STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505098	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shuksan Rehabilitation and Health Care	1530 James Street Bellingham, WA 98225

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on interview and record review the facility failed to immediately report to the state agency potential abuse/neglect of 1 of 4 residents (Resident 10) reviewed for accidents. Failure to report potential allegations of abuse and/or neglect placed residents at risk for unidentified abuse, and therefore, continued mistreatment and a poor quality of life. Findings included . According to the Nursing Home Guidelines - The Purple Book, sixth edition, dated October 2015, showed Individual mandated reporters must immediately report to the Department's hotline when there is a reasonable cause to believe an incident is abuse, neglect, abandonment, mistreatment, substantial injuries of unknown source, should be reported to the Department of Social Health Services (DSHS) Hotline number, logged within five days and Police or 911 called. Examples of substantial injuries may include, but are not limited to, the following: Abrasions, burns, deep lacerations, bruises of deep color and depth, or those occurring in areas not generally vulnerable to trauma, such as the back, face, head, neck. Review of the facility's policy titled, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property dated 09/21/2022 showed all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (hereafter referred to as abuse) will be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will be reported. RESIDENT 10 Resident 10 was admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], showed the resident had significant cognitive impairment and had falls since their prior assessment on 01/17/2025. Review of a progress note on 12/25/2025 at 6:00 PM showed Resident 10 was added to alert charting for potential alleged neglect and delay in care. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 10's Activities of Daily Living (ADL) care plan initiated on 10/06/2021 showed the resident required supervision/touching assistance of one staff for toileting and directed staff to ensure supervision while the resident was on the toilet related to their cognitive deficits and the resident not remembering they needed assistance. Review of a facility investigation dated 03/16/2025 showed at 1:05 AM, the nurse found Resident 10 laying on their right side in front of the toilet with one hand on their forehead with a small pool of blood under their head. Resident 10 had sustained a 2-inch laceration in the middle of their forehead and exhibited labored breathing, occasional moans or groans, sad, frightened frown and facial grimacing. Resident 10 could not tell the staff what occurred. Predisposing factors on the investigation included poor lighting, and the resident was confused, drowsy, and had impaired memory and gait imbalance. The other information included was that the resident had transferred to the toilet without assistance. Review of a statement from Staff M, Nursing Assistant Certified (NAC) assigned to Resident 10 showed they had last observed the resident sitting on the toilet at 12:50 AM then 10 minutes later the resident was found on the floor with a significant injury. The fall had been unwitnessed. Staff M, NAC documented they did not provide supervision as directed in the resident's care plan. Review of the facility's state reporting log showed this allegation of potential neglect was not documented as reported to the state hotline. The injury type documented on the log was lac but did not indicate the injury as substantial, as it was a S10-deep laceration and S20 in an area not generally vulnerable to trauma. In an interview on 05/01/2025 at 9:01 AM, Staff I Registered Nurse stated they would call Staff A, Administrator for direction on if they should call the hotline. In an interview on 05/01/2025 at 9:49 AM, Staff H, Licensed Practical Nurse stated the expectation was that they report head laceration injuries to the state hotline. During an interview on 05/01/2025 at 10:31 AM, Staff A, Administrator stated the facility staff were to notify the state hotline of abuse and neglect allegations. Refer to F610 Develop/Investigate/Prevent/Correct Abuse/Neglect Reference WAC 388-97-0640(6)(c)

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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** 36787 Based on interview and record review, the facility failed to conduct thorough investigations for 4 of 6 residents (Residents 5, 6, 10 and 27) reviewed for accidents and potential abuse or neglect. The failure to conduct complete and thorough investigations placed residents at risk for repeat incidents, injury, and lack of appropriate corrective action on the part of the facility. Findings included . Review of chapter two of the Nursing Home Guidelines, sixth edition, dated October 2015 showed that A thorough investigation was 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 .The investigation should end with the identification of who was involved in the incident, and what, when, where, why, and how the incident happened, including the probable or reasonable cause. It should also allow the nursing home to determine if the allegations were true or not true. Review of the facility policy titled, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property, dated 09/21/2022, showed the facility had a policy in place which addressed the components and systems for completion of investigations per the regulatory requirements. <RESIDENT 5> Resident 5 admitted [DATE] with diagnoses to include Alzheimer's dementia. According to the Minimum Data Set (MDS-, an assessment tool) assessment dated [DATE], the resident had moderate cognitive impairment. Review of a fall investigation dated 12/07/2024 at 1:00 PM, documented Resident 5 was found on the floor on their left side with a goose egg/hematoma to their left temple. Resident 5 stated they were getting rid of flowers and picking up flower pedals in the bathroom and fell . The investigation showed the facility staff did not know when the resident had last received toileting, repositioning or fluids. There was no statement from the Nursing Assistant Certified (NAC) assigned to care for Resident 5 that shift included in the investigation. The post fall monitoring included with the investigation showed there was no monitoring completed on 12/08/2024 or 12/10/2024 on AM shift. The incident that occurred on 12/07/2025 at 1:00 PM, was logged on the state reporting log two days late on 12/13/2025. The injury type was coded under the substantial injury section as S15, bruises of deep color and depth. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to include witness statements from all staff witnesses involved. The statements that were obtained were not thorough. The statements did not provide information regarding staff implementation of care planned interventions. There was no documentation regarding follow-up related to the resident's transfer or toileting status. There was no evidence of comprehensive review of the situation and no summary of who, what, where, when, and how of the incident to provide a reasonable or probable cause, how the situation may have been avoided, or any appropriate corrective actions needed. <RESIDENT 6> Resident 6 admitted [DATE] with diagnoses which included Multiple Sclerosis, stroke with hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) affecting their right dominant side and severe vascular dementia. Review of Resident 6's MDS assessment on 04/09/2025 showed they had significant cognitive impairment. Review of Resident 6's fall care plan showed they had experienced three falls (08/19/2024, 01/19/2025 and 01/31/2025) from sliding out of their wheelchair. <01/19/2025 fall> Record review of a facility incident investigation dated 01/19/2025 at 1:53 PM, showed Resident 6 was receiving a hair cut from their sister when their wheelchair rolled back, hit a trunk behind them and caused them to slide from the chair. The investigation failed to include witness statements from the NAC assigned to care for Resident 6. The statements that were obtained were not thorough. The statements did not provide information regarding inspection of the wheelchair and/ or wheelchair brakes, the environment where the fall occurred, or staff implementation of care planned interventions. There was no evidence of comprehensive review of the situation or how the situation may have been avoided, or any appropriate corrective actions needed to prevent reoccurrence. <01/31/2025 fall> Review of a facility incident investigation dated 01/31/2025 at 6:35 PM documented Resident 6 slid out of and was sitting on the floor in front of their wheelchair. Other information included was that the resident exhibited no awareness of sliding down and they were unable to reposition or readjust themselves without staff assistance. Review of a statement by Staff N, NAC dated 01/31/2025 documented the incident involving Resident 6 occurred in the dining room at 6:35 PM. Staff N documented they last observed the resident sitting in their chair slightly slumped over at 5:45 PM. The investigation showed no evidence positioning was a factor in the fall. The statements did not provide information regarding staff implementation of care planned interventions. There was no documentation regarding follow-up related to the resident's positioning or wheelchair status. There was no evidence of comprehensive review of the situation and how the situation may have been avoided, or any appropriate corrective actions needed. <RESIDENT 10> (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 10 was admitted to the facility on [DATE]. Review of the quarterly MDS assessment dated [DATE] showed the resident had significant cognitive impairment and had falls since their prior assessment on 01/17/2025. Review of the incident investigation for 12/25/2024 showed Staff O, former Director of Nursing Services (DNS), received a report from Staff A, Administrator, that a complaint was submitted that Resident 10 may not have received care and support in a timely manner. Staff O documented they spoke with Staff I and asked them to write a statement as to what occurred the day prior. Staff O directed Staff P, Registered Nurse (RN) to assess Resident 10. There was no witness statements attached. It was unclear what the allegation was or what Resident 10 had stated or alleged. Review of a progress note on 12/24/2024 at 6:00 PM showed Resident 10 was added to alert charting for potential alleged neglect and delay in care. Review of a progress note on 12/25/2024 at 6:58 PM, did not include any details about the allegation nor an assessment of Resident 10. The facility failed to include witness statements from all staff involved. There was no information about what the allegation was about. There was no assessment of the resident for injury. There was no evidence of a comprehensive review of the