27/2024, showed, Assessment Summary as follows; Accurate measurements for planar ROM on bilateral ankles is not possible as reference points for measurements has shifted due to deformity. Patient donned the PRAFO [pressure relief ankle foot orthotics] on left foot to assess however due to club foot deformity said boots will only increase pressure on calf and toes which may cause skin integrity issues. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/26/2024 at 10:28 AM, Staff M, Physical Therapist, stated, the facility no longer did discharge recommendations to the RNP as they had been without a Restorative Aide since April 2024. Staff M stated Resident 7 had voiced concern about nursing staff not putting on the AFO's however Staff M was unaware if there was any follow-up. Staff M stated they were unable to obtain measurements of the resident's contractures and stated they could not determine if there was a decrease in ROM as it would require an x-ray. Review of a radiology report dated 08/28/2024 showed FINDINGS: The ossification was normal for the right and left foot, including the tarsal bones. There was mild degenerative joint disease seen. There was no fracture, dislocation, or soft tissue swelling. No osteomyelitis (bone inflammation) was seen. CONCLUSION: Mild degenerative joint disease. During an interview on 08/28/2024 at 9:20 AM, Staff B, Director of Nursing Services (DNS), stated although the restorative splint/brace assistance should have been discontinued when we no longer had restorative aides, there should have been an order for nursing staff to don the AFO's as directed. Staff B stated the expectation was that if a resident had a concern with lack of care, staff should have filed a grievance to ensue follow-up. Resident 10 Resident 10 readmitted to the facility on [DATE] with a diagnosis of paraplegia (the inability to voluntarily move the lower parts of the body/hips, legs, and feet) and was able to make needs known. Review of Resident 10's MDS, dated [DATE], showed that the resident had traumatic spinal cord dysfunction (damage to the spinal cord that blocks communication between the brain and the body), Hammer Toe(s) (a foot condition in which the toe has an abnormal bend in the middle joint) on both feet, contracture (shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement) on both feet, muscle weakness and depression. It showed that the resident had one day of occupational therapy on 09/15/2020 and physical therapy services that started on 09/15/2020 and ended 10/15/2020. Resident 10 was not on a restorative nursing program and was at risk for pressure ulcer injuries. Review of Resident 10's Occupational Therapy (OT) initial evaluation dated 09/15/2020 showed that the resident was referred to therapy to assess and update restorative nursing program (RNP) for maintenance of resident's strength and ROM. It showed that Resident 10 was dependent for functional mobility and lower body activities of daily living (ADLs) and required moderate assistance for upper body ADLs. It showed ROM for right upper extremity (limb of the body such as an arm) was impaired; left upper extremity was within functional limits; and right and left lower extremity were impaired (both knee contractures). It showed grip/strength [rating 0 to 5, with 0 = none and 5 = full strength] for right upper extremity was impaired (shoulder 3/5, wrist in moderate flexion [bent] contracture, poor grip strength); left upper extremity was impaired (shoulder, wrist, and elbow 4/5, poor grip strength); right/left lower extremity strength was impaired (paraplegia). Review of Resident 10's current care plan on 08/27/2024 showed no care plan for a restorative nursing program to maintain strength for the upper body parts and/or interventions to provide ROM to maintain available ROM to joints. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/22/2024 at 2:28 PM Resident 10 stated that they were paralyzed (incapable of movement) from the waist down and did not go to therapy or participate in a restorative nursing program. Resident 10 stated that staff would move their body parts upon request and had not been offered to be on a restorative program; however, they would like to be on a restorative program. Observation and interview on 08/28/2024 at 11:29 AM, showed Resident 10 lying in bed and had a right wrist contracture. Resident 10 stated they did not wear any braces or splints on their feet or right wrist/hand but, would be interested in participating in a restorative program to have their legs exercised. Resident 10 did not know if their mobility had maintained or declined. During an interview on 08/28/2024 at 8:08 AM Staff M, Physical Therapist, stated Resident 10 was last on physical therapy (PT) case load from 09/15/2020 - 10/15/2020. Staff M stated Resident 10's PT Discharge Summary dated 10/15/2020 showed measurements of ROM for Resident 10's lower body parts and Resident 10 was referred to a Restorative Nursing Program for a functional maintenance program (FMP). However, they were unable to locate any other subsequent measurements documented by therapy. Staff M stated that they were not sure if Resident 10 was on a restorative nursing program or not; however, the resident should have been receiving some type of passive range of motion (PROM, moving a joint for a person who is unable to move their own body part) to their right wrist and lower body parts, at least three times a week and/or as tolerated by the resident. Staff M stated that if Resident 10 had not been on a restorative program or receiving PROM, then the resident should be referred back to PT to see if there were any changes in their ROM/mobility. On 08/28/2024 at 9:20 AM, Staff B, Director of Nursing Services (DNS), stated when they had Restorative Aides, it was easier. Staff B said now Certified Nursing Assistant's (CNA) did range of motion, active and passive, and could apply braces/splints. Staff B stated they did not have orders for restorative services due to no Restorative Aides. Staff B stated they would discontinue orders for past restorative services due to staffing issues. Staff B the sprint/ brace assistance should have been discontinued. Staff B said the Podus boots should have been getting put on regardless of restorative staff availability and there should have been an order. During an interview on 08/28/2024 at 1:10 PM, Staff D, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated that physical therapy would be responsible to assess, measure contractures and joints with limited ROM, and maintain the documentation. Staff D stated they believed the measurements should be conducted every 90 days. Staff D stated they could not explain why Resident 10 was not on a restorative nursing program but probably should have been receiving restorative services. Staff D stated that without subsequent ROM measurements there was no way to ensure that care plan interventions were effective to maintain ROM and prevent further decline in ROM/mobility and this did not meet expectations. During an interview on 08/24/2024 at 2:16 PM, Staff B, Director of Nursing Services (DNS) stated they were unable to locate documentation of additional ROM/contracture measurements for Resident 10 and there should have been subsequent measurements taken after therapy's 2020 measurements. Staff B stated Resident 10 was not receiving restorative services and that the facility had not had a functioning restorative nursing program since 05/01/2024. Staff B stated Resident 10's care plan needed more interventions to prevent ROM decline and they should have been on a restorative program, and this did not meet expectations. A request was made to obtain and provide Resident 10's current ROM/contracture measurements. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Review of the measurements received on 08/30/2024 at 2:48 PM showed a decrease in the ROM from the measurements completed on 09/15/2020 compared to therapy evaluations completed on 08/28/2024 as follows: -Right knee flexion (bending) went from 120 degrees to -88 degrees. -Right ankle dorsiflexion went from -5 degrees to -7 degrees /plantar flexion (downward movement of the foot) went from 50 degrees to 39 degrees. -Left hip ROM abduction (leg move outward from center) and internal rotation (leg rotate inward) went from 110/70 to -30/5. -Left knee flexion went from 135 degrees to 84 degrees / extension went from -70 degrees to -60 degrees. -Left ankle dorsiflexion went from 120 degrees to 20 degrees / plantar flexion went from 30 degrees to 35 degrees. -Initial OT evaluation dated 09/15/2020 did not include hand/wrist measurements and the completed evaluations on 08/28/2024 did not include upper extremity strength to be able to compare and determine if there was a decline in ROM and strength for upper extremities. During an interview on 09/09/2024 at 9:15 AM Staff A, Administrator, was asked about two referrals to the Restorative Program, an OT eval on 09/15/2020 and a PT discharge summary on 10/15/2020. Staff A stated if Resident 10 was referred and staff were unable to locate documentation of follow through, then that did not meet his expectations. Staff A was asked about a lack of documentation for Resident 10's Restorative Nursing Program services and stated there should have been consistent follow up and documentation showing ROM measurements for contractures and mobility and that we were tracking the progression of Resident 10's contractures; this did not meet his expectations. Staff A said not following facility's policies and procedures for Resident Mobility and Range of Motion, did not meet expectations. When Staff A was asked if he thought the facility had followed the policy for Resident 10, Staff A said if there was no documentation that proved it was unavoidable then we didn't follow it. Staff A stated, I agree that we did not follow our policy. Staff A stated they were aware of not having a functioning Restorative Nursing Program since May 1st of 2024. Resident 85 Review showed Resident 85 admitted to the facility on [DATE] with diagnoses to include acquired absence of right leg above knee and muscle weakness. Resident 85 was able to make needs known. During an interview and observation on 08/22/2024 at 12:43 PM, Resident 85 stated they had a referral for a prosthetic leg and hand surgery from the hospital when they admitted to the facility. Observation showed that Resident 85 used a wheelchair, and one hand was contracted. Resident 85 stated he was unaware if the appointments had been made. Review of the EHR showed a document titled Hospital Document w/ H&P (pg 28).pdf, dated 05/13/2024, showed Resident 85 received a referral for a right prosthetic from their medical provider on 05/09/2024 (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Review of the EHR showed a document titled Ambulatory Referral to Hand Surgery, dated 05/16/2024, showed Resident 85 was referred to hand surgery for a Dupuytren contracture (a condition that causes the fingers to bend toward the palm of the hand). During an interview on 08/28/2024 at 1:38 PM, Staff N, Admission Nurse/Registered Nurse, stated hospital documentation was provided to the medical transporter to determine what referrals were needed after admitting to the facility. During an interview on 08/28/2024 at 1:57 PM, Staff D, RCM/LPN stated the admission nurse would review hospital documentation to determine what referrals were needed. Staff D stated Resident 85 had not had any follow-up on the referrals for hand surgery or a prosthesis. Staff D stated this did not meet the expectation. During an interview on 08/28/2024 at 2:31 PM, Staff B, DNS, stated the admission nurse should review the hospital documentation and inform the medical transporter what referrals were needed. Staff B stated Resident 85's lack of referral for hand surgery and prothesis did not meet expectation. 388-97-1060 (3)(d) 38344 40817

