STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505123	A. Building B. Wing	07/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgeview Care	2701 Clare Avenue Bremerton, WA 98310

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to inform the resident and/or their legal representative, in advance, of the risks and benefits associated with the use of antipsychotic medications (medications capable of affecting the mind, emotions, and behavior) and obtain informed consent prior to administering the medication(s) for 1 of 5 residents (Resident 87) reviewed for unnecessary medications. These failures precluded residents and/or legal representatives from making informed decisions regarding proposed psychotropic medication and prevented them from exercising their right to refuse/decline the proposed medication. Findings included . Resident 87 admitted to the facility on [DATE]. Review of the Admission Minimum Data Set (MDS, an assessment tool), dated 06/12/2024, showed the resident had severe cognitive impairment, no mental health diagnoses and received no psychotropic medications. Review of the electronic health record showed Resident 87 had a 06/18/2024 order to start risperidone (an antipsychotic) once a daily, for dementia with behaviors. A Psychopharmacologic Medication Informed Consent form showed the risks versus benefits related to the use of risperidone were explained, and informed consent obtained on 06/20/2024. The June 2024 Medication Administration Record (MAR) showed facility nurses administered risperidone to Resident 87 on both 06/18/2024 and 06/19/2024, prior to obtaining the resident's and/or the resident's representative's consent for its use. On 09/13/2024 at 9:29 AM, Staff B, Director of Nursing, said when a new order is obtained for a psychotropic medication facility staff needed to explain the risks and benefits associated with the proposed medication, and obtain their informed consent prior to implementing the order and administering the medication. When asked if there was any documentation to show that occurred with Resident 87's 06/18/2024 risperidone order, Staff B stated, No and acknowledged facility nurses had administered two doses of risperidone prior to obtaining informed consent for its use. Reference WAC 388-97-0260

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

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

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 37044 Based on observation, interview and record review, the facility failed to ensure the survey results book included the results for 9 of 10 abbreviated (complaint) surveys that resulted in citations since the facility's previous recertification (annual) survey. These failures prevented residents, family members and visitors from exercising their right to review past survey results and the facility's plans of correction to evaluate the quality of care provided by the facility. Findings included . On 07/09/2024 at 11:01 AM, the facility's survey results binder was observed in a wall mounted receptacle, across from the reception desk in the front lobby. Review of the survey binder showed it did not contain 9 of 10 complaint surveys that resulted in citations, since the facility's previous annual survey, conducted on 09/08/2023. The missing surveys results, and associated plans of corrections were for the following survey dates: 09/27/2023; 11/17/2023; 12/06/2023; 12/14/2023; 01/04/2024; 01/25/2024; 04/05/2024; 04/09/2024; and 05/07/2024. On 07/09/2024 at 11:39 AM, Staff B, Director of Nursing, confirmed the above referenced surveys results were not furnished in the facility's survey binder, and readily available for review by residents, family and visitors. Reference WAC 388-97-0480(1)(b)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 37044 Based on interview and record review the facility failed to ensure grievances were initiated, logged, investigated, and or promptly resolved/responded to for 6 of 12 residents (Residents 10, 29, 33, 37, 46, and 54) reviewed for Resident Council and grievances. This failure placed residents at risk for feelings of frustration, powerlessness, and decreased quality of life. Findings included . <Resident 33> Resident Council meeting minutes, dated 02/29/2024, showed Resident 33 had stated there were not enough linens. The February grievance log showed no entry for Resident 33. On 07/13/2024 at 10:48 AM, when asked if anyone had responded to the grievance regarding the lack of linens, Resident 33 said, no, I didn't hear back about it. <Resident 10> Grievance log, dated 06/06/2024, showed an entry regarding Resident 10 losing two items. On 07/08/2024 at 3:03 PM, when asked if the facility responded to resident concerns, or if the Grievance Official provided a rationale for the response, Resident 10 said, I filed a grievance because staff called me a liar and I never heard back. On 07/11/2024 at 9:41 AM, Resident 10 produced a copy of a grievance, dated 03/28/2024. The March Grievance log showed no entry for this grievance. On 07/11/2024 at 10:14 AM, when asked if they had helped Resident 10 fill out a grievance form in March, Staff F, Restorative Aide said they had. On 07/13/2024 at 8:49 AM, when asked if they had a response to their grievance regarding missing items, Resident 10 said they had never heard anything back. <Resident 29> Resident Council meeting minutes, dated 04/17/2024, showed Resident 29 reported they were missing two blankets. The April grievance log showed no entry regarding Resident 29's missing blankets. On 07/12/2024 at 9:06 AM, when asked if they had received a response from anyone regarding missing blankets, Resident 29 said they reported it in resident council meeting and staff said they were going to check on it and that was all they heard. Resident 29 said the lack of response made them feel 'useless and they would have expected to have heard something back by then. <Resident 54> (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident Council meeting minutes, dated 05/16/2024, showed Resident 54 reported they were missing blankets. The May grievance log showed no entry regarding Resident 54's missing blankets. <Resident 46> Resident Council minutes, dated 04/17/2024, showed that Resident 46 had said the call lights were not being answered quickly and they thought it was a staffing issue. Resident Council meeting minutes, dated 05/16/2024, showed Resident 46 reported they never received a response for submitted grievances and said they never receive the grievances back with the resolution. The May grievance log showed no entry regarding Resident 46's complaint. On 07/10/2024 at 3:52 PM, Staff A, Administrator said the Stop Loss Forms (forms that were filled out when items went missing) should have been added to the grievances. On 07/12/2024 at 12:08 PM, Staff E, Activities Director, when asked what her process was when complaints came in during Resident Council meetings, said she typed up all the notes and then wrote the grievances. On 07/13/2024 at 10:58 AM, when asked if they get responses to grievances filed, Resident 46 said, never, I have filed quite a few grievances, and I got no response. When asked what type of grievances the facility did not respond to, Resident 46 said, shortness of staff. <Resident 37> On 07/07/2024 2:54 PM, Resident 37 said there was a gray-haired lady who wandered around the facility with her wheelchair and frequently entered their room. Resident 37 said a couple of days prior the resident wandered into their room, so she asked her to leave, but instead she reached up and grabbed Resident 37's sandwich and milk off their tray. Resident 37 stated, I told her to put it back and she mouthed 'FU' to me. I reported it to the nurse and filled out the paper (grievance). Resident 37's roommate interjected that the wandering lady was harmless and usually left when asked, but that time she grabbed stuff, so (Resident 37) filled out the paper (grievance.) Review of the facility's grievance and incident logs showed there were no entries related to Resident 37's reported concern/incident. On 07/11/2024 at 10:53 AM, Staff D, Resident Care Manager, said to their knowledge, Resident 37 had not reported any concerns or filed grievance. Review of Resident 37's electronic health record showed a 07/06/2024 nurses note that documented, Resident and daughter reported another resident on the unit wandering into room and grabbing food from tray on 7/5. Resident informed she did not report this incident immediately after happening. Provided resident with a grievance form to fill out. On 07/12/2024 at 12:01 PM, Staff D, Resident Care Manager, said Resident 37's grievance form never made it to them, but since staff was aware of the report, they should have followed up and ensured the grievance was filed and addressed. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:16 PM, Staff E, Activities Director, said the expectation was that a resident would be given an explanation once a solution had been found. At 12:32 PM, when asked how residents were informed of resolution, or lack of ability to resolve grievances, Staff A, Administrator, said, I or the department head would have a one-on-one with the resident. Reference WAC 0920(1-6); 0460 (1)(2)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 42960 Based on interview and record review, the facility failed to report to State Agency (SA) and investigate allegations of abuse for 2 of 4 sampled residents (Residents 20 & 60) reviewed for abuse. This failure placed residents at risk for further abuse violations and lack of protection. Findings included . Record review of the facility's policy titled, Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property; undated, showed the facility was to ensure all alleged violations were reported immediately, but no later than two hours after the allegation was made, if the events that cause the allegation involve abuse or results in serious bodily injury, or no later that 24 hours if the events that cause the allegation do not involve abuse or did not result in serious bodily injury, to the Administrator and others. The policy showed the facility needed to ensure the immediate safety of the resident upon, suspend the identified employee immediately and pending outcome of investigation. <Resident 60> Record review of the facility's incident log showed an entry for Resident 60, listed on 07/02/2024, as the date logged and on 06/29/2024 as date of occurrence. The facility's incident log stated it was reported to the hotline on 07/01/2024 at 10:30 AM. The facility's investigation dated 07/01/2024 described the incident as occurring on 06/29/2024 as a Verbal Resident to Resident Altercation. On 07/11/2024 at 2:21 PM Staff B, Director of Nursing Services, said the incident occurred on Saturday and was not reported until Monday and her expectation was for staff to report it to the state on Saturday when it occurred. 50392 <Resident 20> Resident 20 was admitted to facility 03/12/2021. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 05/10/2024, indicated Resident 20 was moderately cognitively impaired. On 07/08/2024 at 10:41 AM, Resident 20 reported that Staff L, Restorative Aide, had patted her on the arm and it was painful. Resident 20 demonstrated by patting her own arm to indicate what happened. Resident 20 reported they asked Staff L to stop due to pain, but Staff L continued to pat her arm. On 07/09/2024 at 4:03 PM, Staff A, Administrator was informed of allegation of abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/12/2024 at 10:08 AM, Staff A said she had filled out a grievance form regarding Resident 20's allegations but had not pulled Staff L off the floor, stating, it was only one incident. Staff A acknowledged the allegation was not reported to the SA. At 11:03 AM, when asked when an allegation of abuse or neglect was made what was their process, Staff A said, ensure safety of resident, suspend the employee, investigate and print paperwork, and call it in to the State Agency within two hours. Staff A said the allegation had since been reported to the SA and Staff L had been suspended. No further documentation was provided regarding the allegation of abuse. Reference WAC 388-97-0640(5)(a)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on interview and record review, the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR) Level II evaluations were referred and or completed timely for 2 of 6 residents (37, 9) reviewed for PASRRs. This failure placed residents at risk for inappropriate placement, and not receiving timely and necessary mental health services. Review of 42 CFR 483.106(b)(2)(ii) showed an individual who entered a nursing facility (NF) as an exception (an exempted hospital discharge), but later was found to require more than 30 days of NF care, the facility must refer the resident for a Level II PASRR evaluation, and the State mental health or intellectual disability authority must conduct the evaluation within 40 calendar days of admission. Findings included . <Resident 37> Resident 37 admitted to the facility on [DATE]. Review of the 06/03/2024 Admission Minimum Data Set (MDS, an assessment tool) showed the resident was cognitively intact, had a diagnosis of depressive disorder and required the use of antianxiety medication during the assessment period. A Level I PASRR, dated 05/01/2024, showed Resident 37 admitted to the facility as an exempted hospital discharge, thus, a Level II PASRR evaluation was not required prior to admission. Resident 37 remained inpatient at the facility as of 07/12/2024, well beyond the 30 days or less of nursing home care the physician had projected. Review of the electronic health record showed Resident 37 was not reassessed and referred for a Level II until 07/03/2024, 61 days after admission. As of 07/12/2024 (70 days after admission) the Level II PASRR evaluation still had not been completed. On 07/12/2024 at 12:41 PM, when asked if there was any documentation to show Resident 37 was referred for a Level II PASRR evaluation when staff became aware they were not going to discharge in 30 days or less as scheduled, Staff X, Social Service Assistant, stated, no, not until I completed a new Level I PASRR on 07/03/2024, which assessed they required a Level II PASRR evaluation, the referral was made at that time. <Resident 9> Resident 9 was admitted to the facility on [DATE] with a diagnosis of paranoid personality disorder (mental health disorder marked by a long-term pattern of distrust and suspicion of others) and suicidal ideations (thoughts about or a preoccupation with killing oneself). The Quarterly MDS, dated [DATE], indicated the resident was moderately cognitively impaired. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 9's medical record showed a PASRR Level I (screening tool to determine if a resident requires further evaluation for serious mental illness or intellectual disability) was completed by the facility on 02/27/2020 and a Level II evaluation referral required for significant change. A review of Resident 9's medical record did not show a Level II evaluation. On 07/10/2024 at 10:09 AM, Staff Q, Social Services Director, said Resident 9 should have had a level II referral and, I don't see it in the chart. On 07/11/2024 at 2:06 PM, Staff B, Director of Nursing Services, said Resident 9's 2020 PASRR said a Level II referral was required and there was not a Level II evaluation in the chart. Reference WAC 388-97-1915

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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** 37044 Based on interview and record review, the facility failed to ensure resident care plans were reviewed, revised, and accurately reflected resident care needs for 4 of 31 sampled residents (Residents 37, 87, 27 and 48) whose care plans were reviewed. These failures placed residents at risk for unidentified/ unmet care needs and a diminished quality of life. Findings included . <Resident 37> Resident 37 readmitted to the facility on [DATE]. Review of the Admission Minimum Data Set (MDS, an assessment tool), dated 06/08/2024, showed the resident was cognitively intact, had obvious or likely cavities and/or broken natural teeth, received supplemental oxygen and required the use of a bilevel positive airway pressure (BiPAP a device that helps with breathing by providing non-invasive mechanical ventilation.) Review of the 06/10/2024 dental care area assessment (CAA) showed, Resident 37's obvious/likely cavities and broken natural teeth would be addressed in their comprehensive care plan (CP). Review of Resident 37's comprehensive CP showed a dental CP had not been initiated. On 07/13/2024 at 8:40 AM, Staff B, Director of Nursing (DNS), said facility staff should have developed and implemented a dental CP to address Resident 37's poor dentition, but failed to do so. Review of the July 2024 Medication Administration Record (MAR) showed an order for midodrine (a medication used to elevate blood pressure) three times a day for hypotension (low blood pressure), hold if the systolic blood pressure (SBP) is greater than 140. Review of the comprehensive CP showed Resident 37's hypotension and use of midodrine were not identified or addressed. On 07/13/2024 at 8:44 AM, Staff B, DNS, said facility staff should have developed a CP to address the resident's hypotension, use of midodrine and their associated risks, but failed to do so. Review of a therapeutic nutritional risk CP, revised 06/13/2024, showed a goal of Other: (SPECIFY). On 07/13/2024 at 8:46 AM, Staff B, DNS, said all CP must have measurable resident specific goals, and acknowledged Resident 37's did not. A fluid volume overload CP, revised 06/13/2024, provided contradictory instruction, directing staff to monitor weight weekly and to monitor weight monthly. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/13/2024 at 10:17 AM, Staff B, DNS, said Resident 37's weight frequency needed to be clarified, and then the care plan would be revised/updated to reflect the residents current ordered weight frequency. <Resident 87> Resident 87 admitted to the facility on [DATE], Review of the 06/12/2024 Admission MDS showed the resident had severe cognitive impairment, minimal difficulty hearing with hearing aids and impaired vision without corrective lenses. Review of the associated Communication and Vision CAAs showed the facility would Proceed to CP. Review of the comprehensive CP showed facility staff failed to develop a communication or vision CP for Resident 87. On 07/13/2024 at 9:25 AM, Staff B, DNS, said facility staff should have developed and implemented communication and vision CP, but failed to do so. A level I pre-admission assessment and resident review (PASRR) CP, dated 07/03/2024, had a goal of PASRR recommendations will be implemented and followed as appropriate. Review of the electronic health record (EHR) showed Resident 87 did have a level II PASRR evaluation, thus, there would not be any PASRR recommendations to follow or implement. On 07/13/2024 at 9:06 AM, Staff B, DNS, said the identified goal was inappropriate for this resident, and needed to be revised. 50392 <Resident 48> Resident 48 admitted to the facility 08/23/2023. The Quarterly MDS, dated [DATE], indicated Resident 48 was cognitively intact and was not using oxygen. On 07/09/2024 at 12:30 PM, Resident 48 was observed to be on oxygen via nasal cannula. On 07/10/2024 at 10:24 AM, Staff M, Registered Nurse, said Resident 48 was on 1.5 liters per minute of oxygen. The respiratory CP, dated 07/08/2024, did not document oxygen use. On 07/10/2024 at 10:36 AM, Staff B, Director of Nursing Services, said when a resident was placed on oxygen the Resident Care Manager (RCM) should be notified so they can put it on the CP. On 07/12/2024 at 2:24 PM, Staff K, RCM, said if a resident was using oxygen, it would be expected to have an order and be on the CP. Staff K said CPs should be updated for changes in orders, and resident personal preference. When asked who can update the CP, Staff K said RCMs and floor staff. 