situation and no summary of the who, what, where, when, and how of the incident to provide a reasonable or probable cause, how the situation may have been avoided, or any appropriate corrective actions needed, or any staff identified to be involved in the allegation. <FALLS> <11/02/2024 fall> Review of a fall investigation on 11/02/2024 at 9:37 AM, showed the resident was found on the floor in their room. The report did not include the residents' statement about the event. The attached statements did not include when the resident had last been checked on or received care including toileting. The investigation did not include how the incident occurred or how the fall may have been avoided, or any appropriate corrective actions needed. Details of the care plan including whether the care plan was followed were not included. <03/16/2025 fall> Review Resident 10's Activities of Daily Living (ADL) care plan initiated on 10/06/2021 showed Resident 10 required supervision/touching assistance of one staff for toileting and directed staff to ensure supervision while the resident was on the toilet related to their cognitive deficits and they did not remember they needed assistance. (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 a facility investigation on 03/16/2025 showed at 1:00 AM, the nurse found Resident 10 laying on their right side in front of the toilet with one hand on their forehead with a small pool of blood under their head. Resident 10 had sustained a 2-inch laceration in the middle of their forehead and exhibited labored breathing, occasional moans or groans, sad, frightened frown and facial grimacing. Resident 10 could not tell the staff what occurred. Predisposing factors on the investigation included poor lighting, and the resident was confused, drowsy, and had impaired memory and gait imbalance. The other information included was that the resident had transferred to the toilet without assistance. Review of a statement from Staff M, NAC assigned to Resident 10 showed they had last observed Resident 10 sitting on the toilet at 12:50 AM then 10 minutes later the resident was found on the floor with a significant injury. The fall had been unwitnessed. Staff M, NAC documented they did not provide supervision as directed in the resident's care plan. The facility investigation did not identify or address that the care plan was not followed by staff at the time of the fall. The facility did not include how the situation may have been avoided, or any appropriate corrective actions needed or education with involved staff identified to be involved in the allegation. The post fall monitor attached was missing 03/16/2025 at 7:45 AM, 11:45 AM, 3:45 PM and 7:45 PM as well as 03/17/2025, 03/18/2025 and 03/19/2025. In an interview on 05/01/2025 at 9:01 AM, Staff I Registered Nurse stated if a resident had a fall, they would gather the incident report packet and complete the packet including witness statements. Staff I stated for allegations of abuse or neglect, they would talk with the residents to see if it was a true allegation then they would report to Staff A or the DNS. In an interview on 05/01/2025 at 9:49 AM, Staff H, Licensed Practical Nurse stated the expectation was the nurses report falls and allegations in risk management and start getting statements from staff who saw it or worked with the residents then the DNS completed the investigation. In an interview on 05/01/2025 at 10:31 AM, Staff A, Administrator stated the incident investigation process included the nurses starting the investigation, including obtaining statements from staff, and a summary of what happened. Staff A stated if the allegation is abuse or neglect it should include interviews with other residents and they would review. <MEDICATION ERROR> <RESIDENT 7> Review of Resident 7's physician's orders dated 12/08/2024 documented an order for Alendronate (medication to treat osteoporosis) 70mg once per week on Monday at 5:00 AM. Review of Resident 7's physician's orders dated 04/08/2025 showed a duplicate order was entered for Alendronate 70mg per week on Sunday at 7:00 AM to treat osteoporosis. Review of the Medication Administration Record for the month of April 2025 showed signatures for both doses of Alendronate signed as given: Sundays at 7:00 AM on 04/06/2025, 04/13/2025 and 04/20/2025. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Mondays at 5:00 AM on 04/07/2025, 04/14/2025 and 04/21/2025. In an interview on 04/25/2025 at 12:43 PM, Staff F, Resident Care Manager, stated they were not aware of the duplicate order and would discontinue it. Staff F stated they thought the system would alert them to duplication and the pharmacy should catch that when it was ordered. Review of the facility medication error report dated 04/25/2025 showed the investigation did not include verification from the pharmacy regarding the number of tablets sent. The statements from nurses showed the resident may not have received all the documented doses, yet there was no further follow-up. The investigation failed to include the root cause or determine how the systems allowed for a duplicate order to be entered without the system, or pharmacy creating an alert. Refer to WAC 388-97-0640 (6)(a-c)

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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** 36787 Based on observation, interview and record review, the facility failed to ensure that 4 of 5 residents (Residents 6, 10, 15 and 28) reviewed for Pre-Admission Screening and Resident Review (PASRR) assessments, were accurately completed prior to or upon admission to facility, or updated if resident's conditions change. This failure placed residents at risk of not receiving timely and necessary mental health services, and decreased quality of life. Findings included . Review of the facility policy titled, PASRR undated showed that all new admissions and readmissions are screened for mental disorders (MD). Intellectual disabilities (ID) or related disorder (RD) per the Medicaid Pre-Admission PASRR process. The social worker is responsible for making referrals to the appropriate state-designated authority. <RESIDENT 6> Resident 6 admitted to the facility on [DATE] with diagnoses to include major depressive disorder. Review of the quarterly Minimum Data Set (MDS - an assessment tool) assessment, dated 04/09/2025, showed the resident was being treated with an antidepressant medication and there were indications for the use. Review of the clinical record showed there was no PASRR completed preadmission as required. Review of Resident 6's Level 1 Pre-Admission Screening and Resident Review (PASRR) was dated 01/30/2024, 12 days after admission. The PASRR showed the resident had a mood disorder. <RESIDENT 10> Resident 10 admitted to the facility on [DATE] with diagnoses to include moderate dementia with psychotic disturbance, depression and anxiety. Review of Resident 10's Level I PASRR dated 10/06/2021 showed mood disorder and anxiety disorder were selected but psychotic or delusional disorder was not selected. The PASRR showed no level II was required with additional comments that the resident had a diagnosis of depression, anxiety and Alzheimer's dementia and symptoms appeared to be well managed with Seroquel (anti-psychotic medication) every night, Citalopram (anti-depressant) daily and Memantine (cognitive enhancer) twice daily. The inaccurate PASRR was not revised upon admission. <RESIDENT 15> Resident 15 admitted to the facility on [DATE] with diagnoses to include major depressive disorder. Review of the quarterly MDS assessment, dated 04/22/2025, showed the resident exhibited hallucinations and delusions. Resident 15 was being treated with an antipsychotic and antidepressant medications. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record showed there was no PASRR completed preadmission as required. Review of Resident 15's Level 1 PASRR was dated 01/16/2025 at the facility rather than preadmission. The PASRR showed the resident had a mood disorder. Review of a progress note on 01/30/2025 at 11:51 PM showed the resident was experiencing delusions and hallucinations. The resident was having conversations with people that are not there and stated there were swarms of bugs in the room and the walls were moving. The PASRR was not revised when Resident 10 began experiencing hallucinations and delusions. In an interview on 04/28/2025 at 12:39 PM, Staff G, Social Services/Admissions stated Resident 10 transferred from a local Assisted Living Facility (ALF) without a PASRR. Staff G stated they felt the resident needed to be admitted that day, so they completed the PASRR on admit. Staff G stated they attempted to call the ALF for a PASRR, but no one responded. Staff G stated the resident had delusions and they were worse since admission. In an interview and observation on 04/24/2025 at 12:57 PM, Resident 15 stated they had misconstrued things and had been having delusions. The resident stated they thought they were naked in a wheelchair on 44th street in Seattle when they were going to the Huskies game. The residents stated multiple staff were with them and they were asking them if they needed to be changed. 51312 <Resident 28> Resident 28 was a long-term resident at the facility. According to the significant change MDS dated [DATE], Resident 28 was severely cognitively impaired. During record review on 04/24/2025, Resident 28's PASRR documented that Resident 28 was positive for depression but not for a level II evaluation. Instructions on PASRR require staff to send PASRR for level II eval if the positive box was checked. During an interview on 04/29/2025 at 1:49 PM, Staff G stated that they were responsible for ensuring PASRR accuracy. Staff G indicated that their hire date was in August and expressed uncertainty regarding the correctness of the PASRRs. Upon reviewing Resident 28's PASRR, Staff G stated that it had not been completed correctly. In an interview on 05/01/2025 at 10:31 AM, Staff A, Administrator stated they were unsure what happened with Resident 6 and 15 being admitted without Level I PASRR's. Staff A stated they knew Level I PASRR's were required preadmission. Staff A stated Staff G was responsible for the admission process and all PASRR related tasks including revisions for inaccurate PASRR's. Reference WAC 388-97-1915(1)(2)(a-c)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on interview and record review the facility failed to ensure care plans were revised as required for 2 of 5 residents (Resident 10 and 15) reviewed for psychotropic medication review. This failure had the potential to impact staff knowledge of resident needs, placing resident's at risk for decreased quality of care and negative outcomes. Findings included . According to the Resident Assessment Instrument (RAI) manual, dated October 2024 showed the RAI helps nursing home staff gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. It also assists staff with evaluating goal achievement and revising care plans accordingly by enabling the nursing