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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. 40817 Based on observation and interview, the facility failed to ensure resident spaces were free from accident hazards by not locking facility shower rooms where shaving supplies were stored for 3 of 4 sampled shower rooms (East A Hall, East B Hall and [NAME] C Hall) when reviewed for accidents. This failure placed residents at risk for accessing shaving supplies, increased injury risk, and a diminished quality of life. Findings included . Observations on 08/27/2024 and 08/28/2024 showed the East A Hall shower room was unsecured. Observation of the interior showed a plastic storage bin with shaving supplies and nail clippers. Observations on 08/22/2024 and 08/28/2024 showed the East B Hall shower room was unsecured and the door had signage to inform staff to keep the room locked. Observation of the interior showed a cabinet with a lock, which was unsecured, which contained two electric shavers and a razor. Observation on 08/26/2024 and 08/27/2024 showed the [NAME] C Hall shower room was unsecured and the door had signage to inform staff to keep the room locked. Observation of the interior showed shaving razors were accessible. During an interview on 08/28/2024 at 2:38 PM, Staff B, Director of Nursing Services, stated the expectation was the shower rooms would be kept locked, especially if shaving supplies were stored within. Staff B stated the observations of the shower rooms being unlocked did not meet the expectation. Reference WAC 388-97-1060 (3)(g)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on observation, interview, and record review the facility failed to have a clear system in place to monitor and accurately document fluids consumed to ensure fluid restrictions (a diet which limits the amount of daily fluid intake) was implemented per physician's orders and/or to monitor and address nutritional needs for 3 of 4 sampled residents (Residents 60, 92, and 67) reviewed for nutrition and/or dialysis (the process of removing excess water, waste, and toxins from the blood). These failures placed the residents at risk for medical complications, unmet needs, and a diminished quality of life. Findings included . <Fluid Restriction> Resident 60 Review of the electronic health record (EHR) showed that Resident 60 was readmitted to the facility on [DATE] with diagnoses that included heart failure, dementia (a group of thinking and social symptoms that interfere with daily functioning) and kidney failure. The resident was able to make needs known. Review of Resident 60's quarterly minimum data set assessment (MDS) dated [DATE] showed that the resident was on a therapeutic diet and received dialysis services. During an interview on 08/23/2024 at 9:13 AM, Resident 60 stated they were not sure if they were on fluid restrictions. Review of Resident 60's provider order dated 03/27/2024 showed to monitor daily fluid restriction of 1500 milliliters (ml) per 24 hours; dietary to provide 720 ml per 24 hours: breakfast 240 ml, Lunch 240 ml, dinner 240 ml; Nursing to provide 780 ml per 24 hours: day 300 ml, evening 300 ml, night 180 ml, every shift. Review of Resident 60's focused nutrition at risk care plan initiated on 03/02/2022 showed an intervention for staff to monitor daily fluid restriction of 1500 ml per 24 hours; dietary to provide 720 ml per 24 hours: breakfast 240 ml, Lunch 240 ml, dinner 240 ml; Nursing to provide 780 ml per 24 hours: day 300 ml, evening 300 ml, night 180 ml. per providers orders. During an interview on 08/26/2024 at 12:51 PM, Staff AA, Ceritified Nursing Assistant (CNA), stated they documented how much fluid a resident takes with each meal. Staff P, Licensed Practical Nurse (LPN) stated that for residents on fluid restrictions, they documented what was provided during medication administration pass only. During an interview on 08/26/2024 at 1:30 PM, Staff AA stated they were not able to document Resident 60's fluid intake in the computer system and should have been able to. Staff AA stated they would inform the nurse. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/26/2024 at 1:33 PM, Staff P stated they had not been documenting what the aids/nursing assistants gave during meals for residents on fluid restrictions because the aides should be able to document how much they gave for meals in the computer system. Staff P stated there should be a total tally at the end of a 24-hour period to know how much a resident on fluid restriction received; however, Resident 60 did not have total fluids in a 24-hour period documented. During an interview on 06/26/2024 at 1:56 PM, Staff D, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated Resident 60's fluids were not being documented for meals in the computer system and they should have been. Staff D stated that there must be a break in the system, and it needed to be fixed. During an interview on 08/26/2024 at 2:05 PM, Staff B, Director of Nursing Services (DNS), stated for residents on fluid restrictions, nurses should track what fluids were provided during medication administration. Staff B stated they did not know who documented fluids during meal service but thought it was the nursing assistants. After looking at Resident 60's EHR, Staff B stated they were unable to locate how much fluids were being provided during meals and there should have been. Staff B stated they needed to ensure to add documentation in the computer system for the nursing assistants to document fluid intake for meals for residents on fluid restrictions and that this did not meet expectations. Staff B stated there should have been total milliliters documented in a 24-hour period to ensure provider order for fluid restriction was being met; however, that did not happen for Resident 60 and should have. 46067 Resident 92 Resident 92 admitted to the facility on [DATE] with diagnoses of unspecified dementia, moderate with other behavioral disturbance and chronic kidney disease and was able to make needs known. During an interview on 08/23/2024 at 9:03 AM, CC3, Family Member, stated Resident 92 had lost weight since admission and was only drinking fluids and not eating for the past 2 weeks. CC3 stated Resident 92 had lost so much weight they were not able to fit their wedding ring. Review of Resident 92's care plan dated 06/19/2024 showed an intervention to Monitor intake at all meals, offer alternate choices as needed, alert dietitian and physician to any decline in intake. Review of the Meal task in the electronic health records showed lack of consistent documentation of amounts eaten for Resident 92. Review of the last 28 days showed 16 days with incomplete documentation and 11 days where staff documented amount eaten of all three meals. During an interview on 08/27/2024 at 9:15 AM, Staff FF, Certified Nursing Assistant (CNA) stated that Resident 93 usually only drinks milk and juice for meals however all three of the resident's meals should have been documented. Staff FF stated staff did not document right away because they did not have time. During an interview on 08/28/2024 at 9:13 AM, Staff B, DNS, stated staff should have documented all meals. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50945 Resident 67 Review of the EHR showed that Resident 67 was admitted on [DATE] with diagnoses that included protein-calorie malnutrition (not enough protein and calories being consumed, weakening the body), anorexia (fear of gaining weight leading to poor nutrition), and gastroesophageal reflux disease (the backflow of stomach acid). Review of the annual MDS, dated [DATE], showed Resident 67 was cognitively intact and able to make needs known. Resident 67 smoked cigarettes daily. Review of Resident 67's orders showed an order for a house supplement for weight stability and an order for ice cream with dinner for additional calories. Resident 67 also had an order for mirtazapine (an antidepressant that increases appetite) once a day, for poor appetite. Review of Resident 67's nutritional assessment, dated 02/27/2024, showed Resident 67 had a one-month significant weight loss of greater than 5%, caused by inadequate oral intake. The dietician requested a re-weight to confirm weight loss. Review of Resident 67's interdisciplinary team meeting, dated 02/27/2024, showed recommendations to reweight Resident 67 to confirm weight loss, and for weekly weights to be taken for 4 weeks. Review of the EHR showed the next weight was taken on 03/06/2024, over a week later. The following weight was obtained on 03/26/2024, almost three weeks later. Review of Resident 67's nutritional assessment, dated 05/10/2024, showed that the nutritional status for Resident 67 was based on a weight from 04/02/2024, over 5 weeks prior. The dietician noted that the BMI (body mass index, a tool for assessing healthy weight) was underweight for age and recommended an updated weight. The next weight was obtained on 06/28/2024, about 12 weeks after the last weight. During an interview on 08/23/2024, Resident 67 stated they had lost weight recently. Review of Resident 67's weights showed a weight of 126.8 pounds on 01/22/2024 and 118.6 pounds on 2/20/2024, which was identified as a significant weight loss during the nutritional assessment on 02/27/2024. Resident 67's weights showed the last weight was taken on 08/02/2024 at 114 pounds. Compared to the weight on 01/22/2024, the resident had lost 12.8 pounds. During an observation on 08/26/2024 at 12:37 PM, Resident 67's meal ticket on the tray stated, Send chocolate health shake. During multiple observations between 08/26/2024 and 08/28/2024, Resident 67 received house shakes in the strawberry flavor, and Resident 67 stated they would not eat them. All observations showed the strawberry house shakes were untouched by Resident 67. During an interview on 08/27/2024 at 2:00 PM, Staff K, Registered Dietician, stated that if a resident had a significant weight loss, they should have regular weights for four weeks, then the interdisciplinary team would reevaluate if the resident should be changed back to monthly or more frequently. Staff K stated they had not monitored the house shake intake for Resident 67. Staff K reviewed Resident 67's weights and stated that due to Resident 67's size, any weight loss was significant, and they need weekly weights again. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/27/2024 at 2:17 PM, Staff D, RCM/LPN, stated their expectation was for staff to get weights when the registered dietician requests one. Staff D stated no weights were done in December 2023 or May 2024, and that weekly weights (for four weeks) were not done after the 02/27/2024 interdisciplinary team meeting. During an interview on 08/27/2024 at 2:29 PM, Staff B, DNS, stated their expectation was that weights were to be taken at least once a month. Staff B's expectations were not met, by Resident 67 receiving strawberry house shake (instead of chocolate) and not consuming any of it. Staff B stated it did not meet expectations that an interdisciplinary meeting had not occurred since February 2024, due to Resident 67's weight loss. Reference WAC 388-97-1060 (3)(h)(i)