50488 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 27> Resident 27 admitted to the facility on [DATE] with diagnosis including hemiplegia (paralysis) and hemiparesis (weakness) to the right side of the body due to stroke (damage to the brain due to loss of blood flow), and an open wound. The Admission Minimum Data Set (MDS), an assessment tool, dated 05/19/2024, indicated resident was bed bound, needed extensive assistance for Activities of Daily Living and was moderately cognitively impaired. On 07/08/2024 at 11:42 AM, Resident 27 stated, Some of the staff are good about sitting with me and taking their time to feed me. Sometimes they just set my tray down and walk away. The table is always out of reach. My husband has come in around lunch time and my full breakfast tray is still sitting there. CP initiated on 05/10/2022 stated, needs supervision for meals and a revision on 05/13/2024 noted resident had a mechanical altered diet, therapeutic diet with thickened liquids. On 07/09/2024 at 09:44 AM, Staff U, Speech Therapist, said resident needed an altered diet when she first admitted due to weakness. She changed her to a regular diet with thin liquids on 05/28/2024 and said the CP should have been updated. When asked how the resident ate due to physical limitations, she stated, always a 1:1 feed. The expectation is for the resident to be fed by staff or their husband. On 07/11/2024 at 09:16 AM, Staff V, Licensed Practical Nurse, was asked how an aide would know how to assist a resident with meals. She said nurses would look at the CP and aides would look at the Kardex which was created and updated by the CP. When asked if Resident 27's CP was accurate for meal assistance, she stated, No, it's not. The resident needs to be fed if her husband isn't here. At 9:22 AM, Staff W, CNA, was asked how she would know what level of assistance to provide a resident for meals. She said she would look at the Kardex. When asked what she would do for Resident 27 according to the CP, she stated, it says supervision so I would take the tray in, open things up, and make sure the tray was within reach. At 10:12 AM, Staff D stated, 1:1 feeding should be on the care plan as well as have specific instructions for each resident. Reference WAC 388-97-1020(2)(c)(d)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of practice for 4 of 31 sampled residents (Residents 87, 37, 13, and 27) reviewed for medication management. The failure to follow, obtain, and/or clarify incomplete physicians' orders when indicated, to sign for medication(s) that were administered, to document the reason and notify the provider when medications were held, placed residents at risk for medication errors, adverse side effects, delayed review of their medication regimen and unmet care needs. Findings included . <Resident 87> Resident 87 admitted to the facility on [DATE] with an order for oxycodone (pain medication) every six hours as needed for moderate to severe pain of 4-10 on a scale of 1 to 10. The July 2024 Medication Administration Record (MAR) showed facility staff administered the oxycodone outside of the physician ordered parameters on the following occasions: 07/07/2024 at 9:14 PM for a pain level of 2; 07/11/2024 at 11:12 AM for a pain level of 3; and 07/11/2024 at 5:27 PM for a pain level of 3. On 07/12/2024 at 1:13 PM, Staff D, Resident Care Manager (RCM), said on the above referenced occasions facility nurses administered Resident 87 oxycodone outside of the physician ordered parameters. <Resident 37> <Leg compression> Resident 37 readmitted to the facility on [DATE] with orders to apply ace wraps to both lower extremities (LEs) daily, on in the AM and off at bedtime. On 07/07/2024 at 3:06 PM, Resident 37 indicated they went to see their heart doctor a week or two prior because their LEs were constantly swollen, and the doctor ordered compression wraps to be applied to both lower extremities in the morning and removed at bedtime. When asked why the compression wraps were not in place, Resident 37 said the nurses applied them a couple of times but couldn't find them the past few days. On 07/09/2024 at 1:41 PM, Resident 37 was lying in bed with LEs exposed. Tubi-Grip (tubular gauze) had been applied to both LEs. Resident 37 indicated the facility nurse was using the tubular gauze for compression while awaiting new compression wraps to come in. (continued on next page)

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	505123	A. Building B. Wing	07/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgeview Care	2701 Clare Avenue Bremerton, WA 98310

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the electronic health record (EHR) showed no order had been obtained to apply tubular gauze to the resident's LEs in lieu of compression wraps. Additionally, the July 2024 MAR showed facility nurses had signed daily that they applied and removed Resident 37's LE compression wraps daily as ordered. On 07/12/2024 at 1:52 PM, accompanied by Staff D, RCM, Resident 37 was observed in bed with compression wraps in place to both lower extremities. The resident held up the tubular gauze and stated, todays the first day they put them on, they were using these. The compression wraps were observed in place from just above the ankle and ended just below the knee. This caused a marked increase in pedal edema due to the compression wraps not starting at the toes. On 07/12/2024 at 2:01 PM, Staff D, RCM, confirmed facility nurses had been signing for a treatment (compression wraps) they had not performed, and were applying a different treatment without an order. Staff D said facility nurses should have notified the physician the ordered treatment was not available and obtained a temporary treatment order until supplies for the initial treatment arrived but failed to do so. <Oxygen> Resident 37 had a 06/25/2024 order for continuous oxygen via nasal canula at three liters per minute, to keep oxygen (O2) saturation at 89%. On 07/07/2024 at 3:09 PM, Resident 37 was observed in bed receiving O2 via an open oxygen face mask at three liters per minute. On 07/09/2024 at 1:41 PM, Resident 37 was lying in bed receiving O2 at three liters per minute via an open oxygen face mask. On 07/12/2024 at 1:32 PM, when asked if Resident 37 was to receive supplemental O2 via nasal canula or an open oxygen mask Staff D, RCM, said the resident liked to use both. When asked what was ordered Staff D said a nasal canula was ordered. Staff D then acknowledged facility nurses had signed daily that O2 was administered via nasal canula as ordered which was incorrect and nurses administered O2 via open face mask without an order to do so. Staff D said nursing should have obtained an order for the open face mask when Resident 37 requested one and should not have signed that they administered O2 via nasal canula as ordered. <Resident 13> Resident 13 admitted to the facility on [DATE] with an order for furosemide (a diuretic) every Monday, Wednesday and Friday, with direction to hold the medication for a systolic blood pressure (SBP) less than 100 or Pulse (P) less than 60. The June 2024 MAR showed on 06/24/2024 Resident 13 had a pulse of 56, but the nurse administered the furosemide, rather than holding the medication as ordered. Resident 13 had a 06/10/2024 order for losartan (blood pressure medication) every morning, with direction to hold the medication for a SBP less than 100 or P less than 60. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The June 2024 MAR showed on 06/24/2024 Resident 13 had a pulse of 56, but the nurse administered the losartan, rather than holding the medication as ordered. Resident 13 had a 06/10/2024 order for metoprolol (a blood pressure medication) twice daily, with direction to hold the medication for a SBP less than 100 or P less than 60. The June 2024 MAR showed on the following dates the evening dose of metoprolol was administered outside of the physician ordered parameters: 06/13/2024- P=58; 06/15/2024- P=52; 06/16/2024- P=58; 06/18/2024- P=54; 06/20/2024- P= 53; and 06/24/2024- P=56 On 03/12/2024 at 1:41 PM, Staff D, Resident Care Manager, said on the above referenced occasions facility nurses should have held Resident 13's furosemide, losartan and metoprolol as ordered, but failed to do so. 50488 <Resident 27> Resident 27 admitted to the facility on [DATE] with diagnosis including Hemiplegia (paralysis) and Hemiparesis (weakness) to the right side of the body due to Stroke (damage to the brain due to loss of blood flow), and an open wound. The Admission Minimin Data Set (MDS), an assessment tool, dated 05/19/2024, indicated resident was bed bound, needed extensive assistance for Activities of Daily Living and was moderately cognitively impaired. On 07/09/2024 resident said they their genital area was sore and very itchy. Resident 27 stated, the aides had been putting a powder on me. It was getting worse, so I asked [Staff Y, Certified Nursing Assistant], to show me what powder they were using. It had miconazole (anti-fungal) in it, and I am allergic. At 1:41 PM, Resident 27's pelvic area was observed to have a reddened rash with and opened area along the abdominal crease. At 1:48 PM, Staff B, Director of Nursing, said miconazole was a medication that should only be applied by a licensed nurse or medication technician, should not be applied without an order, and should not be applied to anyone who was allergic. The medication administration