home to track changes in the resident's status. As the process of problem identification is integrated with sound clinical interventions, the care plan becomes each resident's unique path toward achieving or maintaining his or her highest practical level of well-being. The focus of the psychotropic care plan/goals of therapy include maximizing the resident's functional potential and well-being, while minimizing the hazards associated with medication side effects. <RESIDENT 10> Resident 10 admitted to the facility on [DATE] with diagnoses to include moderate dementia with psychotic disturbance, depression and anxiety. Review of Resident 10's care plan revised 03/15/2023 showed the resident used an anti-anxiety medication Clonazepam related to anxiety disorder. The care plan for 10/18/2021 showed the resident was taking Citalopram for depression. The care plan had two interventions listed for each care plan. One was to administer the medication as ordered and to monitor, document and report any adverse effects. The care plans did not include symptoms the resident was experiencing, resident goals, nor non-pharmacological interventions. <RESIDENT 15> Resident 15 admitted to the facility on [DATE] with diagnoses to include major depressive disorder. Review of the quarterly MDS assessment, dated 04/22/2025, showed the resident exhibited hallucinations and delusions. Resident 15 was being treated with an antipsychotic and antidepressant medications. Review of a progress note on 01/30/2025 at 11:51 PM showed the resident was experiencing delusions and hallucinations. The resident was having conversations with people that are not there and stated there were swarms of bugs in the room and the walls were moving. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 15's care plan initiated 01/21/2025 showed the resident was receiving three anti-depressant medications (Effexor, Wellbutrin, and Duloxetine) for depression. The care plan for psychotropic medication Seroquel for behavior management was initiated on 01/21/2025. Each care plan had two interventions listed for each care plan. One was to administer the medication as ordered and to monitor, document and report any adverse effects. The care plans did not include symptoms the resident was experiencing, resident goals, nor non-pharmacological interventions. In an interview on 05/01/2025 at 10:31 AM, Staff A, Administrator, stated they were aware of care planning issues, and they had begun working on them. They stated the expectation was that care plans were correct and revised when needed. Reference WAC 388-97-1020(2)(c)(d)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on interviews and record review, the facility failed to ensure 1 of 7 sampled staff (Staff EE) had an active professional Nursing Assistant Certification (NAC). Findings included . Review of Staff EE's employment record showed they were hired on [DATE] as an NAC. Review of the NAC certification in Staff EE's employee record dated [DATE] showed it had expired on [DATE]. Review of the staff roster provided on [DATE] showed Staff EE was an NAC. Review of the website Washington State Provider Credential Search on [DATE] showed Staff EE's, NAC certification expired as of [DATE]. Review of Staff EE's timecard showed they had worked at the facility on the following dates, without a certification: [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE], [DATE], and [DATE]. In an interview on [DATE] at 10:12 AM Staff L, Business Office manager, stated Staff EE was hired on their birthday and their certification was active when they were hired. Staff L stated they failed to follow up to ensure Staff EE had gotten their certification current. Staff L stated they had taken Staff EE off the schedule when they realized their certification was still expired. Staff L stated they had a process in place in which they audit licenses monthly, but the audit had not been completed yet. Staff L stated Staff EE was removed from the schedule once they found their certification was expired. In an interview on [DATE] at 1:06 PM Staff B, Interim Director of Nursing Services, stated they expected the NAC's working at the facility to be certified and current in their certification. Reference WAC [DATE] (1)(a)

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	505098	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on interview and record review the facility failed to thoroughly provide professional standards of care and services for 3 of 5 residents (Residents 10, 15, and 27) reviewed for medication management. The facility failed to hold cardiac medications per physician orders, and to reassess abnormal blood pressure (BP) or heart rate (HR) values and notify the provider of abnormal findings. This failed practice placed residents at risk for adverse health effects, medication complications, hospitalization , and a diminished quality of life. Findings included . <RESIDENT 15> Resident 15 admitted on [DATE] with cardiac diagnoses of atherosclerosis of aorta (hardening of heart valve), prosthetic heart valve, hypertension (high blood pressure) and hyperlipidemia (high cholesterol). Review of Resident 15's physician's orders directed the nurses to give Amlodipine 5 MG daily and hold the dose for systolic blood pressure SBP- the first number, called systolic blood pressure, measures the pressure in your blood vessels when your heart beats) hold for diastolic BP less than 110, or heart rate (HR) less than 60. Review of the January 2025 MARs showed Amlodipine and Metoprolol (blood pressure medications) were administered when the medications should have been held on the following dates: - 01/21/2025, the HR was 50. - 01/22/2025, the DBP was 56. - 01/25/2025, the HR was 57. Review of the February 2025 MARs showed Amlodipine and Metoprolol were administered when the medications should have been held on the following dates: - 02/01/2025, the DBP was 58. - 02/21/2025, the HR was 59. Review of the March 2025 MARs showed Amlodipine and Metoprolol were administered when the medications should have been held on the following date: - 03/27/2025, the HR was 59. Review of the April 2025 MARs showed Amlodipine and Metoprolol were administered when the medications should have been held on the following dates: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 04/10/2025, the HR was 54. - 04/11/2025, the HR was 54. - 04/16/2025, the SBP was 108, DBP was 58 and HR was 52. <RESIDENT 10> Resident 10 admitted to the facility on [DATE] with diagnoses to include congestive heart failure, atherosclerotic heart disease, cardiac pacemaker, hypertensive heart and chronic kidney disease with heart failure, hyperlipidemia and postural orthostatic tachycardia syndrome (symptoms from reduced blood volume when standing) Review of Resident 10's physician's orders directed the nurses to give Amlodipine 5 MG daily and hold for SBP less than 100 or HR less than 60. Review of the February 2025 MARs showed Amlodipine were administered when the medications should have been held on the following date: - 02/07/2025, the SBP was 95 and Amlodipine was administered. <RESIDENT 27> Resident 27 was admitted to the facility on [DATE] with cardiac diagnoses to include hypertension (high b/p). Review of Resident 27's March physician's orders directed the nurses to give Amlodipine 5 MG daily and hold the dose for SBP less than 110 and DBP or HR less than 60. Review of the March 2025 MARs showed Amlodipine was administered when it should have been held on the following dates: - 03/10/2025, the BP was 107/74. - 03/24/2025, the BP was 100/59. In an interview on 05/01/2025 at 9:25 AM, Staff I, Registered Nurse (RN), stated they were to hold Amlodipine or Metoprolol medications if the BP was under 110 or HR< 60. Staff I stated that 95 % of their residents had parameters. They said they take vital signs 20 minutes before giving those meds and then document the vital signs and if the medication was given or held. In an interview on 05/01/2025 at 9:49 AM, Staff H, Licensed Practical Nurse stated they take the blood pressure and heart rate before giving the medications with parameters and if the vital signs were below, the medication was to be held. In an interview on 05/01/2025 at 10:31 AM, Staff A, Administrator, stated the expectation was medications should be held per the parameters. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC: 388-97-1060 (1)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890 Based on observation, interview, and record review, the facility failed to ensure a pressure offloading mattress was ordered and implemented timely to prevent pressure ulcer (PU)/pressure injury (PI) development for 1 of 2 residents (Resident 7) reviewed for facility acquired PU. Resident 7 experienced harm when they developed a preventable Stage 3 PU to their coccyx (tailbone), requiring wound vacuum treatment which impacted the resident's rehabilitation and discharge potential. This failure placed residents at risk for adverse outcomes and a decreased quality of life. Findings included . PRESSURE ULCER DEFINITION AND STAGES The National Pressure Ulcer Advisory Panel (NPUAP) April 2016, defined Pressure Ulcer (PU) Definition and Stages as: -A PU is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present itself as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear (a combination of downward pressure and friction). -Stage 2 PU: Partial-thickness skin loss with exposed dermis. Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. -Stage 3 PU: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an unstageable PI. -Unstageable PU: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. RESIDENT 7 Resident 7 admitted to the facility on [DATE] with diagnoses which included diabetes (abnormal processing of sugar), existing stage 2 PUs on the right and left buttocks areas and an unstageable PU to the left foot. The resident's discharge plan included the resident's intention to return home when wounds were manageable with home health assistance. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 7's admission nursing assessment dated [DATE] documented the healing stage 2 PU on the right and left buttocks, and an unstageable PU to the left foot. The assessment showed no skin breakdown on the coccyx area on admission. Review of the Braden Scale (an assessment tool that measures risk for pressure injury) dated 10/17/2024, scored the resident as 12 which was moderate risk for PU development. Review of the resident's care plan dated 10/17/2024 showed Resident 7 required total assistance of two staff for bed mobility and was able to use a bed enabler bar to assist with turning and positioning. Further review of the care plan on the date of admission showed no care plan problem related to existing pressure ulcers, pressure ulcer prevention or interventions put in place upon admission. Review of Resident 7's care plan showed a focus area initiated on 10/24/2024 instructing staff to offer and assist with turning and repositioning every two-three hours, off load pressure with positioning side to side when in bed, limit time on back to meals. The care plan included a low air loss mattress (a higher-level surface which is rated for prevention and treatment of pressure ulcers) on the bed for pressure relief and a pressure reduction cushion in the wheelchair. Review of Resident 7's nursing progress note dated 10/31/2024 at 3:24 PM, documented the resident with a new stage 3 PU to the coccyx that started as slit open area a week ago and now the wound bed was covered with 100% slough. The progress note stated the provider and resident were notified and that the resident had pain that limited their mobility to turn and reposition frequently. The note stated the Resident Care Manager (RCM) was notified to see if a Low air loss (LAL) mattress could be provided in addition to turning and repositioning, as the resident was not tolerating side to side positioning due to low back and lower leg pain. Review of Resident 7's progress notes and care plan updated on 11/24/2024, documented that the resident was not placed on the LAL mattress until 11/24/2025 (30 days after the RCM was notified to order the LAL). Review of Resident 7's medical record showed they were being seen by an outside wound clinic related to existing wounds and the wound clinic began following the coccyx wound in December of 2024. Review of the wound clinic notes documented the wound as unstageable and treatment plan included placement of a wound vacuum, which was changed three times per week and was in place until 04/08/2025. Review of the facility wound assessment notes showed inconsistent documentation of the coccyx wound characteristics and size, obtaining wound clinic assessment notes and interchanges the location of the wound to be coccyx or sacrum. The documentation was as follows: - 10/24/2024 coccyx documented as a slit with no measurement. - 10/31/2024 coccyx ulcer stage 3 with no measurement included in the note. - 11/26/2024 50% wound bed noted with covered with slough, with tunneling measuring 5.5 centimeters (cm) at 12 o'clock, 4 cm at 3 o'clock, 2 cm at 6 'o'clock, 1.5 cm at 9 o' clock. There were no would bed dimensions documented. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- 12/07/2024 Length (L) 5.6cm x Width (W) 5.5cm wound vacuum to coccyx wound, changed three times per week. - 01/25/2025 wound on coccyx L 2.2cm x W 1.8 cm, Depth (D) of 2 cm - 02/01/2025 wound on coccyx L 2.0cm x W 1.8 cm x D 2.0 cm - 02/12/2025 wound on sacrum L 1.5cm, W1.5cm, D 1.0 cm - 02/12/2025-04/08/2025 - continued slow healing - 04/08/2025 wound vac discontinued - 04/22/2025 L 0.5cm, W 0.4cm, D 0.4cm (most current measurements) continues to be followed by wound clinic visits every other week. In an interview and observation on 04/23/2025 at 3:00 PM, Resident 7 was sitting up in their wheelchair with foam boots noted on bilateral feet. Resident 7 stated when they admitted they were on a flat mattress that felt like an army cot. The current mattress was observed to be an air mattress. Resident 7 stated they were supposed to have been on a specialty bed from day one, but I did not get one for over a month. Resident 7 stated they already had wounds when they admitted and then developed the one on their tailbone. Resident 7 stated (the tailbone) is the one that has given me the most trouble. Resident 7 stated they were frustrated that due to the wound vacuum and positioning restrictions, they had not been able to effectively participate in therapy until recently, so they lost strength and needed to be able to walk in order to go home, which they stated was still very much their goal. In an interview on 04/30/2025 at 12:57 PM, Staff F, RCM, stated there were standard batch orders for basic skin interventions that auto populate when a resident admitted and from there, individualized interventions would be entered, but stated there was no standard protocol to follow. Staff F stated air mattresses, overlays or special beds are indicated for anyone with skin issues, obesity, or bony prominences. Staff F reviewed Resident 7's medical record and verified that there were no PU prevention interventions in the record until 10/25/2024, when the coccyx wound was first identified as a slit. Staff F stated they did not know why Resident 7 did not have a higher-level mattress placed on admission. Staff F stated they were not very knowledgeable about the types of mattresses but stated Staff A, Administrator, would know because they were the ones who ordered the mattresses. In an interview on 04/30/2025 at 1:40 PM, Staff B, Interim Director of Nursing, stated Resident 7 admitted with several existing wounds, and stated upon admission, residents were assessed for risk and interventions were put in place. Staff B stated if a wound developed or worsened, it was ours, and stated interventions would include turning and positioning, pressure prevention mattresses and cushions, nursing assessments, wound specialists, dietician, and ensuring the practitioner assessed. Staff B stated that for a stage 3 or higher it was common sense to have an air mattress, the mattresses that are standard are pressure relieving, but they were not enough for stage 3 or higher. Staff B acknowledged that Resident 7 admitted with a stage 3 or higher already present and stated they do not know why a higher-level mattress was not placed until 11/24/2024. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 04/30/2025 at 2:00 PM, Staff A, Administrator, stated Resident 7 did not have an LAL mattress on admission. Staff A stated they remembered ordering the mattress for Resident 7 and assisting with putting it on their bed when it arrived, Staff A stated they double checked the dates and the documentation showing it was not placed until 11/24/2024 was correct and that they dropped the ball in preventing the development of a preventable stage 3 PU for Resident 7. Refer to F835- Administration Reference WAC 388-97-1060 (3)(b)

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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** 36787 Based on observation, interview and record review, the facility failed to ensure 1 of 1 resident (Resident 6) reviewed for hydration were consistently monitored and received adequate fluids. This failure placed residents at risk for dehydration, constipation, urinary tract infections (UTI), and other health complications including worsening cognitive impairment and behavioral changes. Findings included . Resident 6 admitted to the facility on [DATE] with diagnosis including severe vascular dementia and a history of UTI's. The resident's quarterly Minimum Data Set (MDS), an assessment tool, dated 04/09/2025, documented the resident had significant cognitive impairment and required extensive assistance with activities of daily living including eating. The resident had no rejection of care. Review of the Registered Dietician (RD) assessment dated [DATE] showed Resident 6's estimated daily fluid needs were 1900 cc. Review of the Med Nutrition Therapy progress note dated 01/02/2025 at 7:03 PM, showed no documentation about Resident 6's hydration intake or needs. Review of the Med Nutrition Therapy progress note dated 04/03/2025 at 8:57 PM, showed no documentation about Resident 6's hydration intake or needs. Review of the clinical record showed there were no recent labs other than a lipid panel on 01/12/2025. Review of the pressure related injury care plan dated 02/02/2024 showed the only documentation about hydration was to encourage good nutrition and hydration to promote healthier skin. In an interview on 04/23/2025 at 11:25 AM, Collateral Contact 6 (CC 6), family member of Resident 6 stated they were concerned that when they or other family members visited the resident on multiple occasions there were no liquids at bedside. CC 6 stated the resident could no longer feed themself, but they were able to drink on their own. CC 6 stated that they had to go get their fluids for them. In observations on 04/23/2025 at 8:47 AM, 9:51 AM, 11:42 AM and 3:24 PM there were no fluids beside Resident 6. Review of Resident 6's fluid consumption documentation on 04/23/2025 showed the resident had consumed 536 cc total which included 236 cc of Mighty shake supplement. In observations on 04/24/2025 at 8:46 AM, 9:44 AM, 1:53 PM and 2:54 PM there were no fluids beside Resident 6. Review of Resident 6's fluid consumption documented on 04/24/2025 showed the resident consumed 586 cc total which included 236 cc of Mighty shake supplement. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In observations on 04/25/2025 at 8:57 AM, 9:54 AM, 10:44 AM, 12:32 PM and 1:40 PM there were no fluids beside Resident 6. Review of Resident 6's fluid consumption documented on 04/25/2025 showed the resident consumed 716 cc total which included 236 cc of Mighty shake supplement. In an observation on 04/28/2025 at 8:34 AM, Resident 6 was in bed. There was a 60-cc cup of water on their nightstand out of reach. At 10:58 AM, 11:39 AM, and 1:25 PM, there were no fluids by the resident. Review of Resident 6's fluid consumption documented on 04/28/2025 showed the resident consumed 896 cc total which included 236 cc of Mighty shake supplement. In an observation on 04/29/2025 at 2:06 PM, Resident 6 was sitting in their wheelchair with a full 300 cc mug of water. Their tongue was observed to be dry. At 3:00 PM and 3:52 PM, Resident 6 was in bed and their mug was on their nightstand, out of reach. Review of Resident 6's fluid consumption documented on 04/29/2025 showed the resident consumed 718 cc total which included 178 cc of Mighty shake supplement. Review of the electronic health record fluid intake documentation 01/01/2025 through 04/30/2025 showed the resident had consumed 336 cc to 1056 cc daily. Resident 6 did not receive 1900 cc of fluids on any date. In an interview on 05/01/2025 at 9:59 AM, Staff H, Licensed Practical Nurse stated if they handed Resident 6 their nourishment shakes, they would take it and drink it. In a joint interview on 05/01/2025 at 10:08 AM, Staff K, Nurse's Aide Certified (NAC) and Staff J, NACs were coming out of Resident 6's room. Staff K had Resident 6's juice in their hand containing 120 cc. Staff K stated Resident 6 would sometimes drink fluids at bedside. Staff J stated the resident would rarely initiate drinking on their own and needed cues and hand held assistance for drinking usually. In an observation on 05/01/2025 at 10:10 AM, Resident 6 was in bed and their overbed table with their blue mug was across the room and out of their reach. When the resident was asked if they had a good breakfast and had enough to drink, they shook their head indicating no. Resident 6's tongue was dry. In an interview on 05/01/2025 at 10:31 AM, Staff A, Administrator, was informed of inadequate fluid intake documentation, multiple observations of no fluids at bedside for and observations of dry tongue for Resident 6. Staff A stated they were not aware of any hydration concerns. Staff A stated their expectation was for nursing to pass water every