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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** 38344 Based on observation, interview and record review, the facility failed to provide respiratory care consistent with professional standards of practice for 2 of 6 sampled residents (Residents 60 and 78) reviewed for respiratory care. Failure to obtain and/or follow physician orders for oxygen (O2) therapy, care plan, ensure O2 tubing was appropriately maintained, regularly changed, and O2 concentrators (a device used for O2 therapy) filters (used to protect the resident from particulate matter) were cleaned and maintained routinely, placed residents at risk for unmet needs and potential negative outcomes. Findings included . Resident 60 Review of the electronic health record (EHR) showed that Resident 60 was readmitted to the facility on [DATE] with diagnoses that included heart failure, anxiety disorder, and kidney failure. The resident was able to make needs known. Review of Resident 60's quarterly minimum data set assessment (MDS) dated [DATE] showed that the resident received 02 therapy. Observation on 08/23/2024 at 9:20 AM showed Resident 60 receiving O2 set to 2 liters (L) per minute via a nasal canula (devise to deliver O2 through a tube into the nose) that was connected to an O2 concentrator in place. The tubing was not dated. Review of the physician order dated 02/20/2024 showed that Resident 60 was prescribed O2 therapy at 2 L per minute, every 24 hours as needed (PRN), to keep O2 saturation (sats, the amount of O2 circulating in the blood) above 90%. Review of Resident 60's current active care plan on 08/23/2024 showed no documentation of a care plan or an intervention for the use of O2 therapy. Observation on 08/26/2024 at 12:41 PM showed Resident 60 laid in bed with the head of the bed elevated and had O2 running at 2 L per O2 concentrator via nasal canula. Resident 60 stated that they received O2 therapy continuously. Review of Resident 60's August 2024 medication administration record (MAR) from 08/01/2024 - 08/26/2024 showed the physician order with a start date of 02/20/2024 for PRN O2 therapy and it showed no initials to show that O2 was provided (the MAR was blank for this physician order). This MAR had no other physician order 's regarding O2 therapy. Review of Resident 60's August 2024 Treatment Administration Record (TAR) from 08/01/2024 - 08/26/2024 showed no orders and/or documentation to check O2 sats, change O2 tubing or clean the O2 filter on the O2 concentrator for appropriate maintenance. (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 08/27/2024 at 10:16 AM, Staff P, Licensed Practical Nurse (LPN), stated Resident 60 received O2 therapy continuously to include during showers and when going to appointments out of the facility. Staff P stated that it looked like Resident 60's physician order for O2 was PRN but perhaps needed to be ordered continuously. Staff P stated that Resident 60 should have had an order to check O2 sats every day, every shift and an order to clean the O2 concentrator filter and Resident 60's O2 therapy documentation did not meet expectations. During an interview on 08/27/2024 at 11:14 AM Staff D, Resident Care Manager/Licensed Practical Nurse (RCM/LPN) stated that Resident 60 was missing the following O2 therapy physician order; monitor O2 sats and parameters of when to notify the provider, O2 tubing changes/replacement, and filter changes for the O2 concentrator. Staff D stated that Resident 60's use of O2 therapy had not been cared planned and should have been. Staff D stated that Resident 60's August 2024 MAR was missing documentation for the use of O2 for the entire month and there should have been documentation to show O2 was being provided. During an interview on 08/27/2024 at 11:42 AM, after reviewing Resident 60's EHR, Staff B, Director of Nursing Services (DNS), stated Resident 60's oxygen therapy care and services did not meet expectations. Resident 78 Review of the EHR showed that Resident 78 was readmitted to the facility on [DATE] with diagnoses that included heart failure and asthma (a persistent/chronic lung disease that makes breathing difficult). The resident was able to make needs known. Review of Resident 78's quarterly MDS dated [DATE] showed that the resident received 02 therapy. Observation and interview on 08/22/2024 at 11:56 AM, showed Resident 78's room with an O2 concentrator located near the bed with O2 tubing located in a bag; however, O2 was not being provided at this time. Resident 78 stated they had asthma and the O2 was there just in case they needed it. Review of Resident 78's EHR showed a provider Order dated 10/17/2023 for pulse oximetry (devise used to measure amount of O2 in the blood) every shift to keep oxygen sats greater than or equal to 90%. Additionally, it showed a provider order dated 08/22/2024 for O2 at 2 L per minute via nasal canula PRN for chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe) indication for asthma, congestive heart failure (CHF, a chronic condition in which the heart does not pump blood as well as it should). Review of the August 2024 MAR from 08/01/2024 - 08/26/2024 showed the order dated 08/22/2024 for O2 at L per minute via nasal canula PRN, documentation showed it was initialed every shift on 7a-3, 3p-1 and 11p-. Documentation showed initials by staff for all three shifts. This MAR further showed the order dated 10/17/2023 for Pulse oximetry was being documented as being completed every shift; however, did not show documentation of O2 sat results every day/every shift. (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 08/27/2024 at 11:24 AM, Staff D, RCM/LPN, stated Resident 78's 08/22/2024 oxygen physician order description showed it was a PRN order; however, was written as a continuous order and needed to be clarified with the provider. Staff D stated that Resident 78's August 2024 MAR for the 10/17/2023 pulse oximetry physician order did not have O2 sats documented or when to notify the provider and it should have. During an interview on 08/27/2024 at 11:54 AM, after reviewing Resident 78's EHR related to O2 therapy, Staff B, stated Resident 78's O2 therapy and documentation did not meet expectations. Reference WAC 388-97-1060 (3)(j)(vi)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on interview and record review, the facility failed to maintain a safe dialysis program for 2 of 2 sampled residents (Residents 308 and 60) when reviewed for dialysis. Failure to accurately document, care plan, and communicate with the dialysis provider placed residents at risk of not receiving dialysis care as ordered and a diminished quality of life. Findings included . Resident 308 Resident 308 admitted to the facility on [DATE] with diagnoses to include end stage renal disease (a condition where the kidneys are damaged and lose their ability to function normally) and dependence on renal dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). Resident 308 was able to make needs known. Review of provider's orders showed Resident 308 received dialysis on Tuesday, Thursday, and Saturday with a 3:00 PM pick-up time. Review of Resident 308's care plan, dated 08/09/2024, showed the resident received dialysis on Tuesday, Thursday, and Saturday with a 3:00 PM pick-up time and staff were instructed to send a communication book to dialysis with the resident and were to review the book upon the resident's return. Review of the dialysis binder for Resident 308 showed two communication forms dated 08/17/2024 and 08/19/2024. Review of the 08/17/2024 communication form showed the facility nurse did not complete the form in entirety upon Resident 308's return to the facility. Review of the 08/19/2024 communication form showed the dialysis provider did not complete their section of the form. No other communication forms were in the dialysis binder for Resident 308. Review of the electronic health record (EHR) showed a dialysis communication form for 08/15/2024. During an interview on 08/27/2024 at 12:06 PM, Resident 308 stated they went to dialysis on Monday, Wednesday, and Friday with a start time of 1:00 PM. Resident 308 stated they previously went on Tuesday, Thursday, and Saturday, but they had changed days and times after admitting to the facility. During an interview on 08/28/2024 at 2:06 PM, Staff D, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated dialysis communication forms should be completed and scanned into the EHR after each dialysis visit. Staff D stated if the dialysis provider does not complete the communication form, then facility staff should call to obtain the information and complete the communication form. Staff D stated the communication forms for 08/17/2024 and 08/19/2024 did not meet expectation because they were not completed in entirety. Staff D stated they were unaware Resident 308 had changed dialysis days/times and that the resident's care plan and orders did not meet expectation. During an interview on 08/28/2024 at 2:33 PM, Staff B, Director of Nursing Services (DNS), stated Resident 308's dialysis communication, orders and care plan did not meet expectation. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	38344 Resident 60 Resident 60 was readmitted to the facility on [DATE] with diagnoses that included heart failure, dementia (a group of thinking and social symptoms that interfere with daily functioning), end stage renal disease (ESRD) and dependence on renal dialysis. Resident 60 was able to make needs known. Review of Resident 60's provider orders showed the following: -Order dated 05/12/2024 showed the resident received dialysis on Tuesday, Thursday, and Saturday with a 12:50 PM pick-up time. It further showed, Transportation: ____ Phone number: ____ Nephrologists' name: ____Phone Number: _____. It showed blanks/incomplete for name of transportation and phone number, and the Nephrologists (medical doctor who specialize in the care of kidneys) name and phone number. -Order dated 05/16/2024 showed the dialysis communication records were to have documentation of dialysis access site (site used to receive dialysis), vital signs (VS, temperature, pulse, respirations, and blood pressure), bruit (sound of turbulent blood flow in an artery) and thrill (vibration felt at a dialysis access site) for AV [arteriovenous] shunt [fistula, a surgically created shunt that connects an artery to a vein in the artery of the arm] only, any new order from dialysis center, and if any PRNs (as needed) mediations administered prior to dialysis treatment on the dialysis record every day shift on Tuesday, Thursday, and Saturday. Resident 60 did not have an AV shunt but instead had a perma cath (a flexible tube placed into the blood vessel in the neck or upper chest and was threaded to the right side of the heart used for dialysis access) this order was inaccurate. -Order dated 02/16/2024 showed, Post Dialysis Communication Record: Document access site, VS, Bruit and Thrill for AV Shunt ONLY, Update any new order from Dialysis center. Verify Post dialysis weight is entered into [Facility's computer system] every evening shift every Tue, Thu, Sat. Resident 60 did not have an AV shunt, this order was inaccurate. -Order dated 02/16/2024 showed to provide, Calcium Acetate (a medication used for patients receiving dialysis) tablet 667 milligrams (mg) two tablets by mouth with meals for ESRD. -Order dated 06/01/2024 showed to Send Calcium Acetate Tab 667 mg with sack lunch to dialysis. One time a day every Tuesday, Thursday, Saturday and PRN for additional dialysis days. Review of Resident 60's focused care plan for impaired renal function initiated on 11/08/2022 had interventions dated 11/08/2022 that showed, dialysis to access perma cath to the right chest only and pick up around 2:30 PM from facility. The care plan's pick-up time from facility did not match the provider ordered pick up time of 12:50 PM, this was inaccurate information documented. Review of Resident 60's dialysis communication forms from 08/01/2024 through 08/22/2024 showed several incomplete forms with missing documentation by facility staff and dialysis center staff. It showed that on Friday 08/02/2024 and Wednesday 08/21/2024 Resident 60 went to dialysis; however, the communication forms did not show the resident was sent to dialysis with medications to take with meal. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 60's August 2024 medication administration record (MAR) for the order dated 06/01/2024 to Send Calcium Acetate Tab 667 mg with sack lunch to dialysis, PRN for additional dialysis days, showed no documentation (it was blank); however, the resident had gone to the dialysis center on Friday 08/02/2024 and Wednesday 08/21/2024. During an interview on 08/28/2024 at 12:36 PM, Staff D, RCM/LPN, stated Resident 60's provider order dated 05/12/2024 for dialysis services did not show name and phone number of the transportation service and did not show the name and number of the Nephrologist and this did not meet expectations. Staff D stated Resident 60's provider order for dialysis services showed that pick up time from the facility was 12:50 PM; however, Resident 60's care plan showed it was at around 2:30 PM and was inaccurate and needed to be revised. Staff D stated that 10 out of 12 dialysis communication forms from 08/10/2024 - 08/22/2024 for Resident 60 were not completely filled out and did not meet expectations. Staff D stated that Resident 60 went to dialysis on 08/02/2024 and 08/21/2024; however, the August 2024 MAR did not show documentation the resident was provided Calcium Acetate per provider's order and should have. Staff D stated that the provider orders dated 05/16/2024 for pre dialysis communication documentation and order dated 02/16/2024 for post dialysis communication documentation were inaccurate because it showed it was for AV shunt only and Resident 60 had a perma cath, and these orders needed to be clarified with the provider. During an interview on 08/28/2024 at 12:36 PM, after looking at Resident 60's EHR related to dialysis care and services, Staff B, DNS, stated Resident 60's dialysis services order, pre and post dialysis communication orders, dialysis communication forms documentation, August 2024 MAR's Calcium Acetate PRN medication documentation, and inaccurate care plan intervention for dialysis pick-up time did not meet expectations. Reference WAC 388-97-1900(1),(6)(a-c)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on interview and record review, the facility failed to act on the consultant pharmacist's Medication Regimen Review (MRR) recommendations for 2 of 5 sampled residents (Resident 83 and 460) reviewed for unnecessary medication use. Failure to act on the pharmacist's recommendations placed the residents at risk for experiencing adverse side effects, medical complications, and a decreased quality of life. Findings included . Resident 83 Review of Resident 83's electronic health record (EHR) showed the resident readmitted on [DATE] with diagnoses to included heart and lung disease, anxiety, depression and bipolar (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). The resident was able to make needs known. Review of the document titled, Consultant Report a pharmacist's medication regiment review, dated 06/01/2024 and 06/30/2024, showed that the pharmacist had noted Resident 83 had a recent fall and showed that they were prescribed multiple medications that may have contributed to it to include Norco (a medication used to treat moderate to moderately severe pain) to be administered as necessary every six hours and cyclobenzaprine (a medication used as a muscle relaxer) to be administered every eight hours. The pharmacist recommended on 06/18/2024 for the provider to consider reducing the cyclobenzaprine medication to every 12 hours and attempt non-pharmacological (NPI, i.e. massage, application of heat, offer food/fluids) interventions first prior to administering the Norco medication. The provider documented on 07/12/2024 that they re-evaluated the recommendations and for the Licensed Nurses (LNs) to decrease the cyclobenzaprine medication from every eight hours to every 12 hours. Review of Resident 83's medication regiment review (MRR) dated August 2024 showed that the cyclobenzaprine order remained on the MAR for LNs to continue to administer the medication every eight hours instead of every 12 hours as per the pharmacist recommendation and provider's order. During an interview on 08/28/2024 at 09:13 AM, Staff B, Director of Nursing Service (DNS) stated that it was their expectation that if the pharmacist made the recommendation to decrease to cyclobenzaprine order from every eight hours to every 12 hours and to implement NPI prior to administration of the Norco medication than the orders should have been changed. Resident 460 Review of the Medicare 5-day minimum data set assessment (MDS) on 08/23/2024 showed Resident 460 admitted to the facility 08/17/2024 with multiple diagnoses to include heart disease, diabetes, Alzheimer's disease (a brain disorder that gradually destroys memory and thinking skills), and dementia. The electronic health record (EHR) showed the resident's cognitive skills for decision making were moderately impaired. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 460's medication administration record (MAR) dated August 2024 showed that the provider had ordered quetiapine (a antipsychotic medication) on 08/17/2024 and that the LNs continued to administer the medication as ordered on the date of the MAR's review on 08/26/2024. During an interview on 08/27/2024 at 10:55 AM, Staff B, DNS stated they were unable to open the pharmacist report earlier but would contact the pharmacist to get a copy of their 08/21/2024 recommendation related to Resident 460. Review of a document received on 08/28/2024 at 10:56 AM, via email, titled, Consultant Report a pharmacist's medication regiment review, dated 08/01/2024 and 08/30/2024, showed that the pharmacist had documented on 08/21/2024 that Resident 460 had a provider's order to receive quetiapine, 25 milligrams (mgs) at bedtime for dementia with agitation. The pharmacist noted the resident was recently treated for a urinary tract infection (UTI) and that behavior monitoring of agitation alone was not appropriate to support antipsychotic therapy. The pharmacist recommended for an initial attempt at a gradual dose reduction (GDR) and to please reduce to 12.5 mg at bedtime for 5 days and stop. The document further showed that the provider had not conducted either to accept the pharmacist recommendation, accepted the recommendations with the following modifications or declined the recommendations and continue the used of the medication. During an interview on 08/28/2024 at 11:49 AM, Staff B, DNS stated that the pharmacist recommendation should have been provided to the provider and any pharmacist recommendation options implemented in a timely manner. Reference WAC 388-97-1300(4)(c)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148 Based on interview and record review the facility failed to offer nonpharmacological interventions (NPI, i.e. repositioning, massage, distractions prior to administering pain medications) for 4 of 5 sampled residents (Residents 458, 83, 308 and 20) when reviewed. The facility also failed to include the locations for topical pain medications and follow parameters for blood pressure medications for 1 of 5 residents (Resident 20) when reviewed for unnecessary medications. These failures placed the residents at risk for adverse side effects and a diminished quality of life. Findings included . Resident 458 Review of the electronic health record (EHR) showed Resident 458 admitted to the facility on [DATE] with a diagnosis of peripheral vascular disease and was receiving hospice services. Further review showed an order for oxycodone (a narcotic pain medication) every 3 hours as needed (PRN) for pain. Resident 458 received oxycodone multiple times between the dates of 08/09/2024 - 08/26/2024. During an interview and observation on 08/22/2024 at 10:24 AM, Resident 458 sat on the side of the bed with their legs resting on pillows on the floor. The resident stated they had a lot of pain and had to reposition frequently to help the pain. Record review showed an order for nurses to document NPI with a start date of 08/09/2024. There were no documented NPI attempted from 08/09/2024 to 08/26/2024. During an interview on 08/26/2024 at 10:33 AM, Staff Z, Registered Nurse (RN) stated nursing staff should try 2 NPI prior to giving a narcotic. Staff Z stated some residents have NPI attached to the narcotic order, and some do not. During an interview on 08/27/2024 at 1:39 PM, Staff B, Director of Nursing Services (DNS) stated it was their expectation that the nurses follow the policy and provide NPI prior to administering as needed pain medications. 34567 Resident 83 Review of Resident 83's EHR showed the resident readmitted on [DATE] with diagnoses to include heart and lung disease, anxiety, depression and bipolar (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). The MDS further showed that the resident was able to make needs known. During an observation and interview on 08/22/2024 at 10:01 AM, Resident 83 sat on the side of their bed. Resident 83 stated they took pain medication related to back issues. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 83's focus care plan dated 10/16/2023 showed the resident exhibited or was at risk for alterations in comfort related to chronic pain, lumbar (relating to the lower part of the back) fracture. Interventions included to medicate the resident as ordered for pain, monitor effectiveness and side effects. Additionally, staff were to assist the resident to a position of comfort, utilize pillows and appropriate positioning devices and to offer /encourage food and fluid of choice. Review of Resident 83's medication administration record (MAR) dated August 2024 showed a provider's order dated 07/19/2024 for Licensed Nurses (LNs) to administer pain medications as necessary to include ibuprofen (a medication used in the treatment of moderate inflammatory pain) 1 tablet every 24 hours as necessary for pain. An additional provider's order showed LNs were to administer Norco (a medication used to treat moderate to moderately severe pain) one tablet every six hours as needed for the treatment of pain. Furthermore, a provider's order dated 07/17/2024 showed LNs were to document non-pharmacological interventions to include the application of heat, repositioning, relaxation breathing, food/fluid, massage, exercise, immobilization of joint, or other and write (document) results as either effective (+), or ineffective (-). The MAR lacked documentation that NPI were applied prior to the administration of the pain medication throughout the month of August 2024. During an interview on 08/28/2024 at 9:13 AM, Staff B, DNS, stated that their expectation would be if the provider had ordered NPI than the LNs should document interventions prior to administration of pain medications. 