record showed no orders for miconazole had been obtained. The resident's list of allergies, dated 05/10/2024, included miconazole. Reference WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to develop and implement a discharge planning process that ensured required medical equipment was ordered, available at the time discharge, and documented in residents' discharge plans for 3 of 4 residents (Residents 144, 145 and 146) reviewed for discharge planning. These failures placed residents at risk for accidents, injuries, rehospitalization , and diminished quality of life. Findings included . Review of the facility's Resident's Discharge policy, revised 05/18/2023, showed the facility would complete a discharge summary for each resident before discharge which would include: A recapitulation of the resident's stay; a final summary of the resident's status, including the most recent nursing assessment; and a post-discharge plan of care which would assist the resident to adjust to his/her new living environment. Social services would assist with the development and coordination of services required to affect the resident's discharge. In the case of a Medicaid resident, social services would coordinate the discharge plan with the resident's Department of Social and Health Service's Home and Community services staff (DSHS case manager). On 06/28/2024 the state agency received an anonymous complaint that alleged Residents 144, 145, and 146, were discharged without the durable medical equipment (DME) they were assessed to require for a safe transition to the community, which included shower chairs/benches. On 07/10/2024 at 12:43 PM, Staff Q, Social Services Director (SSD), explained that social services was responsible for ordering the necessary DME for residents prior to discharge. Staff Q indicated the decision for what DME was needed was obtained from discharge planning meetings, nursing, therapy staff, and if the resident was on Medicaid and in coordination with the the state DSHS case manager. Staff Q said each resident's DME needs, and any home health referrals would also be documented on their discharge paperwork. When asked if Residents 144, 145 or 146 had a case manager, Staff Q said they did and provided the contact information. On 07/13/2023 at 6:41 AM, DSHS caseworker, was contacted and was requested to provide any pertinent communications with the facility related to the discharges of Residents 144, 145 and 146, and any DME they were to have at the time of discharge. <Resident 144> Resident 144 admitted to the facility on [DATE]. Review of the 04/12/2024 Discharge Minimum Data Set (MDS, an assessment tool), showed the resident had a planned discharge to the community on 04/12/2024. At that time Resident 144 required cues and touching/steadying assistance to get in out of the shower and had been referred to a local contact agency (LCA). A Resident Discharge Summary/Instructions, dated 04/10/2024, showed Resident 144 was referred to DSHS Home and Community Services and required a bariatric (larger) raised toilet seat and shower bench upon discharge. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the email communications from the Case Manager to Staff Q, pertaining to Resident 144's discharge, showed the following: - An email, dated 04/09/2024, showed a request for an update on the prescriptions and read, Any update on the RX she was needing for medical equipment? - An email, dated 04/22/2024 (after discharge), read, checking in on the prescription for [Resident 144's] shower chair and raised toilet seat. Any updates? <Resident 145> Resident 145 admitted to the facility on [DATE]. Review of the 05/16/2024 Discharge MDS, the resident had a planned discharge to the community on 05/16/2024. A Resident Discharge Summary/Instructions, dated 5/16/2024, showed Resident 145 was referred to DSHS Home and Community Services and required a four wheeled walker upon discharge. No shower chair or bench was identified. Review of the email communications between from the Case Manager to Staff Q, pertaining to Resident 145's discharge, showed the following: - An email dated, 04/09/2024 (prior to discharge), showed Resident 145 would need some medical equipment for the bathroom like grab bars, bath bench, and raised toilet seat. Would someone be able to coordinate getting a RX [prescription] for these items to me? - An email dated, 05/16/2024 (day of discharge), showed Resident 146 still needed a shower chair and requested a prescription so it could be ordered. <Resident 146> Resident 146 admitted to the facility on [DATE]. Review of the 06/14/2024 Discharge MDS showed the resident had a planned discharge to the community on 06/14/2024. At the time of discharge, Resident 146 required cues and touching/steadying assistance to get in and out of the shower. A Resident Discharge Summary/Instructions, dated 06/14/2024, showed Resident 145 was referred to DSHS Home and Community Services and required a four wheeled walker upon discharge had been ordered. Review of the email communications between the Case Manager and Staff Q, pertaining to Resident 146's discharge, showed the following: - An email dated, 06/05/2024 (before discharge), read, [Resident 146] might need a walker and shower chair upon discharge. Can I get a prescription for the shower chair. - An email dated, 06/13/2024 (before discharge), read, can I get a prescription for a shower chair or will you [Staff Q] be ordering all the DME. - An email, dated 06/13/2024, from Staff Q, SSD to the Case Manager, showed that Staff Q was going to get the prescription for the shower chair. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/16/2024 at 4:38 PM, DSHS Case Manager for Residents 144, 145 and 146, explained that each resident was supposed to be discharged home with a shower chair or bench, but they were never provided the chairs or a prescription to get one. The Case Manager said Residents 144 and 145 had subsequently, through community resources, managed to obtain shower chairs on their own, but Resident 146 was still in need. During a call with Staff A, Administrator, Staff B, Director of Nursing, and Staff Q, SSD, on 07/17/2024 at 11:00 AM, Staff Q acknowledged they were aware before discharge that a prescription for a shower chair was requested for Residents 144, 145 and 146, but indicated they did not know what a prescription for a shower chair meant and did not ask anyone and the prescriptions for the shower chairs were not obtained. WAC Reference 388-97-0080 (7)(c).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 50392 Based on observation and interview facility failed to provide assistance with Activities of Daily Living (ADL), related to grooming for 1 of 4 sampled residents (Resident 20). This failure placed residents at risk for, matted hair, feeling unclean, and diminished quality of life. Findings included . Resident 20 was admitted to facility 03/12/2021. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 05/10/2024, indicated Resident 20 was moderately cognitively impaired, impaired on one side of both upper and lower extremities, and required partial/moderate assistance with personal hygiene, which included combing hair. On 07/08/2024 at 10:54 AM, Resident 20 said their hair was in a solid matt in the back. Observation showed hair behind their head to be tangled and stuck together in clumps. Resident 20 said, it really bothers me to have clumps in the back of my head. It makes me feel less than. On 07/11/2024 at 2:44 PM, Resident 20 said they had told the Certified Nursing Assistant's (CNA) about 200 times about the matting issue every time they had their hair washed. Resident 20 said, I can't brush my hair because I can't hold my arm up. I only lay on my back because I cannot roll. They wash my hair, it is like sheep's wool with matting, this is one solid mass. At 2:54 PM, Staff N, CNA, entered Resident 20's room and was asked to look at Resident 20's hair, Staff N stated, oh wow, it is terrible, it is a mat. Staff N said the condition of Resident 20's hair was unacceptable. At 3:05 PM Staff H, Licensed Practical Nurse, Unit Manager, entered Resident 20's room and looked at the back of Resident 20's head. When asked how she would describe Resident 20's hair, she stated I would call it matted hair. When asked if it was acceptable she said that it was not acceptable. Reference WAC 388-97-1060 (2)(c)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on interview and record review, the facility failed to provide the necessary care and services to maintain residents' highest practicable level of well-being for 5 of 10 residents (Residents 9, 37, 87, 40 and 44) reviewed for bowel management, edema (fluid retention) management, monitoring of non pressure skin conditions and call lights within reach. The failure to initiate bowel care in accordance with physician's orders, address changes in bowel habits, monitor edema and non pressure skin conditions and to have resident call lights in reach for residents, placed residents at risk of being unable to reach staff in emergency situations, unmet care needs, medical complications and/or decreased quality of life. Findings included . <Resident 9> Resident 9 was admitted to the facility on [DATE] with a diagnoses including hypertension and muscle weakness. The Quarterly Minimum Data Set (MDS), an assessment tool, dated 05/03/2024, indicated the resident was moderately cognitively impaired and needed setup to moderate assistance with Activities of Daily Living (ADL). Resident 9's physician orders showed to give 30 milliliters of Milk of Magnesia Suspension (a laxative that is thought to work by drawing water into the intestines, an effect that helps to cause movement of the intestines) every 24 hours as needed for constipation at bedtime or at the resident's preferred time if there was not a bowel movement (BM) on the 3rd day. The Bowel Record for 06/09/2024 - 07/08/2024 documented Resident 9 did not have a BM on 06/22/2024, 06/23/2024, 06/24/2024 and 06/25/2024. A review of the Medication Administration Record for June 2024 documented the resident received Milk of Magnesia (MOM) suspension on 06/27/2024. On 07/11/2024 at 1:44 PM, Staff P, Licensed Practical Nurse (LPN) and Unit Manager (UM) said staff should have given a bowel medication on 06/25/2024. At 2:06 PM, Staff B, Director of Nursing Services (DNS), said Resident 9 went 4 days without a BM and the bowel protocol should have been initiated. 