morning and evening and provide fluids to residents as requested. Staff A stated if the resident needed 1900 cc of fluids, dietary would look at the amount of fluids on the trays and supplement the rest of the fluids needed so they consume their estimated fluid needs. Staff A stated staff would document the residents' fluid intake. Reference WAC: 388-97-1060 (3)(i)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51312 Based on an interview, observation, and record review, the facility did not adequately reassess, report, or provide effective pain management for 1 of 1 (Resident 1). This oversight resulted in the resident experiencing discomfort during routine tasks such as repositioning and peri-care. Furthermore, the situation may have affected the resident's quality of life and increased the risk of developing bed sores. Findings Included . <Resident 1> Resident 1 was a long-term resident of the facility. According to the admission MDS dated [DATE], Resident 1 was mildly cognitively impaired. Review of policy titled 'Pain Assessment and Management' dated 03/25/2024, documented: Staff will identify situations or interventions that increase resident pain, staff will know why pain medication is being administered, and staff will conduct and document pain levels when residents' pain increases . During an observation on 04/25/2025 at 8:37 AM, Resident 1 was in the hall next to the nursing cart where Staff H, Licensed Practical Nurse (LPN), was passing out medications. Resident 1 was waiting for physical therapy. While waiting, Resident 1 was trying to reposition themself in their wheelchair and stated, 'my bum hurts.' Resident 1 then told the nurse their bum hurt. Staff H indicated that they had already administered Resident 1's pain medication and they returned to administering medication to another patient. Resident continued to try and reposition themself, and was heard yelling 'Oh God, I have to get up, my bum hurts'. During an observation on 04/25/2025 at 11:01 AM, Resident 1 was lying in bed and stated their bum was sore and they needed to get off of it. During an observation on 04/25/2025 at 3:05 PM, Resident 1 was lying in bed and stated they were having 9 out of 10 pain in her bum, and that she told unknown staff. During an observation on 04/28/2025 at 8:45 AM, Resident 1 was sitting in their wheelchair and stated that their pain was 5 out of 10. During an observation on 04/30/2025 at 10:09 AM, Resident 1 was in their room, sitting in their wheelchair, moaning and attempting to reposition themselves. Staff J, Nursing Aid Certified (NAC), entered Resident 1's room with an unidentified staff member and transferred Resident 1 to the bed. Staff J performed perineal care on Resident 1, during which a red area was observed on the bilateral sides of the gluteal region, measuring approximately 7 by 7 inches on both cheeks. Additionally, there was an open area in the center of their buttocks measuring about 2 inches in length. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/29/2025 at 11:22 AM, Staff B, Interim Director of Nursing Services (DNS), stated that staff should be assessing Residents' pain before administering scheduled pain medication. Staff B stated Resident 1's pain was not assessed before or after the pain medication was administered. Staff B stated pain assessments had recently been changed to weekly. During an interview on 04/29/2025 at 2:01 PM, Staff Q, Medical Doctor, indicated that they were not informed about Resident 1 experiencing pain, which they considered important information. Staff Q stated the nurse practitioner was scheduled to evaluate Resident 1 that day due to an increase in hallucinations and behaviors that may be associated with pain. Staff Q then indicated that Resident 1 has no current diagnosis to support worsening pain or scheduled Acetaminophen. During an interview on 04/29/2025 at 10:36 AM, Staff F, Registered Nurse/RCM (RN/RCM), Stated Resident 1's pain assessments were to be conducted before medication administration and then again 30-40 minutes afterward. Staff F indicated that Resident 1 was only being assessed for pain on a weekly basis and not after her daily doses of pain medication and that the medical doctor was to be notified when a resident experienced an increase of pain, and the expectation was that pain issues were to be addressed in Resident 1's care plan based on scheduled pain medications. During an interview on 04/30/2025 at 11:53 AM, Staff J, NAC, stated that Resident 1 had complained of bum pain in the past and that usually meant Resident 1 had something developing on their bum. During an interview on 05/01/2025 at 10:52 AM, Staff H stated that Resident 1 had an as needed pain medication, and that if as-needed medicines were administered, staff would evaluate and chart the resident's pain levels. Staff H then indicated that the provider would only be notified if as-needed medication were administered. Staff H further stated that Resident 1 experienced general body pain and a sore coccyx. Reference WAC 388-97-1060(1)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shuksan Rehabilitation and Health Care	1530 James Street Bellingham, WA 98225

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on interview and record review the facility failed to ensure that 9 of 9 sampled Certified Nursing Assistant (CNAs) (Staff W, Staff J, Staff X, Staff Y, Staff Z, Staff AA, Staff BB, Staff CC, and Staff K) reviewed for background checks were verified as active on the Omnibus Budget Reconciliation Act (OBRA). This failure placed residents at risk of being cared for by unqualified staff, unmet care needs, diminished quality of life, and possible harm. Findings included . Staff M, Nursing Assistant Certified (NAC) was hired on [DATE]. In a review of Staff M, employment records showed no completed OBRA verification. In an interview on [DATE] at 1:47 PM Staff L, Business Office Manager, stated they were aware Staff M did not have an updated OBRA. Staff L provided an expired OBRA verification for Staff M, which showed an expiration of [DATE]. Staff L stated they were completing OBRA verifications for NAC's as they expired and did not have a plan in place to update expired OBRA's previous to their employment. Staff L stated they were worried if they pulled new OBRA verifications for staff they would come back expired and so they did not pull them. Staff L stated the facility was not provided OBRA documentation for any of their agency staff. Staff L stated Staff M had been scheduled and working at the facility with an expired OBRA. In a review of all facility staff showed a total of nine staff members with expired OBRA's Staff W, expired [DATE], Staff J, expired [DATE], Staff X expired [DATE], Staff Y expired [DATE], Staff Z expired [DATE], Staff AA expired [DATE], Staff BB expired [DATE] and Staff CC expired [DATE] and Staff K expired [DATE]. In an interview on [DATE] at 2:51 PM Staff L stated the staff identified with expired OBRA's had been working in the facility. Staff L stated they were unsure of what to do about the expired OBRA's. Staff L stated they would have to remove the identified staff off the schedule until the OBRA's could be verified as active. In an interview on [DATE] at 2:22 PM Staff A, Administrator stated OBRA's are updated as expired. Staff A stated there was a time when OBRA's were not processed timely, and staff were taken off the schedule. Staff A stated the facility should be getting OBRAs for agency staff. Staff A stated if NAC's do not have an updated and current OBRA then they don't work until it is resolved. Reference WAC [DATE]

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 47047 Based on interview and record reviews, the facility failed to complete annual staff performance reviews yearly as required and provide education based on the outcome of these reviews for 1 of 5 sampled staff (Staff M), reviewed for performance reviews. This failure placed residents at risk of receiving care from inadequately trained and/or underqualified care staff, and diminished quality of life. Findings Included . Staff M was hired on 12/02/2022 as a nursing assistant certified (NAC). In a review of Staff M's performance evaluation showed it was an annual evaluation but was not dated or signed by the evaluator or the staff. The performance evaluation was one page and at the bottom of the page indicated there was two pages to the evaluation. No other documents were provided for Staff M's performance evaluation. In an interview on 05/01/2025 at 11:30 AM Staff A, Administrator stated they had just recently gotten evaluations caught up to August of 2025 and they were now doing the evaluations on the staff's anniversary date. No other information was provided. Reference WAC 388-97-1680 (2) (a-c) This is a repeat deficiency from SOD dated 05/16/2024.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890 Based on observation, interview and record review, the facility failed to ensure pharmaceutical services including all procedures that assured accurate order entry, dispensing and administration of medications in the facility, occurred for 1of 1 resident (Resident 7) reviewed for pharmaceutical services. The failure to ensure accurate orders and administration for Resident 7 resulted in a duplication error and placed residents at risk for adverse outcomes. Findings included . Resident 7 admitted on [DATE] with diagnoses which included osteoporosis. Review of Resident 7's physician's orders dated 12/08/2024 documented an order for Alendronate 70mg once per week on Monday at 5:00 AM to treat osteoporosis. Review of Resident 7's physician's orders dated 04/08/2025 showed a duplicate order was entered for Alendronate 70mg per week on Sunday at 7:00 AM to treat osteoporosis. Review of the Medication Administration Record for the month of April 2025 showed signatures for both doses of Alendronate signed as given: Sundays at 7:00 AM on 04/06/2025, 04/13/2025 and 04/20/2025. Mondays at 5:00 AM on 04/07/2025, 04/14/2025 and 04/21/2025. In an interview on 04/25/2025 at 12:43 PM, Staff F, Resident Care Manager, stated they were not aware of the duplicate order and would discontinue it. Staff F stated they thought the system would alert us to duplication and the pharmacy should catch that when it was ordered. Review of a facility medication error report for Resident 7 dated 04/25/2025 showed the investigation was not thorough to determine whether the pharmacy actually sent additional tablets or reconcile discrepancies in staff statements regarding the administration of the duplicate ordered medication. Reference WAC 388-97-1300 (2)