40817 Resident 308 Resident 308 admitted to the facility on [DATE] with diagnoses to include pneumonia and chronic pain. Resident 308 was able to make needs known. Review of provider's orders on 08/27/2024 at 11:15 AM, showed an order for as needed (PRN) pain medication and an order to provide NPI. Review showed the order for NPI did not specify when they were to be provided. Review of the August 2024 MAR showed Resident 308 received PRN pain medications on three occasions and NPI were never provided. During an interview on 08/28/2024 at 2:11 PM, Staff D, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated the order for PRN pain medications should be attached to the order for NPI so staff were aware to provide NPI prior to the use of PRN pain medications. Staff D stated this did not occur for Resident 308 and this did not meet the expectation. During an interview on 08/28/2024 at 2:30 PM, Staff B, DNS, stated that the lack of NPI prior to the use of PRN pain medication did not meet the expectation. 50945 Resident 20 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 20's EHR showed the resident was admitted on [DATE] with diagnoses that included chronic kidney disease (gradual loss of kidney function) and chronic pain. Review of the annual MDS assessment, dated 07/31/2024, showed Resident 20 was able to make needs known. <Non-pharmacological Interventions> Review of Resident 20's orders showed an order to document non-pharmacological interventions and effectiveness, with a start date of 07/26/2024. Review of Resident 20's care plan showed an intervention, initiated on 09/25/2019, to monitor pain, to provide non-pharmacologic interventions and document their effectiveness. Review of Resident 20's EHR for August 2024, showed that they were receiving multiple doses of as needed pain medications without any non-pharmacological interventions documented. During an interview on 08/26/2024 at 10:39 AM, Staff D, RCM/LPN, stated that for August 2024, they could not see any non-pharmacological interventions documented for Resident 20, and their expectation was for staff to document. During an interview on 08/26/2024 at 10:52 AM, Staff B, DNS, stated they expect non-pharmacological interventions to be documented per policy, and that they would be offered anytime a resident reports pain. <Blood Pressure Parameters> Review of Resident 20's EHR providers orders showed an order for lisinopril (a medication used to treat high blood pressure), one time a day, and with an order for the LN to hold if the pulse was less than 60. Review of the MAR for August 2024 showed Resident 20 had multiple dates with a heart rate of less than 60 and the LN had documented that the lisinopril medication was administered. During an interview on 08/26/2024 at 10:39 AM, Staff D, RCM/LPN, stated that heart rate parameters were missed for the administration of lisinopril, for Resident 20, on the dates of 08/05/2024, 08/06/2024, 08/07/2024, 08/08/2024, 08/15/2024, 08/16/2024, 08/22/2024, and 08/23/2024. During an interview on 08/26/2024 at 10:52 AM, Staff B, DNS, stated that Resident 20 received lisinopril outside of heart rate parameters, multiple times in August 2024. Staff B stated their expectation was for nursing to follow parameters for medication administration. <External Medication> Review of Resident 20's orders showed an order for a lidocaine patch (local numbing agent), to be applied to the affected area once a day for pain. Resident 20 also had an order for diclofenac gel (decreases pain and inflammation), to be applied to the affected area every 6 hours as needed for pain. During an interview on 08/26/2024 at 10:39 AM, Staff D, RCM/LPN, stated a medicated lotion or cream would need a specific location for application, in the order. Staff D stated the orders for the lidocaine patch and the diclofenac gel do not have a location specified, and that they should. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/26/2024 at 10:52 AM, Staff B, DNS, stated the facility had not been consistent with making sure orders had a location specified, and that Resident 20's should be specified in the order. Reference WAC 388-97-1060 (3)(k)(i)

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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** 34567 Based on observation, interview and record review, the facility failed to ensure monitoring of potential adverse side effects (ASE) related to the use of psychoactive (used for the treatment of certain mental health conditions) medications for 2 of 5 sampled residents (Resident's 460, and 25) and ensure an appropriate diagnosis was in place prior to the administration of an antipsychotic medication for 1 of 5 sampled residents (Resident 460) reviewed for unnecessary medication use. These failures placed the residents at risk for adverse side effects and medical complications and unmet needs. Findings included . Review of a document titled, Psychotropic Medication Use, July 2022, showed residents will not receive medications that were not clinically indicated to treat a specific condition. Additionally, psychotropic medication management included indications for use, adequate monitoring for efficacy and adverse consequences; and preventing, identifying and responding to adverse consequences. Furthermore, residents who have not used psychotropic medications were not to be prescribed or to be administered these medications unless the medication was determined to be necessary to treat a specific condition that was diagnosed and documented in the medical record. Resident 460 Review of the Medicare 5-day minimum data set assessment (MDS) on 08/23/2024 showed Resident 460 admitted to the facility 08/17/2024 with multiple diagnoses to include heart disease, diabetes, Alzheimer's (a brain disorder that gradually destroys memory and thinking skills), and dementia. The electronic health record (EHR) showed the residents cognitive skills for decision making were moderately impaired. Review of Resident 460's MAR dated August 2024 showed that the provider had ordered quetiapine (an antipsychotic medication used to treat several types of mental health conditions) on 08/17/2024 and that the licensed nurses (LNs) continued to administer the medication as ordered on the date of the MAR's review on 08/26/2024. Review of a document titled, Consultant Report showed a pharmacist's medication regiment review, dated 08/01/2024 and 08/30/2024, documented Resident 460 had a provider's order to receive quetiapine, for dementia with agitation; however, the pharmacist noted the resident was recently treated for a urinary tract infection (UTI) and that behavior monitoring of agitation alone was not appropriate to support antipsychotic therapy. The pharmacist recommended for an initial attempt at a gradual dose reduction (GDR) and to reduce to the medication for 5 days and stop. The document further showed that the provider had not conducted either to accept the pharmacist recommendation, and/or accepted the recommendations with the following modifications or declined the recommendations or continue the used of the medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/27/2024 at 2:33 PM, Staff C, Director of Social Services, (DSS), stated the quetiapine medication needed to have a defined psychotic disorder and not just dementia with agitation. Review of Resident 460's treatment administration record (TAR) for August 2024 showed LNs were to monitor the resident for side effects related to antipsychotic medication use of the medication quetiapine to include monitoring hypotension. Review of Resident 460's electronic health record (EHR) showed a provider's order dated 08/17/2024 for licensed nurses (LNs) to obtain orthostatic blood pressures on the 15th of each month. The medication administration record (MAR) for August 2024 showed no orthostatic blood pressure was obtained During an interview on 08/27/2024 at 11:09 AM, Staff D, Licensed Practical Nurse (LPN) stated that the orthostatic blood pressures should have been obtained from Resident 460 prior to the administration of the antipsychotic medication quetiapine. During an interview on 08/28/2024 at 11:49 AM, Staff B, DNS stated that the pharmacist recommendation related to Resident 460's antipsychotic medication quetiapine should have been updated per the pharmacist recommendation. 49926 Resident 25 Review of the Electronic Health Record (EHR) showed Resident 25 was admitted to the facility on [DATE] with multiple diagnoses to include retention of urine, depression and heart failure. Resident 25 was able to make needs known. Review of providers orders showed Resident 25 was received Seroquel (an antipsychotic medication) every day at bedtime for Insomnia (persistent problems falling asleep or staying asleep) with a starting date of 06/24/2024. Review of Pharmacy Consultation report for June of 2024, showed a recommendation on 06/08/2024 to reduce the Seroquel dose to half and discontinue using it within five days after. Review of Resident 25's provider orders showed an order dated 06/14/2024 for Seroquel to give 12.5 milligrams at bedtime for 5 days. Review of Resident 25's provider orders showed a Seroquel order for insomnia on 06/24/2024 without any documentation and evaluation about the cause of insomnia. Review of the EHR on 08/27/2024 showed no documentation about monitoring hours of sleep. During an interview on 08/28/2024 at 8:20 AM, Staff D, RCM/LPN stated that Seroquel should have had monitors for hours of sleep, and should have been reviewed for gradual dose reduction. During an interview on 08/28/2024 at 9:44 AM, Staff B, DNS stated the expectation was for antipsychotic medications to have correct monitors for effectiveness. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference WAC 388-97-1060(3)(k)(i)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49926 Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than five percent. A total of two errors were made out of twenty seven opportunities during medication administration for 1 of 5 sampled residents (Resident 465) reviewed for medication administration. This placed the residents at risk for receiving medications that were not effective or less effective and a diminished quality of life. Findings included . During a medication administration observation on 08/26/2024 at 9:38 AM, Staff BB, Licensed Practical Nurse (LPN), prepared and administered seven medications including simethicone (medicine for flatulence) and diphenhyd-lidocaine-nystatin suspension (medication that treats fungal infection in mouth) to Resident 465. Review on 08/26/2024 at 10:00 AM of the providers orders for Resident 465, showed an order for simethicone and diphenhyd-lidocaine-nystatin suspension with specific times to be administered at 8:00AM. During an interview on 08/26/2024 at 11:50 AM, Staff B, Director of Nursing Services, stated the expectation is for nurses to follow orders including the correct time of administration, and this did not meet expectations. Reference WAC 388-97-1060 (3)(k)(ii)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on observation, interview, and record review, the facility failed to provide dental services to ensure residents could eat and drink for 1 of 4 sampled residents (Resident 308) reviewed for dental. This failure placed residents at risk of discomfort while eating, diminished nutritional intake, and a diminished quality of life. Findings included . Resident 308 admitted to the facility on [DATE] with diagnoses to include pneumonia and chronic pain. Resident 308 was able to make needs known and was a Medicare participant. During an interview and observation on 08/22/2024 at 1:42 PM, Resident 308 stated they had no natural teeth, they used dentures, the dentures were at their home, and they had difficulty eating because they did not have their dentures. Observation showed Resident 308 had no natural teeth. Review of a minimum data set assessment, dated 08/15/2024, showed Resident 308 had no natural teeth or had fragments of teeth. Review of the care plan, dated 08/09/2024, showed Resident 308 had