37044 <Edema Monitoring/Management> <Resident 87> Resident 87 admitted to the facility on [DATE]. Review of the 06/12/2024 Admission MDS, showed the resident had diagnoses including heart failure and required diuretic (medication that draws fluid from the body through urine) therapy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An edema care plan (CP), initiated 07/10/2024, directed staff to monitor, document and report to the provider any signs and symptoms of skin problems related to edema: redness, edema, blistering, itching, burning, bruises, cuts, other skin lesions. Resident 87 had 06/05/2024 orders for: a) Furosemide (a diuretic) daily, with direction to hold medication for a systolic blood pressure of less than 100. b) A 07/03/2034 order to monitor edema to bilateral lower extremities (BLE) every morning using edema scale: 1+ / slight indent disappears rapidly. 2+ / indent disappears in 10-15 seconds. 3+ / deep indent, disappears in 1-2 min. 4+ / deep indent, visible after 5 min. Notify provider if change in edema is noted. Review of the July 2024 Medication Administration Record (MAR) showed on 07/01/2024 the resident was assessed with 1+ edema to BLE. On 07/02/2024 and 07/03/2024, the resident was assessed with 3+ BLE, a marked increase from the 1+ edema present on 07/01/2024. Review of the electronic health record (EHR) showed no documentation or indication facility nurses notified the provider of the increased edema as ordered. On 07/13/2024 at 9:21 AM, Staff B, DNS, said the nurses that identified and documented Resident 87's increased BLE edema should have notified the provider as ordered. When asked if there was any documentation to support that occurred Staff B stated, not that I see. <Resident 37> Resident 37 readmitted to the facility on [DATE]. Review of the 06/06/2024 Admission MDS showed the resident was cognitively intact had diagnoses including heart failure and required diuretic therapy. An edema CP, revised 07/04/2024, directed staff to monitor, document and notify the provider of excessive edema and encouraged resident to elevate legs when sitting or sleeping. Review of Resident 37's physicians' orders showed: a) a 07/03/2024 order directing staff to monitor the residents BLE edema every morning using the following edema scale: 1+ / slight indent disappears rapidly. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2+ / indent disappears in 10-15 seconds. 3+ / deep indent, disappears in 1-2 min. 4+ / deep indent, visible after 5 min. Notify provider if change in edema is noted b) a 06/05/2024 order to apply ace wraps (compression wraps) every morning and remove at bedtime for edema management. On 07/07/2024 at 3:06 PM, Resident 37 said they were seen by their heart doctor 1-2 weeks prior due to increased edema in their LEs. The resident said their legs were supposed to be wrapped with ace wraps every morning and were to be removed at bedtime. When asked why the compression wraps were not in place, Resident 37 said the nurses applied them a couple of times but could not locate them. On 07/09/2024 at 1:41 PM, Resident 37 was lying in bed with LEs exposed. Tubi-Grip (tubular gauze) were observed applied to both LEs. Resident 37 indicated the facility nurse was using the tubular gauze for compression until new ace wraps arrived. Resident 37 said it had been five to six days since the ace wraps had been applied The July 2024 MAR showed on 07/04/2024 the resident was assessed with 1+ BLE edema. On 07/05/2024 and 07/06/2024 the resident was assessed with 2+ BLE edema. The July 2024 Treatment Administration Record (TAR) showed facility nurses failed to obtain an order for the Tubi-grip they were applying, and continued to sign daily, and erroneously, that the ace wraps (compression wraps) were applied as ordered. On 07/13/2024 at 9:21 AM, Staff B, DNS, said nurses were expected to only sign for tasks they completed and confirmed nurses signed for, but failed to provide Resident 87's LE compression wraps as ordered to manage their LE edema. <Non-Pressure Skin> Review of Resident 37's 06/06/2024 Admission MDS, showed the resident received anticoagulant therapy. On 07/07/2024 at 3:03 PM, large areas of purple bruising were observed to both Resident 37's arms above and below the elbow. Resident 37 indicated they recently went to the hospital and believed the bruising was from multiple blood draws. Review of the EHR showed no documentation was present to show the facility was assessing and monitoring the bruising. The bruising was not identified or and monitored with the weekly skin checks and or the TAR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/12/2024 at 2:08 PM, Staff D, Resident Care Manager (RCM), said the facility monitored bruises via the TAR and would either measure them weekly or would mark the edges of the bruises so they could identify if they were getting larger or not. When asked if there was any documentation to show Resident 37's bruises were identified and monitored, Staff D stated, no, I don't see any. 46751 <Resident 59> Resident 59 was admitted to the facility on [DATE] with multiple diagnoses. The MDS, dated [DATE], documented the resident was cognitively intact. The Bowel & Bladder Elimination task sheet documented Resident 59 had a BM on 6/15/2024 at 6:14 PM, and did not have another BM until 6/21/2024 at 1:16 PM, over 140 hours since his previous BM. The June 2024 MAR showed the bowel protocol was not initiated on 6/21/2024 at 5:17 PM (6 days after last BM). Resident 59 was administered MOM. On 07/11/2024 at 2:37 PM, Staff H, Unit Manager and Licensed Practical Nurse (LPN), said if a resident did not have a BM in three days, the bowel protocol was triggered and documentation would be on the MAR. Staff H stated, I expect my nurses to document. It should have been triggered on the 18th. Staff H was unable to produce additional documentation. On 7/12/2024 at 9:37 AM, Staff D, Unit Manager and Licensed Practical Nurse (LPN), said the bowel protocol triggered after three days of no BM. Staff D stated, he should have gotten milk of magnesia on the 18th. At 11:08 AM, Staff B said the BM protocol should have been triggered at day 3. Staff B was unable to provide further documentation of the BM protocol being initiated for resident 59. 50392 <Resident 40> On 07/08/2024 at 8:29 AM, Resident 40 was observed lying in bed, the call bell was not in sight. Staff G, CNA, was informed a call bell was not observed for Resident 40. Staff G then retrieved Resident 40's call bell from the floor, approximately five feet away. At 8:31 AM, Staff H said the expectation was all call bells were to be within reach of the resident and clipped to the sheets. <Resident 44> On 07/07/2024 at 11:47 AM, Resident 44 was seen lying in bed and their call bell was not visible. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgeview Care	2701 Clare Avenue Bremerton, WA 98310

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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 - Some	At 11:52 AM, Staff J, CNA, was stopped in the hallway and informed the call bell was not visible for Resident 44. Staff J entered Resident 44's room and located the call bell on the right side of the bed, wrapped around the bed railing and out of Resident 44's reach. When asked what the expectation for the location of a call bell was, Staff J said she would expect Resident 44's call bell to be in his bed, by his side. On 07/10/2024 at 8:42 AM, when asked what the expectation of call bell location was, Staff B, DNS said preferably within their reach, wherever that may be. When asked whose responsibility it was to ensure call bell location, Staff B said all staff. Reference WAC 388-97-1060 (1), (3)(c)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50488 Based on observation, interview, and record review, the facility failed to ensure Podiatry (the treatment of feet and their ailments) care and services were provided for 1 of 1 resident (Resident 27) reviewed for foot care. This failure placed the resident at risk for further skin impairment, discomfort, and a diminished quality of life. Findings included . The Personal Needs Policy, dated 12/20/2024, showed, facility must provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. Resident 27 admitted to the facility on [DATE] with diagnosis including hemiplegia (paralysis) and hemiparesis (weakness) to the right side of the body due to stroke (damage to the brain due to loss of blood flow), diabetes, and ulcer to the left heel. The Admission Minimum Data Set, an assessment tool, dated 05/19/2024, indicated Resident 20 was bed bound, needed extensive assistance for Activities of Daily Living (ADLs) and was moderately cognitively impaired. An admission assessment, dated 05/10/2024, showed Resident 27's toenails were thick, have a fungal like appearance. Diabetic foot checks and diabetic nail care were added to the Treatment Administration Record as weekly tasks for nursing. On 07/08/2024 at 11:04 AM, Resident 27 was observed to have long, uneven, thickened toenails. Resident 27 said no foot care had been provided, including toenail cutting, since being in the facility. Resident stated, I had a provider come to my home every month. Now my toenails are really bad. At 12:18 PM, Staff D, Unit Manager/Licensed Practical Nurse, stated, any nurse can provide diabetic foot care, including nail cutting. Part of the admit process is to look at the resident's feet and to let Social Services know if a referral to a podiatrist is needed. Social Services handles the appointments. On 07/09/2024 at 9:20 AM, Staff Q, Social Services Director, said Resident 27 had not been seen by the podiatrist during the last two visits, on 05/21/2024 and 06/26/2024. On 07/10/2024 at 2:25 PM, Resident 27's toenails were observed with Staff D present and Staff D said the resident should have been referred to a podiatrist. Staff D said, as a nurse, she would not feel comfortable cutting the nails because of the poor condition of the nails. Reference WAC 388-97-1060 (3)(j)(viii)