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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** 37890 Based on observation, interview and record review, the facility failed to ensure pharmaceutical services including all procedures that assured accurate order entry, dispensing and administration of medications in the facility, occurred for 1of 1 resident (Resident 7) reviewed for pharmaceutical services. The failure to ensure accurate orders and administration for Resident 7 resulted in a duplication error and placed residents at risk for adverse outcomes. Findings included . Resident 7 admitted on [DATE] with diagnoses which included osteoporosis. Review of Resident 7's physician's orders dated 12/08/2024 documented an order for Alendronate 70mg once per week on Monday at 5:00 AM to treat osteoporosis. Review of Resident 7's physician's orders dated 04/08/2025 showed a duplicate order was entered for Alendronate 70mg per week on Sunday at 7:00 AM to treat osteoporosis. Review of the Medication Administration Record for the month of April 2025 showed signatures for both doses of Alendronate signed as given: Sundays at 7:00 AM on 04/06/2025, 04/13/2025 and 04/20/2025. Mondays at 5:00 AM on 04/07/2025, 04/14/2025 and 04/21/2025. The resident had an order for enoxaparin (an injectable blood thinner) dated 04/17/2025 to prevent blood clots. Review of the consultant pharmacist review dated 04/22/2025 showed Resident 7 had been reviewed and the recommendation included a request for the physician to review the resident's blood thinner (Enoxaparin) which the resident had been taking since admission to prevent blood clots. Review of the prior six months of pharmacy reviewed provided did not include the Enoxaparin to clarify a stop date or clarification of treatment course. There was no mention related to the duplicate order of Alendronate that had been entered on 04/08/2025. In an interview on 04/25/2025 at 12:43 PM, Staff F, stated the facility had not discussed a stop date for Resident 7's Enoxaparin and stated the pharmacy reviewed residents every month. Staff F stated they thought the system would alert to duplication and the pharmacy should catch that when it was ordered. In an interview on 04/25/2025 at 4:36 PM, CC1, consultant pharmacist, stated the pharmacy was providing services according to their contract, which included consultant pharmacist reviews and supplying medications. Reference WAC 388-97-1300 (1)(c)(iii),(4)(c)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on interviews and record review, the facility failed to ensure timely laboratory services were provided for 5 of 5 residents (Residents 7, 10, 15, 34 and 95) reviewed for laboratory services. Resident 15 did not have a urinalysis sample collected for laboratory study per physician order, Resident 7 did not have a Hemoglobin A1C (lab measures blood sugars in the body over a period) test completed as ordered and Resident 95 did not have a metabolic panel and blood count completed timely. Resident 10 and 34's Depakote levels (critical lab test to determine therapeutic drug level in the body and prevent toxicity for seizure medications, reference range 50-100) were not completed timely as ordered and constituted an Immediate Jeopardy (IJ). These failures placed residents at risk of delay in treatment, drug toxicity, decline in medical conditions, hospitalization and a diminished quality of life. On 05/01/2025, the facility was notified of an IJ for F770. The immediate jeopardy was determined to begin on 04/23/2025 when laboratory services were not able to be provided timely due to vendor non-payment. The immediate jeopardy was removed on 04/26/2025 as confirmed by an onsite verification by a surveyor after the facility obtained an alternate vendor to obtain missing labs, all other residents were audited to ensure labs were completed as ordered and overnight payments were sent out to the lab to cover the demand bills. Findings included . Review of facility lab contract titled Trident Care, Letter of Agreement, signed 07/29/2020, showed the facility would pay the Provider (lab) in accordance with the pricing terms of the agreement. The contract directed the facility to pay the provider within thirty (30) days of the date of the invoice, unless required by law to pay sooner, in which case the earlier date required by law shall apply. If payment due to the provider by facility is more than ten (10) days past due, the provider shall have the right to refuse to provide services to the facility without further notice. <RESIDENT 10> Resident 10 was admitted to the facility on [DATE] with diagnoses to include dementia (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems) with psychotic disturbance, anxiety (a mental health condition that involves excessive worry and feelings of fear, dread, and uneasiness) and depression. Review of the physician's orders showed Resident 10 was receiving Depakote 250 mg (milligrams) every day and evening for gradual dose reduction of Quetiapine (anti-psychotic) and behavior management related to Major Depressive Disorder, severe with psychotic features since 01/29/2025. Review of a social service progress note on 04/22/2025 at 4:42 PM showed a psychotropic meeting recommendation that the psychiatric physician was increasing Depakote to 375 MG twice a day and ordering a Depakote level in hopes to relieve Resident 10's distress due to increased aggressive and distressing behaviors. (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of a progress note on 04/24/2024 at 10:52 AM, showed the new order was processed to increase Depakote dose and draw a Depakote level on the next lab day. Review of the physician's orders dated 04/23/2025 at 10:00 PM directed the facility to draw a Depakote level every night shift until 04/24/2025. There was an additional order to draw a complete metabolic panel (CMP - a lab that provides an overview of the body's chemical balance and metabolism) on 04/28/2025 at 10:00 PM. Review of the April Medication Administration Record (MAR) showed the Depakote level was not signed as completed on 04/24/2025. The CMP was signed as not completed with a code of 9 indicating to see the progress notes. Review of the Depakote lab requisition showed the Depakote level was obtained from an alternate lab on 04/26/2025 (two days after it was ordered to be drawn) and results were reported to the facility on [DATE] (two days after the lab was obtained). The results were low at 19 ug/ml with a normal reference range at 50-100 ug/ml. Review of the progress note on 04/29/2025 at 12:22 PM, documented the 04/26/2025 Depakote results were reviewed by the physician. Review of the progress notes and MAR did not show if the CMP had been drawn as ordered on 04/28/2025. <RESIDENT 34> Review of the physician's orders showed Resident 34 was receiving Depakote every day related to mood disorder. Review of the physician's orders dated 04/23/2025 at 10:00 PM directed the facility to draw a Depakote level every night shift until 04/24/2025. Review of Resident 34's medical record on 04/25/2025 showed the Depakote level was not drawn. <RESIDENT 7> Resident 7 admitted on [DATE] with diagnoses which included diabetes (disease that results in abnormal processing of sugar in the body). Review of Resident 7's medical record showed an order for a Hemoglobin A1C (test to determine average blood sugar levels) to be completed on 04/23/2025. Review of Resident 7's April 2025 Treatment Administration record showed a blank for the A1C on 04/23/2025. Review of Resident 7's medical record on 04/25/2025 showed no documentation that the lab had been drawn or any result of the lab, or any documentation regarding the lab. <RESIDENT 95> (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Resident 95 admitted on [DATE] with diagnoses to include a left hip fracture, recent toe amputation after an infection, dementia and depression. Review of the physician visit note on 04/22/2025 showed the physician assessed the second toe tip and noted it to be gangrenous and would need close follow-up on this with frequent exams and a repeat a CBC (complete blood count) lab in three days. The assessment and plan for the congestive heart failure was to repeat a CMP next week. Review of an ARNP (Advanced Registered Nurse Practitioner) visit note dated 04/23/2025 showed the assessment plan related to Resident 95's chronic congestive heart failure was to monitor and consider increasing their diuretic with a repeat CMP next week. Review of a laboratory progress note on 04/23/2025 at 12:49 PM showed CBC and CMP labs were to be drawn on 04/25/2025. Review of the clinical record on 04/25/2025 showed the CMP and CBC had not been drawn. Review of the lab requisition in the lab book showed the labs had not been drawn yet. Review of the lab faxed to the facility on [DATE] at 10:06 AM showed the results of a BMP (Basic Metabolic Panel) panel rather than the ordered CMP. The BMP had been drawn on 04/29/2025 at 10:37 PM (four days after it was ordered to be collected). <RESIDENT 15> Resident 15 admitted on [DATE] with a diagnosis of calculus of ureter (presence of stones within the tube that carries urine from the kidneys to the bladder). Review of a progress note on 01/31/2025 at 5:10 PM, showed Resident 10's family member was in the facility and stated that when their family member was delusional (holding a belief of altered reality that is believed) they were septic (a life-threatening bloodstream infection from an overwhelming infection) with a urinary tract infection (UTI). Physician orders were to be obtained to rule out UTI as the cause of the increased confusion and delusions. Review of a progress note on 02/04/2025 at 3:33 PM showed a urinalysis (UA) order was received due to recent delusions and hallucinations (perception of having seen, heard, touched, tasted or smelled something that was not actually there) to rule out a UTI. Review of the February MAR showed the UA with culture and sensitivity was ordered to be completed on 02/05/2025. The order was signed as 9 indicating to see the progress notes. The lab was not set up in the MAR for another shift to collect and follow up on the missed UA. Review of a progress note on 02/05/2025 at 1:34 PM showed the nurse was not able to collect a UA due to the resident not cooperating. Review of the clinical record after the 02/05/2025 progress notes and lab results contained no further information about the urinalysis or if the physician had been informed the lab was not completed as ordered. (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	In an interview on 04/25/2025 at 12:32 PM, Staff F, Registered Nurse (RN)/ Resident Care Manager (RCM) stated the lab was supposed to come on Sundays, Mondays, Tuesdays and Thursdays. The labs due are kept in a binder at the nurse's station and should be audited for completion and then results usually come in a day or two depending on the type of test. Staff F confirmed that Residents 7,10, 34 and 95 had labs ordered to be drawn on 04/23/2025 (which is the night shift that begins on 04/23/2025 but then becomes 04/24/2025), which were not done. Staff F stated they could not see documentation about why those labs had not been ordered but stated the lab may not have come, I heard something about a bill not being paid. Staff F was asked if there was an alternative option or an alternative laboratory available and they stated there was a different lab they used only