a nutritional intake issue, but did not indicate the resident had missing teeth, used dentures, or had difficulty eating because of the lack of dentures. Review of an oral health evaluation, dated 08/09/2024, showed Resident 308 had their own teeth which were healthy, did not use a denture, and had no oral health issues. During an interview on 08/28/2024 at 1:41 PM, Staff N, Admission Nurse/Register Nurse, stated that they created Resident 308's care plan and the resident had no dental issues. Staff N stated if Resident 308 had missing teeth/dentures they would be referred to speech therapy for assessment. Staff N stated Resident 308 had not told anyone about difficulty eating, so they were not assisted with dental services. Staff N stated they had never included information about dentures on a care plan. During an interview on 08/28/2024 at 2:03 PM, Staff D, Resident Care Manager/Licensed Practical Nurse, stated Resident 308 had their own teeth or used a denture. Staff D stated residents were assessed on admission for dental status and the care plan was updated. Staff D stated Resident 308's oral assessment and care plan was inaccurate. During an interview on 08/28/2024 at 2:35 PM, Staff B, Director of Nursing Services, stated Resident 308's oral assessment, care plan, and lack of dental services did not meet expectation. Reference WAC 388-97-1060 (1), (3)(j)(vii)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on interview and record review, the facility failed to assist residents with obtaining routine dental care for 1 of 4 sampled residents (Resident 67) reviewed for dental care. This failure placed residents at increased risk of pain, nutritional concerns, and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed that Resident 67 was admitted on [DATE] with diagnoses that included protein-calorie malnutrition (not enough protein and calories being consumed, weakening the body), and gastroesophageal reflux disease (the backflow of stomach acid). Review of the annual minimum data set assessment (MDS), dated [DATE], showed Resident 67 was able to make needs known. Resident 67 smoked cigarettes daily. Review of Resident 67's care plan, initiated on 06/01/2022, showed the resident was at risk for dental care problems, with instructions to obtain a dental consult and/or referral as needed/ordered. Resident 67 had previously been seen by Sound Dental Care in 2023, with no documentation provided of any visits with them after 06/06/2023. Review of the EHR showed Resident 67 had an oral health evaluation on 09/19/2023 that stated they had 1-3 decayed or broken teeth. Review of a communication to the provider dated 02/19/2024 stated the resident was having trouble chewing related to missing upper teeth. Review of Resident's 67's dental referral, dated 02/27/2024, stated the referral was due to trouble chewing and due to missing teeth. During an interview on 08/23/2024 at 9:22 AM, Resident 67 stated they were waiting to see a dentist for dental concerns, as it was challenging to eat due to pain. During an interview on 08/27/2024 at 8:47 AM, Staff C, Social Services Director, stated they were unaware of why Resident 67 had not had a dental appointment, and that they would follow up. During a follow up interview on 08/27/2024 at 12:15 PM, Staff C stated they just called the referral office, and the referral office does not have a referral at this time. Staff C stated that this did not meet their expectations, as the referral was placed in February, and it is now August. During an interview on 08/27/2024 at 2:27 PM, Staff D, Resident Care Manager/Licensed Practical Nurse, stated their expectation was that the facility would follow through on Resident 67's dental referral. During an interview on 08/27/2024 at 2:52 PM, Staff B, Director of Nursing Services, stated that it did not meet their expectations that Resident 67 had been waiting since February for dental care. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97-1060 (1), (3)(j)(vii)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 40817 Based on observation, interview, and record review, the facility failed to follow the posted menu for 1 of 1 tray line observation (Lunch) when reviewed for kitchen. This failure placed residents at risk of lack of nutritional intake, unintended weight loss, decline in condition, and a diminished quality of life. Findings included . During an interview on 08/22/2024 at 1:41 PM, Resident 62 stated half the items on the menu were not received. Review of the facility menu for lunch on 08/26/2024 showed one cup of macaroni with ham would be served at lunch. Observation and interview on 08/26/2024 at 11:42 AM showed staff serving a single scoop of macaroni with ham using a scoop with a grey handle. Review of the wall posted Scoop Guide showed a grey spoon was one half cup. During an interview on 08/26/2024 at 11:55 AM, Staff R, Dietary Manager, stated the grey scoop was a half a cup and the server should be providing two scoops. Review of the resident council minutes, dated 06/17/2024, showed a section for Food and Nutrition which showed 1 of 14 residents had a concern of the menu not being followed, and 4 of 14 residents had concerns about the menu being changed suddenly. Review of the resident council minutes, dated 08/19/2024, showed residents wanted real-time notification of menu changes. During an interview on 08/28/2024 at 12:50 PM, Staff R stated the facility ensured resident's received sufficient nutritional intake by developing the menu in consultation with a registered dietician team. Staff R stated the menu needed to be followed to ensure resident's received sufficient nutritional intake. Staff R stated the server had used the wrong scoop during meal service on 08/26/2024 and some residents received a half portion of the main course. Staff R stated this did not meet the expectation. During an interview on 08/28/2024 at 1:09 PM, Staff A, Administrator, stated the facility ensured residents received adequate nutritional intake by following the registered dietician developed menus. Staff A stated the menu should be followed. Reference WAC 388-97-1160 (1)(a)(b)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 40817 Based on observation, interview, and record review, the facility failed to provide palatable food served at appetizing temperatures for 6 of 22 sampled residents (Residents 68, 7, 93, 20, 10, 62) and failed to resolve resident council grievances regarding unpalatable food for 3 of 3 months (June, July, and August 2024) when reviewed for palatable food. This failure placed residents at risk of lack of nutritional intake, unintended weight loss, decline in condition, and a diminished quality of life. Findings included . During an interview on 08/22/2024 at 10:16 AM, Resident 68 stated the food was usually cold. During an interview on 08/22/2024 at 11:13 AM, Resident 7 stated the facility food was bland and often arrived cold. Resident 7 stated they had their daughter bring them food because they did not like the facility's food. During an interview on 08/22/2024 at 11:46 AM, Resident 93 stated the facility food was always cold and they frequently did not receive lunch until 3:00 PM. During an interview on 08/22/2024 at 1:02 PM, Resident 20 stated they did not like the smell, taste or texture of the facility food and only ate sandwiches as a result. Resident 20 stated the facility offered alternative foods, but everything provided was unappetizing. During an interview on 08/22/2024 at 1:06 PM, Resident 10 stated the facility food tasted bland and processed. During an interview on 08/27/2024 at 1:40 PM, Resident 62 stated the facility food was terrible quality. Resident 62 stated they attended food council meeting, but nothing had improved in two years. Observation on 08/26/2024 at 11:31 AM showed the food for lunch had been prepared and was waiting on the tray line. Observation and interview on 08/26/2024 at 11:42 AM showed staff serving a main dish of macaroni with ham, spinach, and a roll with alternate options of a chicken breast or pork chop. Observation showed that the rolls had fallen, were flat, and were approximately one inch tall. Staff R, Dietary Manager, stated the rolls were cooked while connected and frequently fell after being broken apart. Observation showed that the spinach was flaccid and soggy. Observation showed that the macaroni was scooped into a mound and served, resembling a scoop of ice cream. Observation on 08/26/2024 at 12:07 PM showed staff produce a new pan of baked rolls which were round and approximately 3 inches tall. Observation showed staff began pulling apart the rolls by hand and the rolls began to fall and flatten. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 08/26/2024 at 12:34 PM showed the tray line ran out of spinach. Observation showed staff took a white bag, placed it in a microwave in a container of water, and began to microwave it. Staff R stated the bag contained new spinach. Observation on 08/26/2024 at 12:53 PM (1 hour and 22 minutes after tray service started) showed that the chicken breast and pork chops had become dry, and the macaroni had congealed. Observation showed the staff removed a white bag from the microwave, cut a corner off, and drained spinach into a compartment of the steam table. Observation showed the spinach was flaccid and soggy. Observation on 08/26/2024 at 1:14 PM showed the last resident tray was served (1 hour 43 minutes after tray service started). A test tray was requested with macaroni, spinach, chicken breast, and a roll, which was prepared and placed by staff on top of the serving cart. Observation on 08/26/2024 at 1:15 PM showed the serving cart with the test tray arrived on the resident hall. Observation at 1:26 PM showed staff start to pass resident trays and did not close the serving cart doors between residents. Observation at 1:40 PM showed that the last resident tray was delivered (2 hours and 9 minutes after tray service began). Observation on 08/26/2024 at 1:43 PM showed the roll had fallen and did not look appealing on the plate. Observation showed the macaroni was served in two yellow mounds, was congealed, and it was not readily apparent it was macaroni. Observation showed the spinach was served in a small bowl and appeared flaccid and soggy. Observation showed this meal did not appear appetizing. Continued observation showed the test tray items had the following temperatures: macaroni - 115 Fahrenheit (F), chicken breast - 115 F, and spinach - 110 F. Observation showed the provided test tray temperatures were lukewarm and not appetizing. Continued observation showed the macaroni had congealed, the noodles lacked texture, and it felt mushy when eating. Observation showed the chicken breast was dry, lacked flavor or sauce, and came apart similarly to stringed cheese. Observation showed the spinach lacked seasoning and had a mushy and slimy mouth feeling. Observation showed the provided test tray was not palatable. Observation on 08/28/2024 at 12:04 PM, 12:21 PM, and 12:38 PM showed trays being transported on top of different serving carts during meal service. Review of the resident council minutes, dated 06/17/2024, showed a section for Old Minutes which showed Food is overcooked sometimes. (Working on). Review of New Minutes showed 3 of 14 residents had concerns with the food not being hot. Review of the resident council minutes, dated 07/15/2024, showed 13 of 13 residents had concerns with the breakfast eggs being overcooked. Review of the resident council minutes, dated 08/19/2024, showed residents had concerns with the juice being watered down. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/28/2024 at 12:50 PM, Staff R stated the facility ensured residents found the meals palatable by conducting resident interviews and having a monthly food council meeting. Staff R stated food trays should not be stored on top of serving carts as this would affect food temperatures. Staff R stated staff passing food trays should close the doors and not doing so could affect the temperature of the food items. During an interview on 08/28/2024 at 1:09 PM, Staff A, Administrator, stated the facility ensured residents found the food palatable through resident interviews, resident council, and test trays. Staff A stated residents should not receive food two hours after preparation and resident council's concerns regarding food quality and temperature should have been resolved. Reference WAC 388-97-1100 (1), (2)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 40817 Based on observation, interview, and record review, the facility failed to honor resident food preferences for 4 of 22 sampled residents (Residents 62, 67, 87, and 8) when reviewed for food preferences. This failure placed residents at risk of lack of nutritional intake, unintended weight loss, decline in condition, and a diminished quality of life. Findings included . During an interview on 08/22/2024 at 1:41 PM, Resident 62 stated fresh fruit was not available daily, and half the items on the menu were not received. During an interview on 08/23/2024 at 8:52 AM, Resident 67 stated the alternative meals were grilled cheese and hamburger. Resident 67 stated they were tired of the alternatives, so there were no real alternatives. Resident 67 stated they requested fresh fruit but only occasionally received them. Observation on 08/27/2024 at 1:38 PM showed Resident 67's menu tray card had a preference for chocolate protein shakes, but the resident was provided with strawberry. During an interview on 08/27/2024 at 1:04 PM, Staff T, Certified Nursing Assistant, stated they had just returned from returning three resident food trays to the kitchen because the residents were not satisfied. Staff T stated the food trays were often missing requested items and preferences were often ignored. Staff T stated Resident 87's tray card stated they did not want milk but would receive milk with every meal. During an interview on 08/27/2024 at 1:16 PM, Resident 87 stated they did not like milk, their tray menu indicated to not provide milk, and the facility provided them with milk every meal. Observation on 08/28/2024 at 12:25 PM showed Resident 8 in bed with a meal tray with sliced cabbage and a meal card which indicated the resident ordered green beans. During an interview on 08/28/2024 at 12:28 PM, Staff U, Activity Director, stated Resident 8 had received the wrong vegetable. During an interview on 08/28/2024 at 12:43 PM, Staff P, Licensed Practical Nurse, stated many of the kitchen trays needed to go back to the kitchen because they were inaccurate or missing items. Review of the resident council minutes, dated 06/17/2024, showed a section for Food and Nutrition which showed 10 of 14 residents wanted an alternate to eggs in the mornings and 3 of 14 wanted more fresh fruit. Review of the resident council minutes, dated 07/15/2024, showed residents complained of not receiving a menu on one Friday during the previous month and were not able to order alternate foods. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/28/2024 at 12:50 PM, Staff R, Dietary Manager, stated that resident preferences were assessed on admission and quarterly and were printed on the resident's meal ticket to ensure the residents received their preferred foods. During an interview on 08/28/2024 at 1:09 PM, Staff A, Administrator, stated the facility ensured that residents received preferred foods by conducting interviews and printing preferences on tray cards. Staff A stated residents should receive preferences per their tray cards. Reference WAC 388-97-1120 (2)(a), -1100(1), -1140 (6)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40817 Based on observation, interview, and record review, the facility failed to prepare and store food safely for 1 of 2 kitchen observations and failed to monitor resident food refrigerators for 2 of 2 sampled refrigerators (East and West). These failures placed residents at risk of consuming tainted food, foodborne illness, discomfort, and a diminished quality of life. Findings included . Observation on 08/26/2024 showed two cans of food (butterscotch pudding and cut sweet potato) were stored on the canned food shelf and had dents in the cans stored in dry storage. Observation and interview on 08/26/2024 at 12:34 PM showed the tray line ran out of spinach. Observation showed staff took a white bag, placed it in a microwave in a container of water, and began to microwave it. Staff R stated the bag contained new spinach. Observation on 08/26/2024 at 12:47 PM and 1:01 PM showed Staff S, Dietary Aid, performed hand hygiene and turned the water off with their bare hands. Review on 08/28/2024 showed the East Hall resident refrigerator had a temperature log showing an acceptable range of 36 Fahrenheit (F) to 46 F and did not contain a monitor for the freezer. Review showed the refrigerator was above a temperature of 40 F on 28 of 28 days. Review on 08/28/2024 showed the [NAME] Hall resident refrigerator had a temperature log showing an acceptable range of 36 F to 46 F. Review showed an area with Room Temperature printed, which was crossed out and handwritten was Freezer. Review showed the refrigerator was above a temperature of 40 F on 5 of 28 days and the freezer was above 0 F on 11 of 28 days. During an interview on 08/28/2024 at 12:50 PM, Staff R, Dietary Manager, stated the facility followed the Food Code to ensure that food products remained safe to eat. Staff R stated the nursing staff were responsible for monitoring the temperatures in the resident refrigerators. Staff R stated the temperature logs used to monitor the resident refrigerators on East and [NAME] Halls were not for food, and food should remain between 33 F and 40 F. Staff R stated the monitoring of the temperature for the resident refrigerators did not meet expectation. In continued interview, Staff R stated during hand hygiene, staff should take a paper towel, dry their hands, then use that paper towel to turn off the faucet. Staff R stated Staff S's hand hygiene process did not meet expectation. Staff R stated dented food cans could be contaminated and should not be used. Staff R stated the two dented cans on the canned food shelf did not meet expectation. During an interview on 08/28/2024 at 1:09 PM, Staff A, Administrator, stated the facility ensured resident food was safe and sanitary by following the Food Code. Staff A stated Staff S's hand hygiene, dented cans on can shelf, and resident refrigerator temperature monitoring did not meet expectation. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference WAC 388-97-1100 (3), -2980

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on interview and record review, the facility failed to provide or obtain the required specialized rehabilitative services for 1 of 2 sampled residents (Resident 67) reviewed for rehabilitation. This failure placed the residents at a risk for decreased activities of daily living (ADL), decreased range of motion, preventable pain, and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 67 was admitted on [DATE] with multiple diagnoses that included difficulty in walking, reduced mobility, dependence on a wheelchair, monoplegia of upper limb following a cerebral infarction affecting the right dominant side (paralysis of one limb caused by a stroke), osteoarthritis (joint pain and stiffness), and chronic obstructive pulmonary disease (chronic lung disease making it difficult to breath). The annual minimum data set assessment (MDS), dated [DATE], showed Resident 67 was able to make needs know, had constant pain, and was not receiving occupational therapy (OT) or physical therapy (PT) at that time. Care areas triggered on the MDS included activities of daily living functional/rehabilitation potential. Review of Resident 67's care plan for ADLs, initiated on 06/01/2022, showed the resident was to receive PT/OT treatment as ordered by provider. During an interview on 08/23/2024 at 9:10 AM, Resident 67 stated they needed both physical and occupational therapy. Resident 67 was observed to be wearing braces on both hands and stated the right wrist/hand brace was to avoid contractures and the left-hand brace was needed due to using the wheelchair with that hand. Review of OT visits from 11/17/2023 - 01/19/2024, showed Resident 67 received 3 evaluations and 5 treatment visits. Review of Resident 67's discharge summary, with a discharge date listed as 01/19/2024, showed discharge diagnoses of weakness, pain, decreased BADLS (basic activities of daily living), and hemiplegia (one sided weakness) of the right upper extremity. Review of a neurology referral, dated 04/03/2024, showed Resident 67 needed PT. Record review for Resident 67 showed no appointments for PT therapy in or outside of the facility. Review of an order, placed on 05/07/2024, showed another OT evaluation and treatment was requested. An evaluation was done on 06/23/2024, and Resident 67 had 2 treatment visits. During an interview on 08/28/2024 at 10:25 AM, Staff L, Director of Rehabilitation Services, stated they would not comment on Resident 67's appointments or PT referral. Staff L stated that for referrals made by providers outside of the facility, that their expectation was for the nursing staff to contact the provider to get an order in the system. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/28/2024 at 10:41 AM, Staff B, Director of Nursing Services, stated their expectation regarding rehabilitative services was that the department would have evaluated the resident, made a treatment plan, and then followed the treatment plan. Staff B stated the frequency of documented OT visits for Resident 67 did not meet expectations. Staff B stated that for referrals from outside providers, their expectation was for staff to either coordinate transportation or to place an order for the facility's PT department. Staff B stated they did not see a PT order in their system, and that PT had not seen Resident 67. Staff B stated that it did not meet expectations that the referral was placed in April, and it now was August and they had not arranged PT services. Reference WAC 388-97-1280 (1)(a-b), (3)(a-b)

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. 46067 Based on interview and record review, the facility failed to have a written transfer agreement with at least one area hospital approved for participation in Medicare/Medicaid programs. This failure placed residents at risk for delayed transfers and timely admissions to the hospital when medically appropriate. Findings included . Review of facility documentation on 09/09/2024 related to written transfer agreements showed no documentation of a transfer agreement with a local hospital and/or documented attempts to establish a transfer agreement. During an interview on 09/09/2024 at 2:36 PM, Staff A, Administrator, stated they were unable to provide any documentation related to hospital transfer agreements. Reference WAC 388-97-1620 (6)(a)