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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** 37044 Based on interview, and record review, the facility failed to timely identify, assess, develop and implement nutritional interventions, and evaluate the effectiveness of the interventions for 1 of 4 residents with weightloss (Resident 87) reviewed for nutrition. Additionally, the facility failed to have a system in place that ensured fluid intake was accurately monitored, documented, and 24-hour intake totals were calculated and evaluated for 1 of 1 resident (Resident 37) reviewed with a fluid restriction. These failures placed residents at risk for continued weight loss, inadequate nutrition, fluid volume overload, fluid and electrolyte imbalances and other medical complications. Findings included . <Weight Loss> Resident 87 admitted to the facility on [DATE]. Review of the Admission Minimum Data Set (MDS, an Assessment tool), dated 06/12/2024, showed the resident had no swallowing issues or significant weight loss. A potential nutritional risk care plan, revised 06/21/2024, with a goal of no significant weight loss, directed staff to explain the importance of the prescribed diet, the need for adequate nutritional intake, and to notify the physician of significant weight loss/gain. An activities of daily living care plan, revised 06/24/2024, informed staff Resident 87 was independent with eating. Review of Resident 87's weight record showed the following: 06/05/2024 admit weight - 138 06/10/2024 - 125.5 lbs., a weight loss of 7% in less than a week. 07/01/2024 - 121.5 lbs., a weight loss of 12.2% in less than 30 days. 07/08/2024 - 120 lbs., a weight loss of 13.4 in 33 days. A 06/13/2024 nurses note documented the resident had a significant weight loss of 7% in a week, but indicated staff would re-weigh Resident 87 to validate the weight loss. The weight record showed the re-weigh was performed on 06/14/2024 and was 125.5 lbs., confirming the weight loss. A 06/26/2024 nurses note identified a weight loss trend and indicated finger foods and a whole sandwich would be requested for meals. There was no documentation to show staff assessed the resident's percentage of meal intake, ability to feed self, added any dietary supplements, or referred the resident to the Registered Dietician (RD) Resident 87's weight on 07/01/2024 was 121.5 lbs., showing significant weight loss of 12.2% in less than 30 days. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 07/02/2024 nurses note documented, a dietary referral is required for the following reasons: Weight loss significant. A 07/03/2024 Nutrition Evaluation documented Resident 87 had a very significant weight loss since admission of greater than 12% which was not planned or desired. The RD observed Resident 87 in the dining room and felt the resident was unable to recognize what they were supposed to do with the items on their plate secondary to cognition. The RD recommended the resident be provided with two whole peanut butter and jelly (PB&J) sandwiches four times a day (with each meal and as a bedtime snack). On 07/08/2024 Resident 87 weighed 120 lbs., demonstrating a continued weight loss trend and a loss of 13. 3% in 33 days. Review of the electronic health record showed no documentation or indication the RD's recommendations had been carried out and implemented. Review of Resident 87's tray card showed no direction to dietary staff to provide two PB&J sandwiches with meals or at bedtime. On 07/13/2024 at 8:48 AM, when asked if the 07/03/2024 RD recommendations were carried out and implemented Staff B, Director of Nursing stated, no. <Fluid Restriction> Resident 37 readmitted to the facility on [DATE]. Review of the 06/03/2024 Admission MDS showed the resident had a diagnosis of heart failure and required diuretic (medication to draw extra fluid from the body through urine) therapy. An edema (fluid retention) related to heart failure care plan, revised 07/04/2024, directed staff to monitor and document edema and to elevate the resident's legs while sitting or sleeping. A fluid overload care plan, revised 06/13/2024, showed Resident 37 was on a 2000 milliliter per day (ml/day) fluid restriction, with nursing responsible for 560 ml/day and dietary 1440 ml/day. Review of the July 2024 Medication Administration Record (MAR) showed nurses documented the amount of fluid they provided the resident each shift. However, there was no instruction to staff to reconcile the resident's fluid intake from nurses with their fluid intake at meals so the residents 24 intake could be totaled. On 07/12/2024 at 2:01 PM, Staff D, Resident Care Manager, explained the purpose of Resident 37's fluid restriction was to prevent fluid volume overload and help with edema management. Staff D said staff recorded the amount of fluid the resident drank and calculated their 24-hour total. If the resident was non-adherent with the restriction, they were educated about the risks and benefits of their decision and the physician would be notified. When asked how staff would know if a resident was adherent with a fluid restriction, Staff D said staff calculate the residents 24 fluid intake. When asked if there was any documentation to show nurses had reconciled the resident's fluid intake recorded on the MAR, with their fluid intake recorded on the meal monitor to obtain their 24 hour total intake Staff D stated, no. Reference WAC 388-97-1060(3)(i)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to ensure respiratory care and services were provided in accordance with Physician's orders and accepted professional standards of practice for 2 of 3 residents (Residents 37 and 48) reviewed for respiratory care. The facility failure to ensure residents receiving oxygen (O2) services had active orders for O2, an indication for use, O2 concentrator filters (used to protect the resident from inhaling dust and particulate matter) were routinely cleaned and maintained, and/or was administered by the ordered delivery method and documented on residents' administration records. Additionally, the facility failed to ensure bilevel positive airway pressure orders (BiPAP, a form of non-invasive ventilation therapy used to facilitate breathing) included instruction on when to check, and what solution should be used to fill the BiPAP humidifier chambers. These failures placed residents at risk for unidentified and/or unnecessary oxygen use, respiratory compromise, dried nares and other negative health care outcomes. Findings included . <Resident 37> Resident 37 readmitted to the facility on [DATE]. Review of the 06/03/2024 Admission Minimum Data Set (MDS, an assessment tool), showed the resident was cognitively intact, had diagnoses of heart failure and chronic lung disease, and required use of a BiPAP and supplemental oxygen. On 07/07/2024 at 3:09 PM, Resident 37 was observed in bed receiving O2 via an open oxygen mask at three liters per minute (3L/min). No humidifier bottle was present. The O2 filter on the oxygen concentrator was covered with light gray stringy debris. A BiPAP machine was sitting on the resident's three drawer chest next to the bed. A 'O2 therapy related to heart failure and chronic lung disease' care plan, revised 06/13/2024, directed staff to monitor for shortness of breath or trouble breathing when lying flat and to provide O2 therapy as ordered. Review of Resident 37's physicians' orders showed the following oxygen administration and maintenance and monitoring orders: a) O2 at 3L/min via Nasal Cannula, continuously to keep O2 saturation (SpO2) at 89% for shortness of breath. b) Change, label and date O2 tubing every week. c) Change O2 filter every six months and/or per manufacturers' recommendations. d) Check SpO2 on room air (RA) monthly, in the morning starting on the 1st and ending on the 2nd of every month. Allow time for body to desaturate prior to testing. e) Check SpO2 every shift. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the July 2024 Medication and Treatment Administration Records (MARs/TARs) showed Resident 37's SpO2 was checked on RA on the following dates: 07/01/2024- SpO2= 98%; 07/02/2024- SpO2= 92%; and 07/06/2024- SpO2= 93%. Review of the O2 administration record showed despite Resident 37 maintaining a SpO2 greater than 89% on RA, facility nurses reapplied the resident's O2 at 3L/min without any indication for use. Review of the SpO2's recorded for July 2024 showed the lowest SpO2 documented was 90%. On 07/12/2024 1:13 PM, Staff D, Resident Care Manager (RCM), explained that the purpose of the order directing nurses to check residents' receiving O2 SpO2 on RA, was to determine if residents continued to need supplemental O2 therapy. If a resident could maintain their SpO2 within the physician ordered range on RA, then the nurse would contact the physician to see if the resident could be trialed on RA. When asked if there was any documentation to show that occurred for Resident 37 Staff D stated, no. At 1:32 PM, when asked if Resident 37 was to receive supplemental O2 via nasal cannula or an open face mask, Staff D, RCM, said the resident liked to use both. When asked what was ordered, Staff D acknowledged a nasal cannula was ordered and said nursing should have contacted the physician when Resident 37 requested to use an open face mask instead of a nasal cannula but failed to do so. At 1:43 PM, Staff D, RCM, reported that facility staff did not check or clean O2 concentrator filters, and explained filters were only cleaned by the vendor every six months. Staff D said Staff AA, Central Supply, had contacted the oxygen vendor and that was the vendors recommendation. Documentation of the vendors recommendation was requested at that time. At 2:57 PM, Staff AA provided O2 concentrator maintenance instructions obtained from the vendor. The instructions said to avoid damage to the internal components of the unit and that the concentrator should not be operated with a dirty filter. It instructed that the filter was located on the back of the concentrator and depending on environmental conditions, may require frequent inspection and cleaning. On 07/13/2024 at 9:11 AM, Staff B, Director of Nursing, said facility staff should have been routinely checking and cleaning residents' concentrator filters, but due to a miscommunication with the vendor, had not been. <BiPAP> On 07/10/2024 at 11:13 AM, Resident 37 was observed lying in bed receiving O2 via open mask at 3L/min. No humidifier bottle was present. The oxygen concentrator filter remained covered with light gray stringy debris. Resident 37 said they preferred their oxygen to be humidified but had not informed staff. Resident 37 then motioned to their BiPAP at bedside and indicated it was humidified. The resident then reported it (humidifier reservoir) was getting low. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A BiPAP related to sleep apnea care plan, revised 06/13/2024, had an identified goal that the resident would exhibit adequate oxygenation with the use of CPAP [continuous positive airway pressure]/BiPAP therapy as ordered. Staff were directed to apply CPAP/ BiPAP as ordered, monitor for signs and symptoms of respiratory distress, respirations, pulse oximetry, increased heart rate (tachycardia), restlessness, diaphoresis [excessive sweating], headaches, lethargy, confusion, atelectasis [diminished lung volume], hemoptysis [coughing up blood], cough, pleuritic pain [lung/rib pain], accessory muscle usage, skin color. Report findings and report to the physician as needed. Review of the BiPAP orders showed the following: a) BiPAP setting, see full settings in documents every night shift. b) Wash BiPAP mask and tubing daily with soap and water and let air dry daily. Resident 37's BiPAP orders did not identify what the BiPAP settings should be, instruct staff to apply it, identify if supplemental oxygen should be attached, direct staff to check the humidifier reservoir, or indicate what solution, if any, staff should fill the reservoir with. On 7/12/2024 at 1:43 PM, Staff D, RCM, said Resident 37's BiPAP orders were incomplete and should have included routine checks of the BiPAP humidifier reservoir and to only fill it with distilled water. Staff D, showed the residents BiPAP settings had been scanned into the electronic health record under documents. When asked how an agency nurse would know to look there for the order Staff D said the BiPAP settings should have been included in the order. 50392 <Resident 48> On 07/09/2024 at 12:30 PM, Resident 48 was observed to be receiving oxygen via nasal cannula. On 07/10/2024 at 10:18 AM, Staff M, Registered Nurse (RN), said Resident 48 was receiving 1.5 liters of oxygen per minute. Review of June and July 2024 MAR and TAR showed no entries regarding oxygen use. On 07/10/2024 at 10:36 AM, Staff B, Director of Nursing (DNS), said oxygen use required an order, notification to the doctor, and family notification if necessary. Staff D said the RCM should also be notified to update the care plan. When asked if it should be on the MAR if resident is using oxygen, Staff B said if a standing order was active, it should be on the MAR and the TAR. Reference WAC 1060 (3)(j)(vi) .

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50488 Based on observation, interview and record review, the facility failed to comprehensively assess the use of bedrails/side rails and obtain accurate and complete informed consent from the resident for the use of side rails for 1 of 5 residents (Resident 27) reviewed for accidents. This failure placed the resident at risk for lack of informed care and decreased quality of life. Findings included . The Safety Device policy, dated 09/2022, showed, the center requires the use of the Safety Device Data Collection, Assessment, and Information evaluation when mobility bars or bed rails were in place. Resident 27 admitted to the facility on [DATE] with diagnoses including hemiplegia (paralysis) and hemiparesis (weakness) to the right side of the body due to stroke (damage to the brain due to loss of blood flow), and open wound of right back wall. The Admission Minimum Data Set, an assessment tool, dated 05/19/2024, indicated the resident was bed bound, needed extensive assistance for Activities of Daily Living and was moderately cognitively impaired. On 07/08/2024 at 11:04 AM, Resident 27 was observed with mobility rails attached to the frame of the bed. The Safety Device Data Collection, Evaluation, and Information form, dated 05/13/2024, was not completed for side rails. The care plan did not include side rails. On 07/09/2024 at 3:06 PM, Staff D, Unit Manager/Licensed Practical Nurse, said side rails needed to be on the care plan, to have consent, and to have the safety form completed. Reference WAC 388-97-0230

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview, and record review, the facility failed to develop a dementia care plan that addressed the physical, mental and psychosocial needs of the resident, established personalized and achievable goals, and identified interventions to promote a person-centered environment for 1 of 2 residents (Resident 87) reviewed for dementia care. These failures placed residents at risk for unmet physical and psychosocial needs, increased behaviors and decreased quality of life. Findings included . Resident 87 admitted to the facility on [DATE]. Review of the Admission Minimum Data Set (MDS, an assessment tool), dated 06/12/2024, showed the resident had severe cognitive impairment, a diagnosis of non-Alzheimer's dementia, displayed signs of delirium to include continuous inattention, but demonstrated no behaviors or rejection of care, and received no psychotropic medications. The Cognitive Loss/Dementia Care Area Assessment (CAA) showed the resident had a diagnosis of non-Alzheimer's dementia, which affected their cognition, memory, ability to understand others, and to make self-understood. The CAA indicated Resident 87 resided in a memory care facility prior to hospitalization . They determined a cognitive loss/dementia care plan (CP) would be developed. Review of the 'impaired thought processes related to dementia' CP, revised 06/21/2024, showed a goal of maintaining current cognitive function and the ability to communicate basic needs and make safe decisions. The interventions developed to meet those goals included: Ask yes/no questions as appropriate to determine needs; Call resident by preferred name: Mom; Monitor/document /report to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. The CP did not include any resident specific information about how this residents dementia manifests itself such as, what types of situations/environment increase stress/anxiety or decrease it. Does the resident sundown, if so, what time of day, what does it look like (increased confusion/anxiety, pacing, aggressiveness etc.) and what activities or interventions have been successful in the past to to alleviate such behaviors when they present. On 07/07/2024 at 2:21 PM, Resident 87's daughter and son in law were present at bedside. They reported Resident 87 was in a locked memory care unit prior to hospitalization due to a fall. They explained that Resident 87 enjoyed walking and would frequently walk in circles around the memory care facility and noted that it seemed to increase in the early evenings due to the residents sundowning (a state of confusion that occurs in the late afternoon and lasts into the night, which can cause confusion, anxiety, and lead to pacing and wandering.) On 07/12/2024 at 1:47 PM, when asked if there was any documentation to support the facility interdisciplinary team incorporated input from the resident's family in developing a personalized dementia plan of care, with person-centered goals and interventions based upon a systematic assessment, Staff D, Resident Care Manager, stated, no. Reference WAC 388-97-1040 (1) (a-c)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to ensure 1 of 5 residents (Residents 87) reviewed for unnecessary medications, was free from unnecessary psychotropic drug use. The failure to have an adequate indication for use, approved diagnosis, and to identify individualized Target Behaviors (TBs) the medication was implemented to treat, placed residents at risk to receive unnecessary medications and/or experience adverse side effects Findings included . Resident 87 admitted to the facility on [DATE]. Review of the Admission Minimum Data Set (MDS, an assessment tool), dated 06/12/2024, showed the resident had severe cognitive impairment, a diagnosis of non-Alzheimer's dementia, displayed signs of delirium to include continuous inattention, but demonstrated no behaviors or rejection of care, and received no psychotropic medications. On 07/07/2024 at 2:21 PM, Resident 87's daughter and son in law were present at bedside. They reported Resident 87 was in a