for urinalysis. Staff F was asked if the providers for those residents had been notified that those labs had not been obtained and Staff F stated they did not know. In an interview on 05/01/2025 at 9:25 AM, Staff I, RN stated the facility had a new lab provider due to a payment issue and they were not sure who the new lab provider was. Staff I said the facility had a lab binder and the night shift nurse followed up on labs. Staff I stated they would be told in report if the lab had not been obtained. Staff I said sometimes the lab orders would be placed on the Medication Administration Record (MAR) which was helpful to know who had labs due. They stated they could look at the lab book or ask night shift to know if a lab sample had been obtained. In an interview on 05/01/2025 at 9:49 AM, Staff H, Licensed Practical Nurse (LPN) stated the facility had just changed lab companies. Staff H stated the phlebotomist would come in, grab the lab book and complete the lab draws, then have them sign off that the sample was obtained. Staff H stated night shift was responsible for putting the upcoming labs into the MAR so nurses would know who was due. Staff H stated they would check the lab binder or MAR to see if the lab had been obtained. In an interview on 05/01/2025 at 11:37 AM, Staff B, Interim Director of Nursing (DNS), stated the UA was not collected or followed up on. Staff B stated their expectation was labs were to be completed as ordered and followed up on. Reference WAC 388-97-1620 (2)(b)(i)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890 Based on interview, and record review, the facility Administration failed to ensure the facility's finances were maintained effectively for continuity of resident care and services. The Administration was aware the facility was behind on vendor payments and receiving notices for discontinuation of services. The Administration's failure to ensure the facility met their financial obligations to vendors resulted in the facility laboratory services provider discontinuing services to the facility resulted in four residents (Residents 10, 34, 95, and 7) not receiving timely laboratory services, and placed all 41 residents at risk of not receiving necessary care and services and constituted an Immediate Jeopardy (IJ). On 04/25/2025 at 5:19 PM, the facility was notified of an IJ in F835. The facility removed the immediacy on 04/26/2025 as confirmed by an onsite verification by a surveyor after the facility ensured past due resident lab testing had been completed and an active laboratory services vendor was in place. The facility provided evidence of vendor contract payments to ensure continuity of essential services, audited all resident laboratory orders, and obtained ordered laboratory testing for affected residents. The immediate jeopardy was determined to begin on 04/23/2025 when laboratory services were not provided timely. Findings included . Review of the undated facility policy titled Administrative Management, stated the Facility Administrator appointed was accountable to facility management and operations, which would be reported to a governing board. Based on record review the following vendors sent demand bill notices to the facility: - Trident Lab corporation, past due $9,536.92 with a hold for non-payment with invoices beginning 11/30/2024. - City of [NAME] water, a shut off notice was sent on 04/07/2025 with shut off date of 05/07/2025 with a past due amount of $2,487.91. - Kavala staffing agency statement #3545 dated 03/26/2025 total amount owed $191,210.01 for invoices from 11/25/2024 through 03/21/2025. - Clipboard staffing agency owing $2,563.89, with a notice they will cease to send staff after 05/05/2025. - KCI (a medical supply company) invoice owing $12,550 with a notice on 04/21/2025 demand bill to pay by 04/21/2025 with invoices beginning 10/21/2024. -Cascade Natural Gas invoice with urgent past due notice dated 04/14/2025 requested payment of $1877.85 be received by 5:00 PM on April 22, 2025, or service may be disconnected. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	-According to the Office of Rates Management, as of 04/07/2025, the Safety Net Assessment (SNA) account for Shuksan HealthCare was 60 days past due in the amount of $119,996.01, which included a new outstanding balance for December 2024 days of $29,377.00, due to be paid 01/20/2025. In an interview with the facility lab services provider on 04/25/2025 at 1:42 PM, CC5, the lab services provider confirmed that the facilities lab services were placed on a non-payment hold on 04/23/2025 which had not been corrected in their system. This lack of lab services impacted four residents (Residents 10, 34, 95, and 7) and potentially additional residents if new orders were received or delayed due to the lab vendor not coming out due to the nonpayment) Resident 10's Depakote level (critical lab to determine therapeutic drug level in the body and prevent toxicity for seizure medication) was not obtained. Resident 34's Depakote level (critical lab to determine therapeutic drug level in the body and prevent toxicity for seizure medication) was not obtained. Resident 95's Comprehensive Metabolic Panel (test to determine overview of the body's chemical and metabolic status) and Complete Blood Count (test to determine number and types of blood cells) were not obtained. Resident 7's Hemoglobin A1C (test to determine average blood sugar levels) was not obtained. In a joint interview and record review on 04/25/2025 at 12:32 PM, Staff F, Resident Care Manager, stated the lab was scheduled to come on Sundays, Mondays, Tuesdays and Thursdays. The labs due were kept in a binder at the nurse's station and should be audited for completion and then results usually come in a day or two depending on the type of test. Staff F was asked to review some missing laboratory results, and they stated that Residents 7, 10, 34 and 95 had labs ordered to be drawn on 04/23/2025 which had not been completed as of this interview. Staff F stated they could not see documentation about why those labs had not been ordered but stated the lab may not have come, I heard something about a bill not being paid. Staff F was asked if there was an alternative option or an alternate laboratory available and they stated there was a different lab they used only for urinalysis (lab test to analyze urine samples). Staff F was asked if the providers for those residents had been notified that those labs had not been obtained, and they stated they did not know. In an interview on 04/25/2025 at 1:08 PM, Anonymous facility staff stated the facility had delayed payroll on one recent occasion at which time staff lost benefits for a period of time and staff had to pay out of pocket for medical appointments and prescriptions. In an interview on 04/25/2025 at 1:08 PM, Staff L, Business office Manager, stated invoices, came to them and Staff A, Administrator, and they were processed and sent to the corporate office for payment. The corporate office cuts the checks and pays the vendors unless we were instructed by them to pay for something by credit card. Staff L stated in regard to the laboratory bill, there was a payment that was not received, and a check that was supposed to have been sent overnight and that prevented the non-payment hold. Staff L stated they get calls daily from vendors regarding overdue balances and all they could do was forward that information to corporate. In an interview on 04/25/2025 at 1:55 PM, Staff A stated they receive the invoices for all the bills, and they are all forwarded to the corporate office for payment. Staff A stated they were aware of the lab services hold but thought it had been taken care of. Staff A was aware of a recent demand bill from the natural gas company and that the facility was paying bills late or had payment plans in place with some vendors. Staff A stated the facility had used a company credit card to obtain some resident supplies. (continued on next page)

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	505098	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shuksan Rehabilitation and Health Care	1530 James Street Bellingham, WA 98225

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	In an interview on 04/25/2025 at 4:47 PM, Staff D, Chief Operating Officer, stated the corporation managed vendor contracts and payment plans according to the individual arrangements. Staff D stated they receive invoices every week and they are processed. The laboratory payment was stated to have been sent. The facility was managing cash flow. Refer to F770- Labratory Services Reference WAC 388-97-1620 (1)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890 Based on interviews and record review, the facility Governing Body failed to ensure the facility's finances were maintained. The Governing Body was aware the facility was behind on vendor payments and receiving notices for discontinuation of services. The Governing Body's failure to ensure oversite of the facility Administration to meet their financial obligations to vendors resulted in the facility laboratory services provider discontinuing services to the facility and placed all 41 residents at risk of not receiving necessary care and services. Findings included . Review of the undated facility policy titled Administrative Management (Governing Board), stated the Governing Board had full legal authority and responsibility for the management and operation of the facility. Based on record review the following vendors sent demand bill notices to the facility: Trident Lab corporation, past due $9,536.92 with a hold for non-payment. City of [NAME] water, a shut off notice was sent on 04/07/2025 with shut off date of 05/07/2025 with a past due amount of $2,487.91 Cascade Natural Gas invoice with urgent past due notice dated 04/14/2025 requested payment of $1877.85 be received by 5:00 PM on April 22, 2025, or service may be disconnected. Kavala staffing agency owing $191,210.01 Clipboard staffing agency owing $2,563.89, with a notice they will cease to send staff after May 5. KCI (a medical supply company) invoice owing $12,550 with a notice on 04/21/2025 demand bill to pay by 04/21/2025. According to the Office of Rates Management, as of 04/07/2025, the Safety Net Assessment (SNA) account for Shuksan HealthCare was 60 days past due in the amount of $119,996.01, which included a new outstanding balance for December 2024 days of $29,377.00, due to be paid 01/20/2025. In an interview with the facility lab services provider on 04/25/2025 at 1:42 PM, CC5, the lab provider confirmed that the facility lab services were placed on a non-payment hold on 04/23/2025 which had not been corrected in their system. This lack of lab services impacted 4 Residents (Residents 10, 34, 95, and 7) and potentially additional residents if new orders were received. Resident 10, Depakote level (lab to determine therapeutic drug level for seizure medication) was not obtained. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident 34 Depakote level (lab to determine therapeutic drug level for seizure medication) was not obtained. Resident 95 Comprehensive Metabolic Panel (test to determine overview of the body's chemical and metabolic status) and Complete Blood Count (test to determine number and types of blood cells) was not obtained. Resident 7 Hemoglobin A1C (test to determine average blood sugar levels) was not obtained. In an interview on 04/25/2025 at 12:32 PM, Staff F, Resident Care Manager stated the lab was supposed to come on Sundays, Mondays, Tuesdays and Thursdays. The labs due were kept in a binder at the nurse's station and should be getting audited for completion and then results usually come in a day or two depending on the type of test. Staff F was asked to review some missing laboratory results and Staff F confirmed that residents 7,10,34 and 95 had labs ordered to be drawn on 04/23/2024 which were not done. Staff F stated they could not see documentation about why those labs had not been ordered but stated the lab may not have come, I heard something about a bill not being paid. Staff F was asked if there was an alternative option or an alternative laboratory available and Staff F said there was a different lab they used only for urinalysis. Staff F was asked if the providers for those residents had been notified that those labs had not been obtained and Staff F stated they did not know. In an interview on 04/25/2025 at 1:08 PM, with Anonymous staff, the facility had delayed payroll on one recent occasion at which time staff lost benefits for a period of time and staff had to pay out of pocket for medical appointments and prescriptions. In an interview on 04/25/2025 at 1:08 PM, Staff L, Business office Manager, stated invoices came to them and Staff A, Administrator, and they were processed and sent to the corporate office for payment. The corporate office actually cuts the checks and pays the vendors unless we were instructed by corporate to pay for something by credit card. Regarding the laboratory bill, there was a payment that was not received, and an overnighted check that was supposed to have been sent and that prevented the non-payment hold. Staff L stated they get calls daily from vendors regarding overdue balances and all they could do was forward on that information to corporate. In an interview on 04/25/2025 at 1:55 PM, Staff A, Administrator, stated they get the invoices for all the bills, and they are all forwarded to the corporate office for payment. Staff A stated they were aware of the lab services hold but thought it had been taken care of. Staff A was aware of a recent demand bill from the natural gas company and that the facility was paying bills late or had payment plans in place with some vendors. Staff A stated the facility had used a company credit card to obtain some resident supplies. In an interview on 04/25/2025 at 4:47 PM, Staff D, Chief Operating Officer, stated the corporation managed vendor contracts and payment plans according to the individual arrangements. Staff D stated they receive invoices every week and they are processed. The laboratory payment was stated to have been sent. The facility was managing cash flow. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 04/29/2025 at 2:11 PM, Staff E, Chief Operating Officer, stated the facility was behind on the Safety Net Assessment (SNA) payments, which had been referred for collection to the Office of Financial Recovery. This resulted in unannounced garnishments which have impacted the facility cash flow. Staff E stated they have reached out to the contacts for the SNA and they have had to prioritize payments which has meant allowing some accounts to go to collections. Reference WAC 388-97-1620 (2) (C)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on interview and record review the facility failed to ensure a system in which residents' records were complete, accurate, accessible, and systematically organized for 3 of 5 residents (Residents 6, 7, and 10) reviewed for accurate PASRR (Preadmission Screening and Resident Review), Medication Administration Records (MAR) and Treatment Administration Records (TAR). Failure to ensure clinical records were complete and accurate made it impossible to determine what care and services were provided, or should have been provided, and placed residents at risk for medical complications, unmet care need and for diminished quality of life. Findings included: Review of the facility policy titled Documentation Standards-Resident Health Record, undated documented the policy of the community is to maintain a Resident Health Record that reflects the accurate and progressive condition of the resident, including care provided, interventions and outcomes, in a manner that is consistent with current health care and legal standards of practice. <RESIDENT 6> Review of Resident 6 February 2025 MAR and TAR showed no documentation that Atorvastatin or Melatonin were administered per physician order. The behavior monitoring and side effect monitoring had 9 of 84 omissions of the 84 opportunities. The anti-coagulant bleeding monitor and hours of sleep monitor had 10 omissions of the 84 opportunities. Review of March 2025 MAR and TAR showed medications Cephalexin, Eliquis, Fluoxetine, Losartan, Senna, Medroxyprogesterone were not documented as administered per physician order on 03/15/2025 day shift. The behavior monitoring, side effect monitoring and hours of sleep, anti-coagulant bleeding monitor and hours of sleep monitor had 18 omissions of the 93 opportunities. The weekly skin check on 03/12/2025 was not signed as completed. Review of the April MAR and TAR showed the behavior monitoring, side effect monitoring and hours of sleep, and anti-coagulant bleeding monitor had 12 omissions out of 90 opportunities. The sleep monitor had 14 omissions, out of 90 opportunities. The weekly skin and pain assessments for 04/06/2024 and 04/13/2025 were not signed as completed. <RESIDENT 10> Review of Resident 10's March 2025 MAR and TAR showed no documentation that Clonazepam was administered on 03/28/2025 evening shift. There was no documentation that Metoprolol, Tamsulosin, Depakote, Erythromycin, Memantine, Senna, lubricating eye drops were administered per physician order on 03/30/2025 and 03/31/2025 evening shift. The behavior monitoring, side effect monitoring and anti-coagulant monitor had 18 omissions out of 93 opportunities. The weekly skin check and nail checks on 03/09/2025, 03/23/2025 and 03/30/2024 were not signed as completed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 10 's April 2025 MAR and TAR showed no documentation that Clonazepam was administered on 04/06/2025 at noon. There was no documentation that Metoprolol, Erythromycin, Memantine, lubricating eye drops were administered per physician order on 04/13/2025 evening shift. The behavior monitoring, side effect monitoring and anti-coagulant monitor had 12 omissions out of 93 opportunities. The weekly pain assessments on 04/06/2025, and 04/13/2025 were not signed as completed. The nail check on 04/13/2025 was not signed as completed. 37890 <RESIDENT 7> Resident 7 admitted on [DATE] following a hospital stay related to wound infection. Review of Resident 7's admission records showed the resident was referred for a level two PASRR evaluation (Preadmission Screening and Resident Review, a required evaluation for residents with serious mental illness or mental disability, to determine whether they are receiving the most appropriate level of care, in the most appropriate setting) related to documentation of indicators of severe mental illness, which was done on 11/07/2024. Review of the PASRR evaluator notes documented that a diagnosis of bipolar disorder, found in the resident record, was not accurate. The evaluator stated the resident did not have indicators of serious mental illness and identified that the error originated in the hospital when the diagnosis appeared in error. Review of the resident's medical record on 04/25/2025 showed the facility failed to follow up on the PASRR evaluator's discovery of the diagnosis error, and the diagnosis remained in the facility record on both the Medication Administration Records and the resident's care plan. In an interview on 04/30/2025 at 2:04 PM, Staff B, interim Director of Nursing Services, stated they had not been aware of the diagnosis error for Resident 7. Staff B stated nursing or social services were to follow up on the PASSAR recommendations and would need to confirm and obtain an order from the provider to remove a diagnosis and then send the update to medical records. In an interview on 05/01/2025 at 9: 49 AM Staff H, Licensed Practical Nurse stated the facility expectation was that medications, treatments and behavior monitors needed to be completed and signed for or other nurses would not know if the nurse had provided those medications and treatments. In an interview on 05/01/2025 at 10:31 AM, Staff A, Administrator, stated they were not aware of any documentation concerns and there were no current documentation audits in place. Staff A stated they would add a review of documentation to their daily audits. Reference WAC 388-97-1720 (1)(a)(i-iv)(b) This is a repeat deficiency from SOD dated 05/16/2024.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 47047 Based on interview and record review the facility failed to ensure 1 of 5 nursing assistant certified (NAC) (Staff M) failed to receive the required dementia care, abuse and neglect, communication and quality assurance performance improvement (QAPI) training's and 12-hour training. These failures to ensure NACs received required training placed residents at risk of less than competent care and services from staff. Findings included . Staff M was hired 12/02/2022. In a review of Staff M's training record showed: -A signed statement of understanding for Abuse /Neglect Policy and Procedures on 03/22/2024 -A signed document dated 02/22/2024 titled Mandated Reporter -A completed abuse and neglect quiz dated 02/22/2024. -A signed and completed test titled, Care of the Cognitively Impaired No other training documents were provided for Staff M. In an interview on 04/29/2025 at 10:34 AM Staff L, Business Office Manager stated the facility is not gathering information on 12 hours of education for agency NAC's. Staff L stated for in-house staff there is an online training system for staff to review and sign for the training's they complete. In an interview on 04/29/25 11:35 AM Staff V, Registered Nurse/Infection Preventionist/Staff Development stated they complete competencies for the staff through completion of a checklist and testing. Staff V stated they were not a part of tracking the training for the NAC's. Staff V stated they were completing skill checklists and teach backs. In an interview on 04/29/2025 at 01:16 PM Staff A stated NACs obtain their 12 hours of training through the healthcare academy. Staff A stated Staff L keeps track of the staff trainings. This is a repeat deficiency from SOD dated 05/16/2024. Reference WAC 388-97-1680(2)(a-c)