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. 40817 Based on interview and record review, the facility failed to employ a qualified social worker when reviewed for qualifications of social worker. This failure placed residents at risk of not having access to medically related social services, inability to coordinate care, and a diminished quality of life. Findings included . Review of the facility's daily census report provided on 08/22/2024 at 10:13 AM showed that the facility had 145 available beds. During an interview on 09/09/2024 at 9:30 AM, Staff C, Director of Social Services, stated they did not hold a bachelor's degree. Staff C stated they were aware of the requirement for a facility with greater than 120 beds to employ a qualified social worker, the facility had over 120 beds, and the facility did not employ a qualified social worker. During an interview on 09/09/2024 at 9:43 AM, Staff A, Administrator, stated they were aware of the requirement for a facility with greater than 120 beds to employ a qualified social worker, the facility had 147 beds, and the facility did not employ a qualified social worker. Staff A stated the lack of qualified social worker did not meet expectation. Reference WAC 388-97-0960 (2)(a)(b)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 38344 Based on interview and record review, the facility failed to ensure that the Quality Assessment and Performance Improvement (QAPI) program self-identified deficiencies and failed to develop/implement effective plans of action to sustain plan of corrections for previous deficiencies. Failure to have an effectively functioning QAPI program that consistently self-identified deficient practices led to repeated deficiencies, a pattern of deficiencies, widespread deficiencies, and a pattern of actual harm that placed residents at repeated risk for unmet needs that could negatively impact their safety, quality of life and quality of care. Findings included . During an interview on 08/28/2024 at 4:23 PM, when asked if they had reviewed the [NAME] report (a report with previously cited deficiencies) to identify any repeat deficiencies that needed to be addressed, Staff A, Administrator, stated, Yes, but they had only been in the facility since July 2024 so was unable to speak to last year's survey. When asked if they thought the QAPI process was effective, Staff A stated, Not currently, no. Staff A stated that the QAPI process needed to be looked at and addressed and reevaluated for its effectiveness. Although the facility conducted QAPI meetings, the facility failed to self-identify deficiencies, identify that they did not sustain corrections of previously identified deficiencies, and/or make timely revisions to previous action plans to ensure corrections were sustained. Refer to the following citations identified during survey which were not identified, were identified and not addressed, or had ineffective plans of correction to sustain correction by the QAPI program which led to repeated deficiencies, pattern or widespread of deficiencies, and a pattern of harm. (D = Isolated, E = Pattern, F = Widespread, and H = Pattern of harm): REFER TO F584 (E) Safe/Clean/Comfortable/Homelike Environment: Previous deficiency dated 12/2018 (E), 01/2020 (D), and 10/27/2023 (E). REFER TO F610 (E) Investigate/prevent/correct Alleged Violation: Previous deficiency dated 10/27/2023 (E). REFER TO F625 (D) Notice Of Bed Hold Policy Before/upon Transfer: Previous deficiency dated 10/27/2023 (D). REFER TO F641 (E) Accuracy Of Assessments: Previous deficiency dated 12/2018 (D), 11/2022 (D), and 10/27/2023 (E). REFER TO F645 (E) (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Pre-admission Screening and Resident Review: Previous deficiency dated 10/27/2023 (D). REFER TO F657 (E) Care Plan Timing and Revision: Previous deficiency dated 10/27/2023 (D). REFER TO F658 (D) Services Provided Meet Professional Standards: Previous deficiency dated 10/27/2023 (D). REFER TO F684 (E) Quality Of Care: Previous deficiency dated 10/27/2023 (D). REFER TO 686 (D) Treatment and Services to Prevent and Heal Pressure Ulcers: Previous deficiency dated 10/27/2023 (D). REFER TO F688 (H) Increase/prevent Decrease in range of motion (ROM)/mobility: Previous deficiency dated 10/27/2023 (D). REFER TO F689 (E) Free of Accident Hazards/Supervision/Devices: Previous deficiency dated 12/2018 (D), 01/2020 (E), 11/2022 (D), and 10/27/2023 (E). REFER TO F692 (D) Nutrition/Hydration Status Maintenance: Previous deficiency dated 12/2018 (D), 01/2020 (D), and 10/27/2023 (D). REFER TO F698 (E) Dialysis. REFER TO F756 (D) Drug Regimen Review, Report Irregularities, Act on pharmacist recommendations: Previous deficiency dated 10/27/2023 (D). REFER TO F757 (E) Drug Regimen Is Free from Unnecessary Drugs: Previous deficiency dated 10/27/2023 (D). REFER TO F758 (E) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505093	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Park Health Care & Rehab Center	4755 South 48th Tacoma, WA 98409

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Free from Unnecessary Psychotropic Medications/as need (PRN) use: Previous deficiency dated 12/2018 (D), 01/2020 (D), and 10/27/2023 (D). REFER TO F759 (D) Free of Medication Error Rates 5 Percent or More: Previous deficiency dated 10/27/2023 (E). REFER TO F803 (E) Menus Meet Resident Needs/prep in Advance/followed. REFER TO F804 (D) Nutritive Value/appear, Palatable/prefer Temperature: Previous deficiency dated 11/2022 (E) and 10/27/2023 (E). REFER TO F812 (E) Food Procurement, store/prepare/serve-Sanitary: Previous deficiency dated 10/27/2023 (F). REFER TO F843(F) Hospital Transfer Agreement REFER TO F850 (F) Qualifications of the Social Worker REFER TO F865 (E) Quality Assurance and Performance Improvement (QAPI) Program/Plan, Disclosure/Good Faith Attempt. REFER TO F880 (E) Infection Prevention and Control. Reference WAC 388-97-1760(1)(2)

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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 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** 46148 Based on observations, interviews and record reviews the facility failed to implement transmission-based precautions for 5 of 22 residents (Residents 6, 458, 358, 466 and 93) also the facility failed to ensure staff followed current infection control guidelines for cleaning and disinfecting of the washing machines during use. These failures placed the residents at an increased risk for infections and a decreased quality of life. Findings included . Review of the facility document titled Enhanced Standard/Barrier Precautions undated, showed enhanced standard/barrier precautions referred to the use of a gown and gloves for use during high contact resident care activities for residents known to be colonized or infected with a multi drug resistant organism (MDRO) as well as those at an increased risk of MDRO acquisition (e.g., residents with wounds or indwelling devices). <Enhanced Barrier Precautions> Resident 6 Review of resident 6's electronic health record (EHR) showed the resident admitted on [DATE] with a diagnosis of obstructive uropathy (difficulty passing urine) and required an Indwelling catheter (a tube placed into the bladder to drain urine). Further review showed an order for Enhanced Barrier Precautions (EBP) related to an O/A [open area] and F/C [foley catheter] Observations on 08/22/2024 at 12:13 PM, 08/23/2024 at 09:45 AM and 08/26/2024 at 09:43 AM showed Resident 6 with no sign outside the door for EBP and no isolation cart for personal protective equipment (PPE) by the door. During an interview on 08/26/2024 at 09:43 AM, When asked if staff wore a gown when handling their catheter, Resident 6 stated, No. Resident 458 Review of Resident 458's EHR showed the resident admitted on [DATE] and had multiple wounds to include a vascular wound to the left lower leg and a pressure injury to the left ischium (sitting bone). Further review showed an order for enhanced Barrier Precautions related to an O/A to sacrum and left foot gangrene. Observations on 08/22/2024 and 08/23/2024 showed no sign outside the door for enhanced barrier precautions and no isolation cart for PPE by the door. Resident 358 Review of Resident 358's EHR showed the resident readmitted to the facility on [DATE] with pressure injury wounds to buttocks and left heel that required treatments. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 06/22/2024, 08/23/2024 and 08/26/2024 showed no sign outside the door for EBP and no isolation cart for PPE by the door. <Contact precautions> Resident 466 Review of Resident 466's EHR showed the resident admitted on [DATE] with a diagnosis of urinary tract infection (UTI). Further review showed an order for contact precautions related to ESBL (an MDRO) in urine. Observation on 08/27/2024 at 08:06 AM showed Resident 466 laid in bed, there was an isolation sign outside the door for contact precautions. The directions showed to put on a gown and gloves when entering the room. During an observation on 08/27/2024 at 08:12 AM, Staff Y, CNA, was observed entering Resident 466's room, Staff Y did not stop and put on the required PPE of a gown and gloves prior to entering the room. Upon exiting the room, Staff Y stated they did not know the resident was on contact precautions. Resident 93 Review of Resident 93's EHR showed the resident readmitted on [DATE] with a diagnosis of UTI. Further review showed an order dated 08/11/2024 for contact precautions for UTI with ESBL. Observation on 08/22/2024 at 08:45 AM showed a sign on Resident 93's door for contact precautions. The directions showed to put on a gown and gloves when entering the room. During an observation on 08/22/2024 at 12:10 PM, Staff X, Certified Nursing Assistant (CNA), entered Resident 93's room without putting on PPE and delivered a meal tray, assisted the resident to sit up in the bed, then set up the resident's lunch tray on the overbed table. During an interview on 08/26/2024 at 9:21 AM, Staff X stated it was their understanding that for resident on contact precautions they would only put on PPE when providing toileting hygiene. Staff X also stated for enhanced barrier precautions they would put on a gown and gloves before entering the room. During an interview on 08/26/2024 at 3:52 PM, Staff T, CNA, stated that for residents on contact precautions they would put on a gown and gloves when contacting the patient. During an interview on 08/26/2024 at11:48 AM, Staff V, Licensed practical nurse/infection preventionist (LPN/IP) stated it was their expectation that staff follow the precaution signs that are posted. Staff V also stated that all residents who have an open wound or an indwelling device such as a foley catheter required enhanced barrier precautions. Staff V stated they were on leave and the isolation precautions were not done correctly while they were gone and should have been. <Laundry services> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 08/26/2024 at 2:19 PM, Staff W, Laundry aide, was observed loading soiled isolation gowns into two washing machines. The front of both machines and the rubber gaskets were visibly soiled. Staff W stated they did not wipe down the front of the machines and gaskets after loading or before removing the linens. During an interview on 08/26/2024 at11:48 AM, Staff V, LPN/IP stated it was their expectation that laundry staff sanitize the fronts of the machines to include the gaskets between each load. Staff V further stated that they were aware laundry staff were not sanitizing between loads and had provided them education on it. During an interview on 08/27/2024 at 10:06 AM, Staff B, Director of Nursing Services (DNS) stated it was their expectation that isolation precautions be implemented as required and that staff follow the signs posted. Staff B also stated washing machines should have been sanitized between loads as per the manufacturer's guidelines. Reference WAC 388-97-1320 (2)(b), 1320 (3)