locked memory care unit prior to hospitalization due to a fall. They explained that Resident 87 enjoyed walking and would frequently walk in circles around the memory care facility and noted that it seemed to increase in the early evenings due to the residents sundowning (a state of confusion that occurs in the late afternoon and lasts into the night, which can cause confusion, anxiety, and lead to pacing and wandering.) Review of the electronic health record (EHR) showed on 06/18/2024, Resident 87 was started on risperidone (an antipsychotic medication) for dementia with behavior disturbances. A Psychopharmacologic Medication Informed Consent form, dated 06/20/2024, showed Resident 87 was started on risperidone an antipsychotic medication for dementia with behavior disturbances. Under potential benefits of the antipsychotic medication, staff checked reduced symptoms of psychosis: decreased hallucinations (seeing or hearing things that aren't really there, etc). Decreased delusions (extreme suspiciousness, fears not based on what is really happening, etc). Decreased aggression. Review of the EHR showed no documentation to support Resident 87 had experienced hallucination, delusions or demonstrated aggressive behavior towards other. On 07/12/2024 at 2:13 PM, when asked if there was any documentation to show Resident 87 had experienced hallucinations and delusions, when, what they were, and what effect, if any, they had on the resident, Staff D, stated, no and indicated they were unaware of Resident 87 experiencing hallucinations or delusions. A 'uses antipsychotic medications related to dementia' care plan (CP), initiated 06/23/2024, showed the antipsychotic medication was initiated to treat the following target behaviors (TBs): intrusively going into others' spaces; poor safety awareness; and placing self on the floor. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EHR showed no documentation or indication facility staff considered wandering was a normal and enjoyed activity of the resident or what Resident 87's prior routine was at their memory care facility related to sundowning and pacing/wandering due to sundowning. On 07/13/2024 at 9:19 AM, when asked if a diagnosis of dementia with behavioral disturbances was an appropriate diagnosis, and target behaviors of intrusively going into others' spaces (unsupervised wandering), poor safety awareness, and sitting on the floor were adequate indication for use of antipsychotic medication Staff B, Director of Nursing, stated, no. See also F744 Reference WAC 388-97-1060(3)(k)(i)

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	505123	A. Building B. Wing	07/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgeview Care	2701 Clare Avenue Bremerton, WA 98310

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37044 Based on observation and interview, the facility failed to ensure drugs and biologicals were labeled and dated when opened in accordance with accepted professional standards of practice, and expired medications were discarded for 3 of 3 medication carts (Olympic, Cove 1 and Cove 2) that were observed. These failures placed residents at risk to receive expired medications and negative health outcomes. Findings included . <Cove 2 Medication Cart> Observation of the Cove 2 medication cart on 07/12/2024 at 5:55 AM with Staff O, Registered Nurse (RN), revealed the following expired and/or undated medications: 1) A Lantus insulin pen for Resident 61, opened 05/28/2024. 2) A lispro insulin pen for Resident 61, was opened and undated. 3) A lispro insulin pen for Resident 27, was opened and undated. 4) A vial of lispro insulin for Resident 85, opened 05/30/2024. 5) A humolog insulin pen for Resident 6, opened 06/08/2024. 6) A lispro insulin pen for Resident 151, opened 06/04/2024. 7) A basaglar insulin pen for Resident 151, opened 06/04/2024. 8) A bottle of Vitamin E 180 mg with a best by date of 04/2024. 9) A bottle of multivitamins with a best by date of 03/2024. 10) A bottle of ferrous gluconate with a best by date of 05/2024. On 07/12/2024 at 6:55 AM, Staff O, RN, said unrefrigerated insulin pens were good for 28 days after opening. Staff O confirmed the seven insulin pens referenced above and three over the counter medications were either not dated when opened or had been opened for greater than 28 days and needed to be discarded. When asked if the three over the counter medication referenced above were past their best by dates, Staff O, RN, stated, yes. <Cove 1 Medication Cart> (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the Cove 1 medication cart on 07/12/2024 at 6:12 AM with Staff O, Registered Nurse, revealed the following expired and/or undated medication(s): 1) A basaglar insulin pen for Resident 148, opened 06/02/2024. On 07/12/2024 at 6:55 AM, Staff O, RN, confirmed Resident 148's basaglar insulin pen had been opened greater than 28 days and needed to be discarded. <Olympic Medication Cart> Observation of the Olympic medication cart on 07/12/2024 at 7:13 AM with Staff O, Registered Nurse, revealed the following expired and/or undated medications: 1) A bottle of Combigan eye drops and polymyxin eye drops were found in a plastic cup with no resident name or opened date on the bottles or cup. Per the manufacturer's instructions Combigan and polymyxin eye drops should be discarded four weeks after opening. 2) A bottle of brimonidine eye drops for Resident 5, opened 04/18/2024. The manufacturers' instructions state the brimonidine eye drops should be discarded four weeks after opening. 3) A lispro insulin pen for Resident 78, was opened and undated. On 07/12/2204 at 7:28 AM, Staff O, RN, confirmed the Combigan and polymyxin eye drops were opened, undated, and not labeled with a resident name. Staff O also confirmed facility staff failed to date Resident 5's brimonidine eye drops, and Resident 78's lispro insulin pen when opened, and indicated all the above referenced medications needed to be discarded. Reference WAC 388-97-1300(1)(b)(ii), (c)(ii-v), 1300 (2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46751 Based on observation and interview, the facility failed to ensure food items were labeled and dated when opened, in 1 of 2 Nourishment Refrigerators/Freezers (Bayshore Dining Room). This failure placed residents at risk for cross-contamination, food borne illness, and a diminished quality of life. Findings included . <Nourishment Refrigerator> On [DATE] at 10:38 AM, the Bayshore Dining Room Nourishment Refrigerator/Freezer was observed with the following undated, unlabeled, and opened items: 1. Tyson chicken tender bag 2. Foster Farm popcorn chicken bag 3. 4 ounce glass bottle of horseradish 4. 24 ounce glass bottle of salsa 5. 64 ounce plastic bottle of salsa 6. 24 ounce plastic bottle of Peppermint Califa creamer-with manufacturer expiration date of [DATE] 7. Plastic Tupperware container with beef and rice, labeled [DATE] 8. Slices of American cheese in the bottom drawer On [DATE] at 10:54 AM, Staff Z, Dietary Manager, said kitchen aids were to temp the nourishment fridges, check dates, and without a date or expired should be thrown out. Staff Z stated, they have to have it labeled and dated as soon as they put it in. We go by the expiration date on the bottle. On [DATE] at 11:06 AM, Staff B, Director of Nursing Services and Registered Nurse said she expected food in all the refrigerators and freezers to be dated and labeled. Staff B stated, it should be dated right away. Reference WAC [DATE] (3) & 2980

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. 37044 Based on interviews, the facility failed to employ a qualified social worker (defined as an individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field and one year of supervised social work experience in a health care setting working directly with individuals) on a full-time basis. This failure placed residents at risk for unmet psychosocial needs and a diminished quality of life. Findings included . On 07/09/2024 at 11:57 AM, when asked if they had a bachelor's degree, both Staff Q, Social Services Director, and Staff X, Social Services Assistant, stated, No. Refer to: F644 Coordination of PASRR and Assessments F758 Free from Unnecessary Psychotropic Medications Reference WAC 388-97-0960 (2)(a)(b)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 37044 Based on interview and record review, the facility failed to maintain a Quality Assessment and Assurance (QA&A) committee that met at least quarterly and included the Medical Director or his/her designee, to conduct required Quality Assurance and Performance Improvement (QAPI) and QA&A activities. This failure detracted from the effectiveness of the QA&A committee and placed residents at risk for quality deficiencies, adverse events, and diminished quality of life. Findings included . On 07/13/2024 at 1:09 PM, Staff A, Administrator, said the facility QA&A committee met monthly and the included the Director of Nursing, Administrator, Social Work, Resident Care Managers, Registered Dietician, all department heads and the Medical Director. When asked for a copy of the sign in sheets/attendance sheets to show the Medical Director had attended the meeting at least once in the past two quarters, Staff A, who had just recently started at the facility, indicated they did not know where they were located and would have to find them and then email them after exit. An email was received from Staff A on 07/16/2024 at 2:44 PM, with a document attached, titled QAPI Attendance for a 07/03/2024 QAPI meeting. The attendance sheet did not include the medical director. On 07/17/2024 at 11:00 AM, Staff A, Administrator, said in a telephone interview that they were unable to locate any QAPI attendance sheets in the past two quarters that showed the medical director was in attendance. Reference WAC 388-97-1760(1)(2)